

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet S Parts I-III Date/Time Prepared: 4/30/2014 11:18 am
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<b>PART I - COST REPORT STATUS</b>			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 4/30/2014 Time: 11:18 am	
	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.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by JOHN H. STROGER JR. HOSP OF COOK CTY ( 140124 ) for the cost reporting period beginning 12/01/2012 and ending 11/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) \_\_\_\_\_  
 Officer or Administrator of Provider(s)  
 \_\_\_\_\_  
 CHIEF FINANCIAL OFFICER  
 Title  
 \_\_\_\_\_  
 04/30/2014  
 Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00		
		Part A 2.00	Part B 3.00				
<b>PART III - SETTLEMENT SUMMARY</b>							
1.00	Hospital	0	1,427,048	219,397	939,541	154,986,625	1.00
2.00	Subprovider - IPF	0	0	0	0	0	2.00
3.00	Subprovider - IRF	0	0	0	0	0	3.00
5.00	Swing bed - SNF	0	0	0	0	0	5.00
6.00	Swing bed - NF	0	0	0	0	0	6.00
200.00	Total	0	1,427,048	219,397	939,541	154,986,625	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet S-2 Part I Date/Time Prepared: 4/30/2014 11:17 am
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1.00 Hospital and Hospital Health Care Complex Address:		2.00		3.00		4.00				
1.00	Street: 1901 WEST HARRISON STREET	PO Box:								
2.00	City: CHICAGO	State: IL	Zip Code: 60612-3714	County: COOK						

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

3.00 Hospital and Hospital-Based Component Identification:										
3.00	Hospital	JOHN H. STROGER JR. HOSP OF COOK CTY	140124	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis	JOHN H. STROGER JR. HOSP DIALYSIS	142313	16794		07/01/1973				18.00
19.00	Other									19.00

						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					12/01/2012	11/30/2013	20.00		
21.00	Type of Control (see instructions)					9			21.00	

22.00 Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					Y	N	22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						Y	22.01	
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
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.	41,902	6,500	0	0	9,750	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		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet S-2 Part I Date/Time Prepared: 4/30/2014 11:17 am		
		Urban/Rural S	Date of Geogr			
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1			26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0			35.00	
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 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	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N		39.00	
		V	XVII	XIX		
		1.00	2.00	3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
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	
<b>Teaching Hospitals</b>						
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)	Y			60.00	
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06

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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20	
					1.00		
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
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	
<u>Teaching Hospitals that Claim Residents in Non-Provider Settings</u>							
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 Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
<u>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.</u>							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140124		Period: From 12/01/2012 To 11/30/2013		Worksheet S-2 Part I Date/Time Prepared: 4/30/2014 11:17 am	
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
		1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	288.09	0.000000		66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	FAMILY MED INTERNAL MED, INTERNAL ME	1350	0.00	27.23	0.000000 67.00	
				1.00	2.00	3.00	
<b>Inpatient Psychiatric Facility PPS</b>							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	71.00
<b>Inpatient Rehabilitation Facility PPS</b>							
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 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	76.00
						1.00	
<b>Long Term Care Hospital PPS</b>							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N	80.00
<b>TEFRA Providers</b>							
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		
<b>Title V and XIX Services</b>							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00		95.00

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		V	XIX			
		1.00	2.00			
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	
<b>Rural Providers</b>						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N			105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00	
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				109.00	
		1.00	2.00	3.00		
<b>Miscellaneous Cost Reporting Information</b>						
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
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	1,600,426	27,492,499	0		118.01
				1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N			118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y			121.00
<b>Transplant Center Information</b>						
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	

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		1.00	2.00			
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y				140.00
		1.00	2.00	3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141.00	Name: COOK COUNTY	Contractor's Name:		Contractor's Number: 00131		
142.00	Street: 118 NORTH CLARK STREET	PO Box:				
143.00	City: CHICAGO	State: IL		Zip Code: 60602		
				1.00		
144.00	Are provider based physicians' costs included in Worksheet A?	Y			144.00	
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N			145.00	
				1.00		
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
		1.00		2.00		3.00
						Title XIX
						4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
				1.00		
Multi campus						
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N			165.00	
		Name	County	State	Zip Code	CBSA
		0	1.00	2.00	3.00	4.00
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
				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)	0			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	
		Beginning		Ending		
		1.00		2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	12/01/2012		11/30/2013		170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet S-2 Part II Date/Time Prepared: 4/30/2014 11:17 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	06/15/2014	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	Type	Date
			1.00	2.00	3.00
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	Y			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	Y			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	Y			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N	Legal Oper.	
			1.00	2.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/01/2014	Y	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: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet S-2 Part II Date/Time Prepared: 4/30/2014 11:17 am	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			Y	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			Y	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			Y	33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LEO	JANCI LA		41.00
42.00	Enter the employer/company name of the cost report preparer.	COOK COUNTY HEALTH & HOSPITAL SYSTEM			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	312-864-4778	LJANCI LA@COOKCOUNTYHHS.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet S-2  
Part II  
Date/Time Prepared:  
4/30/2014 11:17 am

		Part B	
		Date	
		4.00	
<b>PS&amp;R Data</b>			
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)	04/01/2014	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	
<b>Cost Report Preparer Contact Information</b>			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ADMINISTRATIVE COORDINATOR III	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

VOLUNTARY CONTACT INFORMATION

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet S-2  
Part V  
Date/Time Prepared:  
4/30/2014 11:17 am

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

HFS Supplemental Information		Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet S-2 Part IX Date/Time Prepared: 4/30/2014 11:17 am
		Title V	Title XIX	
		1.00	2.00	
<b>TITLES V AND/OR XIX FOLLOWING MEDICARE</b>				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient	Outpatient	
		1.00	2.00	
<b>CRITICAL ACCESS HOSPITALS</b>				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
<b>RCE DISALLOWANCE</b>				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
<b>PASS THROUGH COST</b>				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet S-3  
Part I  
Date/Time Prepared:  
4/30/2014 11:17 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	322	117,530	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		322	117,530	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	32	11,680	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT	33.00	8	2,920	0.00	0	10.00
11.00 SURGICAL INTENSIVE CARE UNIT	34.00	14	5,110	0.00	0	11.00
11.01 PEDIATRIC INTENSIVE CARE UNIT	34.01	10	3,650	0.00	0	11.01
11.02 TRAUMA INTENSIVE CARE UNIT	34.02	12	4,380	0.00	0	11.02
11.03 NEURO INTENSIVE CARE UNIT	34.03	10	3,650	0.00	0	11.03
11.04 NEONATAL INTENSIVE CARE UNIT	34.04	52	18,980	0.00	0	11.04
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		460	167,900	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		460				27.00
28.00 Observation Bed Days					2,579	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)		9	3,285			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet S-3  
Part I  
Date/Time Prepared:  
4/30/2014 11:17 am

Component	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)(see instructions for col. 2 for the portion of LDP room available beds)	9,469	26,461	81,373			1.00
2.00 HMO and other (see instructions)	597	16,250				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	9,469	26,461	81,373			7.00
8.00 INTENSIVE CARE UNIT	1,110	3,234	7,508			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT	271	344	1,207			10.00
11.00 SURGICAL INTENSIVE CARE UNIT	264	680	2,430			11.00
11.01 PEDIATRIC INTENSIVE CARE UNIT	0	582	964			11.01
11.02 TRAUMA INTENSIVE CARE UNIT	154	1,320	2,357			11.02
11.03 NEURO INTENSIVE CARE UNIT	200	120	2,222			11.03
11.04 NEONATAL INTENSIVE CARE UNIT	0	7,413	9,073			11.04
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		0	1,800			13.00
14.00 Total (see instructions)	11,468	40,154	108,934	462.40	4,818.72	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				462.40	4,818.72	27.00
28.00 Observation Bed Days		6,368	8,947			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	512	985			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet S-3  
Part I  
Date/Time Prepared:  
4/30/2014 11:17 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,484	7,619	23,153	1.00
2.00 HMO and other (see instructions)			0			2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
11.01 PEDIATRIC INTENSIVE CARE UNIT						11.01
11.02 TRAUMA INTENSIVE CARE UNIT						11.02
11.03 NEURO INTENSIVE CARE UNIT						11.03
11.04 NEONATAL INTENSIVE CARE UNIT						11.04
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	2,484	7,619	23,153	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet S-3 Part II Date/Time Prepared: 4/30/2014 11:17 am			
	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal ari es (from Worksheet A-6)	Adjusted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
<b>PART II - WAGE DATA</b>								
<b>SALARIES</b>								
1.00	Total salaries (see instructions)	200.00	376,193,297	-4,506,754	371,686,543	9,521,342.00	39.04	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		1,998,658	0	1,998,658	27,631.00	72.33	3.00
4.00	Physician-Part A - Administrative		28,243,930	0	28,243,930	242,657.00	116.39	4.00
4.01	Physicians - Part A - Teaching		16,019,138	0	16,019,138	138,661.00	115.53	4.01
5.00	Physician-Part B		61,388,918	0	61,388,918	562,060.00	109.22	5.00
6.00	Non-physician-Part B		7,646,112	0	7,646,112	148,685.00	51.42	6.00
7.00	Interns & residents (in an approved program)	21.00	21,183,191	-3,012,587	18,170,604	832,087.00	21.84	7.00
7.01	Contracted interns and residents (in an approved programs)		8,524,616	0	8,524,616	374,318.00	22.77	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		3,632,996	-969,060	2,663,936	45,555.00	58.48	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>								
11.00	Contract labor (see instructions)		14,434,781	0	14,434,781	446,019.00	32.36	11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		50,925,219	0	50,925,219	1,027,779.00	49.55	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
<b>WAGE-RELATED COSTS</b>								
17.00	Wage-related costs (core) (see instructions)		64,572,622	0	64,572,622			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		704,497	0	704,497			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		526,465	0	526,465			21.00
22.00	Physician Part A - Administrative		10,039,952	0	10,039,952			22.00
22.01	Physician Part A - Teaching		5,694,700	0	5,694,700			22.01
23.00	Physician Part B		21,833,174	0	21,833,174			23.00
24.00	Wage-related costs (RHC/FOHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		15,378,726	0	15,378,726			25.00
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26.00	Employee Benefits Department	4.00	1,515,256	0	1,515,256	38,708.00	39.15	26.00
27.00	Administrative & General	5.00	17,219,403	295,692	17,515,095	693,853.00	25.24	27.00
28.00	Administrative & General under contract (see inst.)		8,742,305	0	8,742,305	130,307.00	67.09	28.00
29.00	Maintenance & Repairs	6.00	5,940,908	0	5,940,908	138,447.00	42.91	29.00
30.00	Operation of Plant	7.00	9,616,218	0	9,616,218	300,452.00	32.01	30.00
31.00	Laundry & Linen Service	8.00	238,118	0	238,118	9,983.00	23.85	31.00
32.00	Housekeeping	9.00	8,210,644	0	8,210,644	421,411.00	19.48	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	2,933,216	-11,093	2,922,123	127,557.00	22.91	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	667,962	0	667,962	44,294.00	15.08	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,893,530	0	2,893,530	74,182.00	39.01	38.00
39.00	Central Services and Supply	14.00	1,686,909	0	1,686,909	75,350.00	22.39	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	3,674,912	0	3,674,912	160,381.00	22.91	41.00

HOSPITAL WAGE INDEX INFORMATION		Worksheet A		Amount		Reclassification of Salaries		Adjusted Salaries		Paid Hours		Average Hourly Wage	
		Line Number	Reported	(from Worksheet A-6)	(col. 2 ± col. 3)	Related to Salaries in						(col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00						
42.00	Social Service	17.00	566,730	0	566,730	8,201.00	69.10					42.00	
43.00	Other General Service	18.00	0	0	0	0.00	0.00					43.00	

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet S-3  
Part III  
Date/Time Prepared:  
4/30/2014 11:17 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	268,174,969	-1,494,167	266,680,802	7,568,207.00	35.24	1.00
2.00	Excluded area salaries (see instructions)	3,632,996	-969,060	2,663,936	45,555.00	58.48	2.00
3.00	Subtotal salaries (line 1 minus line 2)	264,541,973	-525,107	264,016,866	7,522,652.00	35.10	3.00
4.00	Subtotal other wages & related costs (see inst.)	65,360,000	0	65,360,000	1,473,798.00	44.35	4.00
5.00	Subtotal wage-related costs (see inst.)	74,612,574	0	74,612,574	0.00	28.26	5.00
6.00	Total (sum of lines 3 thru 5)	404,514,547	-525,107	403,989,440	8,996,450.00	44.91	6.00
7.00	Total overhead cost (see instructions)	63,906,111	284,599	64,190,710	2,223,126.00	28.87	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet S-3 Part IV Date/Time Prepared: 4/30/2014 11:17 am
				Amount Reported
				1.00
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
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)		42,201,888	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration Fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)		47,321,503	8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan		2,035,368	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		784,908	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			0 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			0 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance		2,109,437	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
<b>TAXES</b>				
17.00	FICA-Employers Portion Only			0 17.00
18.00	Medicare Taxes - Employers Portion Only		5,012,086	18.00
19.00	Unemployment Insurance		158,162	19.00
20.00	State or Federal Unemployment Taxes			0 20.00
<b>OTHER</b>				
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		844,432	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		100,467,784	24.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED - MALPRACTICE EXP		20,310,155	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet S-3  
Part V  
Date/Time Prepared:  
4/30/2014 11:17 am

Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet S-5

Date/Time Prepared:  
4/30/2014 11:17 am

		Outpatient		Training		Home						
		Regular 1.00	High Flux 2.00	Hemodialysis 3.00	CAPD / CCPD 4.00	Hemodialysis 5.00	CAPD / CCPD 6.00					
1.00	Number of patients in program at end of cost reporting period	29	0	0	0	0	0	1.00				
2.00	Number of times per week patient receives dialysis	3.50	0.00	0.00	0.00	0.00	0.00	2.00				
3.00	Average patient dialysis time including setup	5.00	0.00	0.00	0.00			3.00				
4.00	CAPD exchanges per day				0.00		0.00	4.00				
5.00	Number of days in year dialysis furnished	312	0					5.00				
6.00	Number of stations	8	0	0	0			6.00				
7.00	Treatment capacity per day per station	4	0					7.00				
8.00	Utilization (see instructions)	0.00	0.00					8.00				
9.00	Average times dialyzers re-used	0.00	0.00					9.00				
10.00	Percentage of patients re-using dialyzers	0.00	0.00					10.00				
								Y/N				
								1.00				
ESRD PPS												
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter "Y" for yes or "N" for no. (see instructions)							N	10.01			
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter "Y" for yes or "N" for no. (See instructions for "new" providers.)							Y	10.02			
								Prior to 1/1 1.00				
								After 12/31 2.00				
10.03	If you responded "N" to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)							0	0	10.03		
TRANSPLANT INFORMATION												
11.00	Number of patients on transplant list							0	11.00			
12.00	Number of patients transplanted during the cost reporting period							0	12.00			
EPOETIN												
13.00	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider.								13.00			
14.00	Epoetin amount from Worksheet A for Home Dialysis program								14.00			
15.00	Number of EPO units furnished relating to the renal dialysis department								15.00			
16.00	Number of EPO units furnished relating to the home dialysis department								16.00			
ARANESP												
17.00	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider.								17.00			
18.00	ARANESP amount from Worksheet A for Home Dialysis program								18.00			
19.00	Number of ARANESP units furnished relating to the renal dialysis department								19.00			
20.00	Number of ARANESP units furnished relating to the home dialysis department								20.00			
								MCP 1.00				
								INITIAL METHOD 2.00				
PHYSICIAN PAYMENT METHOD												
21.00	Enter "X" if method(s) is applicable							X	21.00			
		ESA Description 1.00	Net Cost of ESAs for Renal Patients 2.00	Net Cost of ESAs for Home Patients 3.00	Number of ESA Units - Renal Dialysis Dept. 4.00	Number of ESA Units - Home Dialysis Dept. 5.00						
22.00	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)							0	0	0	0	22.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet S-10 Date/Time Prepared: 4/30/2014 11:17 am
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				1.00		
<b>Uncompensated and indigent care cost computation</b>						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.557518	1.00	
<b>Medicaid (see instructions for each line)</b>						
2.00	Net revenue from Medicaid			439,798,001	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			Y	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			0	5.00	
6.00	Medicaid charges			443,118,958	6.00	
7.00	Medicaid cost (line 1 times line 6)			247,046,795	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	
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>						
9.00	Net revenue from stand-alone SCHIP			5,880,821	9.00	
10.00	Stand-alone SCHIP charges			5,601,239	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)			3,122,792	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	
<b>Other state or local government indigent care program (see instructions for each line)</b>						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			170,146,507	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			145,943,313	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)			81,366,024	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	
<b>Uncompensated care (see instructions for each line)</b>						
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			0	19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				1.00	2.00	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility			292,919,218	0	292,919,218
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)			163,307,737	0	163,307,737
22.00	Partial payment by patients approved for charity care			0	0	0
23.00	Cost of charity care (line 21 minus line 22)			163,307,737	0	163,307,737
				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
26.00	Total bad debt expense for the entire hospital complex (see instructions)			326,845,888		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			977,860		27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			325,868,028		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			181,677,291		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			344,985,028		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			344,985,028		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet A  
Date/Time Prepared:  
4/30/2014 11:17 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	18,657,420	18,657,420	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	6,882,485	6,882,485	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,515,256	1,526,244	3,041,500	100,451,326	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,219,403	142,996,417	160,215,820	54,156,270	5.00
6.00	00600	MAINTENANCE & REPAIRS	5,940,908	0	5,940,908	5,940,908	6.00
7.00	00700	OPERATION OF PLANT	9,616,218	15,768,868	25,385,086	25,385,086	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	238,118	1,673,205	1,911,323	1,911,323	8.00
9.00	00900	HOUSEKEEPING	8,210,644	1,102,056	9,312,700	11,309,819	9.00
10.00	01000	DIETARY	2,933,216	5,067,597	8,000,813	5,718,889	10.00
11.00	01100	CAFETERIA	667,962	0	667,962	667,962	11.00
13.00	01300	NURSING ADMINISTRATION	2,893,530	537,729	3,431,259	3,431,259	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,686,909	21,067,209	22,754,118	3,963,315	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,674,912	768,086	4,442,998	4,442,998	16.00
17.00	01700	SOCIAL SERVICE	566,730	0	566,730	566,730	17.00
18.00	01851	WAI VER OVERHEAD COSTS	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	1,998,658	1,998,658	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21,183,191	5,800,210	26,983,401	23,970,814	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,446,317	546,078	2,992,395	28,710,666	22.00
23.00	02300	ALLIED HEALTH	0	0	0	255,221	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	68,621,310	7,983,789	76,605,099	67,233,693	30.00
31.00	03100	INTENSIVE CARE UNIT	8,369,877	126,288	8,496,165	8,497,592	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	2,725,541	67,743	2,793,284	2,668,841	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	3,632,656	27,945	3,660,601	3,642,521	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	2,582,014	7,596	2,589,610	2,544,636	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	5,849,480	455,490	6,304,970	6,203,180	34.02
34.03	02060	NEURO INTENSIVE CARE UNIT	3,856,645	36,878	3,893,523	3,408,954	34.03
34.04	02061	NEONATAL INTENSIVE CARE UNIT	10,384,355	58,474	10,442,829	10,057,713	34.04
43.00	04300	NURSERY	2,170,935	18,337	2,189,272	2,189,272	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	31,772,201	16,823,845	48,596,046	58,487,527	50.00
51.00	05100	RECOVERY ROOM	2,330,818	452	2,331,270	2,331,270	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,504,393	13,941	3,518,334	3,518,523	52.00
53.00	05300	ANESTHESIOLOGY	10,332,452	353,258	10,685,710	6,290,544	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,887,742	10,561,186	26,448,928	26,077,592	54.00
60.00	06000	LABORATORY	16,231,945	15,250,220	31,482,165	31,087,300	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,135,959	3,552,833	4,688,792	4,688,792	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	6,507,821	613,583	7,121,404	7,000,501	65.00
66.00	06600	PHYSICAL THERAPY	1,078,329	209,804	1,288,133	1,288,133	66.00
67.00	06700	OCCUPATIONAL THERAPY	436,598	0	436,598	435,459	67.00
68.00	06800	SPEECH PATHOLOGY	452,129	279,719	731,848	731,848	68.00
69.00	06900	ELECTROCARDIOLOGY	5,272,976	2,405,607	7,678,583	7,519,157	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,110,078	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	241,055	16,339,943	16,580,998	18,645,274	73.00
74.00	07400	RENAL DIALYSIS	2,952,331	19,635	2,971,966	2,971,966	74.00
76.00	03950	WAI VER PURCHASED PATIENT SERVICES	0	65,925,227	65,925,227	65,925,227	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	57,793,012	49,546,049	107,339,061	85,341,969	90.00
91.00	09100	EMERGENCY	29,644,413	115,356	29,759,769	27,575,999	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	372,560,301	387,646,897	760,207,198	758,894,710	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.01	19001	DENTISTRY	1,124,900	102,207	1,227,107	1,711,311	190.01
190.02	19002	ACHN SATELLITE CLINICS	0	0	0	0	190.02
190.03	19003	SPECIAL FUNDS	0	0	0	828,284	190.03
190.04	19004	SENGSTACKE CLINIC	2,508,096	62,090	2,570,186	2,570,186	190.04
194.00	07951	WAI VER ADMINISTRATION ONLY COSTS	0	24,411,869	24,411,869	24,411,869	194.00
200.00		TOTAL (SUM OF LINES 118-199)	376,193,297	412,223,063	788,416,360	788,416,360	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet A  
Date/Time Prepared:  
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Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	28,487,816	47,145,236	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,322,327	8,204,812	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	13,436,361	113,887,687	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	90,332,175	144,488,445	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	5,940,908	6.00
7.00	00700	OPERATION OF PLANT	-2,980,654	22,404,432	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,911,323	8.00
9.00	00900	HOUSEKEEPING	0	11,309,819	9.00
10.00	01000	DIETARY	-2,415,532	3,303,357	10.00
11.00	01100	CAFETERIA	0	667,962	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,431,259	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,963,315	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-184,702	4,258,296	16.00
17.00	01700	SOCIAL SERVICE	0	566,730	17.00
18.00	01851	WAI VER OVERHEAD COSTS	525,092	525,092	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-1,998,658	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	23,970,814	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	-8,728,649	19,982,017	22.00
23.00	02300	ALLIED HEALTH	0	255,221	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-31,290,194	35,943,499	30.00
31.00	03100	INTENSIVE CARE UNIT	-404,999	8,092,593	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	-1,161,019	1,507,822	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	-167,868	3,474,653	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	-924,383	1,620,253	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	-2,349,475	3,853,705	34.02
34.03	02060	NEURO INTENSIVE CARE UNIT	-1,237,655	2,171,299	34.03
34.04	02061	NEONATAL INTENSIVE CARE UNIT	-3,848,471	6,209,242	34.04
43.00	04300	NURSERY	0	2,189,272	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-13,556,831	44,930,696	50.00
51.00	05100	RECOVERY ROOM	0	2,331,270	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-133,177	3,385,346	52.00
53.00	05300	ANESTHESIOLOGY	-5,548,769	741,775	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-8,042,611	18,034,981	54.00
60.00	06000	LABORATORY	-4,733,694	26,353,606	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	4,688,792	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	-2,322,939	4,677,562	65.00
66.00	06600	PHYSICAL THERAPY	0	1,288,133	66.00
67.00	06700	OCCUPATIONAL THERAPY	-15,427	420,032	67.00
68.00	06800	SPEECH PATHOLOGY	0	731,848	68.00
69.00	06900	ELECTROCARDIOLOGY	-2,873,459	4,645,698	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,110,078	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,868,314	46,513,588	73.00
74.00	07400	RENAL DIALYSIS	0	2,971,966	74.00
76.00	03950	WAI VER PURCHASED PATIENT SERVICES	-65,925,227	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	-24,111,209	61,230,760	90.00
91.00	09100	EMERGENCY	-4,631,151	22,944,848	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-27,614,668	731,280,042	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	DENTISTRY	0	1,711,311	190.01
190.02	19002	ACHN SATELITTE CLINICS	0	0	190.02
190.03	19003	SPECIAL FUNDS	0	828,284	190.03
190.04	19004	SENGSTACKE CLINIC	-2,570,186	0	190.04
194.00	07951	WAI VER ADMINISTRATIVE ONLY COSTS	842,850	25,254,719	194.00
200.00		TOTAL (SUM OF LINES 118-199)	-29,342,004	759,074,356	200.00

COST CENTERS USED IN COST REPORT		Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet Non-CMS W Date/Time Prepared: 4/30/2014 11:17 am
Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
6.00	MAINTENANCE & REPAIRS	00600		6.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
18.00	WAIVER OVERHEAD COSTS	01851		18.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
21.00	I&R SERVICES-SALARY & FRINGES APPRV	02100		21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	02200		22.00
23.00	ALLIED HEALTH	02300		23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
33.00	BURN INTENSIVE CARE UNIT	03300		33.00
34.00	SURGICAL INTENSIVE CARE UNIT	03400		34.00
34.01	PEDIATRIC INTENSIVE CARE UNIT	02080		34.01
34.02	TRAUMA INTENSIVE CARE UNIT	02180		34.02
34.03	NEURO INTENSIVE CARE UNIT	02060		34.03
34.04	NEONATAL INTENSIVE CARE UNIT	02061		34.04
43.00	NURSERY	04300		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELL	06200		62.00
64.00	INTRAVENOUS THERAPY	06400		64.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
74.00	RENAL DIALYSIS	07400		74.00
76.00	WAIVER PURCHASED PATIENT SERVICES	03950		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
98.00	OTHER REIMBURSABLE COST CENTERS	05950		98.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
190.01	DENTISTRY	19001		190.01
190.02	ACHN SATELITTE CLINICS	19002		190.02
190.03	SPECIAL FUNDS	19003		190.03
190.04	SENGSTACKE CLINIC	19004		190.04
194.00	WAIVER ADMINISTRATIVE ONLY COSTS	07951		194.00
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet A-6  
Date/Time Prepared:  
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		Increases			
Cost Center		Line #	Salary	Other	
2.00	3.00	4.00	5.00		
<b>A - TO RECLASS FRINGE BENEFITS TO EHW</b>					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	97,409,826	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	97,409,826	
<b>B - SERVICE CONTRACTS</b>					
1.00	HOUSEKEEPING	9.00	0	1,997,119	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	273,712	2.00
	TOTALS		0	2,270,831	
<b>C - SAL OF NON RESIDENTS MOVED TO OTHER</b>					
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	1,530,213	0	1.00
	TOTALS		1,530,213	0	
<b>D - TRANSFER MOONLIGHTING TO ER</b>					
1.00	EMERGENCY	91.00	1,482,374	0	1.00
	TOTALS		1,482,374	0	
<b>E - TO RECLASSIFY I/R OTHER COST</b>					
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	8,524,615	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	59,356	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
6.00		0.00	0	0	6.00
	TOTALS		0	8,583,971	
<b>F - TO ALLOCATE PEDS ALGY &amp; PSYCH TO INP</b>					
1.00	ADULTS & PEDIATRICS	30.00	299,840	24,264	1.00
	TOTALS		299,840	24,264	
<b>G - TO TRANSFER DIETARY SAL TO CLINIC</b>					
1.00	CLINIC	90.00	11,093	0	1.00
	TOTALS		11,093	0	
<b>H - TO ALLOCATE REGSTRY AND IN-HOUSE NSG</b>					
1.00	INTENSIVE CARE UNIT	31.00	0	86,979	1.00
2.00	BURN INTENSIVE CARE UNIT	33.00	0	21,301	2.00
3.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	13,821	3.00
4.00	PEDIATRIC INTENSIVE CARE UNIT	34.01	0	762	4.00
5.00	TRAUMA INTENSIVE CARE UNIT	34.02	0	51,947	5.00
6.00	NEURO INTENSIVE CARE UNIT	34.03	39,833	21,368	6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	189	7.00
8.00	EMERGENCY	91.00	0	143,475	8.00
	TOTALS		39,833	339,842	
<b>I - TO RECLASS NON-PHY ANESTH TO PRP GRP</b>					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	1,998,658	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	1,998,658	
<b>J - TO RECLASS HEKTOEN COST TO RESRCH.</b>					
1.00	SPECIAL FUNDS	190.03	828,284	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	TOTALS		828,284	0	
<b>K - TO RECLASS COST OF IMPLANTS</b>					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	4,110,078	1.00
	TOTALS		0	4,110,078	
<b>M - TO RECLASS HBP TEACHING TIME</b>					
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	15,994,992	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00

RECLASSIFICATIONS

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet A-6

Date/Time Prepared:  
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		Increases			
Cost Center		Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	TOTALS		15,994,992	0	
N - DEPRECIATION RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	18,657,420	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,882,485	2.00
	TOTALS		0	25,539,905	
O - SENGSTACKE CLINIC					
1.00	SENGSTACKE CLINIC	190.04	0	2,508,096	1.00
	TOTALS		0	2,508,096	
Q - INSURANCE RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,592,243	1.00
	TOTALS		0	2,592,243	
R - PHARMACY SCHOOL					
1.00	ALLIED HEALTH	23.00	226,548	28,673	1.00
	TOTALS		226,548	28,673	
S - MEDICAL DIRECTOR					
1.00	ADMINISTRATIVE & GENERAL	5.00	331,549	0	1.00
2.00	DENTISTRY	190.01	484,204	0	2.00
	TOTALS		815,753	0	
T - SUPPLY COST					
1.00	OPERATING ROOM	50.00	0	16,519,803	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,271,000	2.00
	TOTALS		0	18,790,803	
500.00	Grand Total: Increases		21,228,930	164,197,190	500.00

RECLASSIFICATIONS

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet A-6  
Date/Time Prepared:  
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		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
<b>A - TO RECLASS FRINGE BENEFITS TO EHW</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	83,297,890	0		1.00
2.00	CLINIC	90.00	0	14,111,936	0		2.00
	TOTALS		0	97,409,826			
<b>B - SERVICE CONTRACTS</b>							
1.00	DIETARY	10.00	0	2,270,831	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	2,270,831			
<b>C - SAL OF NON RESIDENTS MOVED TO OTHER</b>							
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	1,530,213	0	0		1.00
	TOTALS		1,530,213	0			
<b>D - TRANSFER MOONLIGHTING TO ER</b>							
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	1,482,374	0	0		1.00
	TOTALS		1,482,374	0			
<b>E - TO RECLASSIFY I/R OTHER COST</b>							
1.00	TRAUMA INTENSIVE CARE UNIT	34.02	0	28,188	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	4,791,884	0		2.00
3.00	LABORATORY	60.00	0	94,984	0		3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	3,665,322	0		4.00
6.00	CLINIC	90.00	0	3,593	0		6.00
	TOTALS		0	8,583,971			
<b>F - TO ALLOCATE PEDS ALGY &amp; PSYCH TO INP</b>							
1.00	CLINIC	90.00	299,840	24,264	0		1.00
	TOTALS		299,840	24,264			
<b>G - TO TRANSFER DIETARY SAL TO CLINIC</b>							
1.00	DIETARY	10.00	11,093	0	0		1.00
	TOTALS		11,093	0			
<b>H - TO ALLOCATE REGSTRY AND IN-HOUSE NSG</b>							
1.00	ADULTS & PEDIATRICS	30.00	39,833	339,842	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
	TOTALS		39,833	339,842			
<b>I - TO RECLASS NON-PHY ANESTH TO PRP GRP</b>							
1.00	ANESTHESIOLOGY	53.00	1,880,878	0	0		1.00
2.00	CLINIC	90.00	117,780	0	0		2.00
	TOTALS		1,998,658	0			
<b>J - TO RECLASS HEKTOEN COST TO RESRCH.</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	35,857	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	726,573	0	0		2.00
3.00	ANESTHESIOLOGY	53.00	17,469	0	0		3.00
4.00	CLINIC	90.00	37,526	0	0		4.00
5.00	DRUGS CHARGED TO PATIENTS	73.00	10,859	0	0		5.00
	TOTALS		828,284	0			
<b>K - TO RECLASS COST OF IMPLANTS</b>							
1.00	OPERATING ROOM	50.00	0	4,110,078	0		1.00
	TOTALS		0	4,110,078			
<b>M - TO RECLASS HBP TEACHING TIME</b>							
1.00	ADULTS & PEDIATRICS	30.00	3,797,378	0	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	85,552	0	0		2.00
3.00	BURN INTENSIVE CARE UNIT	33.00	145,744	0	0		3.00
4.00	PEDIATRIC INTENSIVE CARE UNIT	34.01	45,736	0	0		4.00
5.00	TRAUMA INTENSIVE CARE UNIT	34.02	125,549	0	0		5.00
6.00	NEURO INTENSIVE CARE UNIT	34.03	545,770	0	0		6.00
7.00	NEONATAL INTENSIVE CARE UNIT	34.04	385,116	0	0		7.00
8.00	OPERATING ROOM	50.00	2,034,040	0	0		8.00
9.00	ANESTHESIOLOGY	53.00	2,496,819	0	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	371,336	0	0		10.00
11.00	LABORATORY	60.00	299,881	0	0		11.00
12.00	RESPIRATORY THERAPY	65.00	120,903	0	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	159,426	0	0		13.00
14.00	CLINIC	90.00	1,539,083	0	0		14.00
15.00	EMERGENCY	91.00	3,809,619	0	0		15.00
16.00	SURGICAL INTENSIVE CARE UNIT	34.00	31,901	0	0		16.00
17.00	OCCUPATIONAL THERAPY	67.00	1,139	0	0		17.00
	TOTALS		15,994,992	0			

RECLASSIFICATIONS

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet A-6

Date/Time Prepared:  
4/30/2014 11:17 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	N - DEPRECIATION RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	22,257,985		9	1.00
2.00	CLINIC	90.00	0	3,281,920		9	2.00
	TOTALS		0	25,539,905			
	O - SENGSTACKE CLINIC						
1.00	SENGSTACKE CLINIC	190.04	2,508,096	0		0	1.00
	TOTALS		2,508,096	0			
	Q - INSURANCE RECLASS						
1.00	CLINIC	90.00	0	2,592,243		0	1.00
	TOTALS		0	2,592,243			
	R - PHARMACY SCHOOL						
1.00	DRUGS CHARGED TO PATIENTS	73.00	226,548	28,673		0	1.00
	TOTALS		226,548	28,673			
	S - MEDICAL DIRECTOR						
1.00	I&R SERVICES-OTHER PRGM	22.00	331,549	0		0	1.00
2.00	COSTS APPRV						
	OPERATING ROOM	50.00	484,204	0		0	2.00
	TOTALS		815,753	0			
	T - SUPPLY COST						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	18,790,803		0	1.00
2.00		0.00	0	0		0	2.00
	TOTALS		0	18,790,803			
500.00	Grand Total: Decreases		25,735,684	159,690,436			500.00

RECLASSIFICATIONS

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet A-6  
Non-CMS Worksheet  
Date/Time Prepared:  
4/30/2014 11:17 am

Increases			Decreases			
Cost Center	Line #	Salary	Cost Center	Line #	Salary	
2.00	3.00	4.00	6.00	7.00	8.00	
<b>A - TO RECLASS FRINGE BENEFITS TO EHW</b>						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	ADMINISTRATIVE & GENERAL	5.00	0	1.00
2.00		0.00	CLINIC	90.00	0	2.00
	TOTALS		TOTALS		0	
<b>B - SERVICE CONTRACTS</b>						
1.00	HOUSEKEEPING	9.00	DIETARY	10.00	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00		0.00	0	2.00
	TOTALS		TOTALS		0	
<b>C - SAL OF NON RESIDENTS MOVED TO OTHER</b>						
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	1,530,213	I&R SERVICES-SALARY & FRINGES APPRV	21.00	1,530,213
	TOTALS		1,530,213	TOTALS		1,530,213
<b>D - TRANSFER MOONLIGHTING TO ER</b>						
1.00	EMERGENCY	91.00	1,482,374	I&R SERVICES-SALARY & FRINGES APPRV	21.00	1,482,374
	TOTALS		1,482,374	TOTALS		1,482,374
<b>E - TO RECLASSIFY I/R OTHER COST</b>						
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	TRAUMA INTENSIVE CARE UNIT	34.02	0
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	ADULTS & PEDIATRICS	30.00	0
3.00		0.00	0	LABORATORY	60.00	0
4.00		0.00	0	ADMINISTRATIVE & GENERAL	5.00	0
6.00		0.00	0	CLINIC	90.00	0
	TOTALS		0	TOTALS		0
<b>F - TO ALLOCATE PEDS ALGY &amp; PSYCH TO INP</b>						
1.00	ADULTS & PEDIATRICS	30.00	299,840	CLINIC	90.00	299,840
	TOTALS		299,840	TOTALS		299,840
<b>G - TO TRANSFER DIETARY SAL TO CLINIC</b>						
1.00	CLINIC	90.00	11,093	DIETARY	10.00	11,093
	TOTALS		11,093	TOTALS		11,093
<b>H - TO ALLOCATE REGISTRY AND IN-HOUSE NSG</b>						
1.00	INTENSIVE CARE UNIT	31.00	0	ADULTS & PEDIATRICS	30.00	39,833
2.00	BURN INTENSIVE CARE UNIT	33.00	0		0.00	0
3.00	SURGICAL INTENSIVE CARE UNIT	34.00	0		0.00	0
4.00	PEDIATRIC INTENSIVE CARE UNIT	34.01	0		0.00	0
5.00	TRAUMA INTENSIVE CARE UNIT	34.02	0		0.00	0
6.00	NEURO INTENSIVE CARE UNIT	34.03	39,833		0.00	0
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0		0.00	0
8.00	EMERGENCY	91.00	0		0.00	0
	TOTALS		39,833	TOTALS		39,833
<b>I - TO RECLASS NON-PHY ANESTH TO PRP GRP</b>						
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	ANESTHESIOLOGY	53.00	1,880,878
2.00		0.00	0	CLINIC	90.00	117,780
	TOTALS		0	TOTALS		1,998,658
<b>J - TO RECLASS HEKTOEN COST TO RESRCH.</b>						
1.00	SPECIAL FUNDS	190.03	828,284	ADMINISTRATIVE & GENERAL	5.00	35,857
2.00		0.00	0	ADULTS & PEDIATRICS	30.00	726,573
3.00		0.00	0	ANESTHESIOLOGY	53.00	17,469
4.00		0.00	0	CLINIC	90.00	37,526
5.00		0.00	0	DRUGS CHARGED TO PATIENTS	73.00	10,859
	TOTALS		828,284	TOTALS		828,284
<b>K - TO RECLASS COST OF IMPLANTS</b>						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	OPERATING ROOM	50.00	0
	TOTALS		0	TOTALS		0
<b>M - TO RECLASS HBP TEACHING TIME</b>						
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	15,994,992	ADULTS & PEDIATRICS	30.00	3,797,378
2.00		0.00	0	INTENSIVE CARE UNIT	31.00	85,552
3.00		0.00	0	BURN INTENSIVE CARE UNIT	33.00	145,744
4.00		0.00	0	PEDIATRIC INTENSIVE CARE UNIT	34.01	45,736
5.00		0.00	0	TRAUMA INTENSIVE CARE UNIT	34.02	125,549
6.00		0.00	0	NEURO INTENSIVE CARE UNIT	34.03	545,770
7.00		0.00	0	NEONATAL INTENSIVE CARE UNIT	34.04	385,116
8.00		0.00	0	OPERATING ROOM	50.00	2,034,040
9.00		0.00	0	ANESTHESIOLOGY	53.00	2,496,819
10.00		0.00	0	RADIOLOGY-DIAGNOSTIC	54.00	371,336
11.00		0.00	0	LABORATORY	60.00	299,881
12.00		0.00	0	RESPIRATORY THERAPY	65.00	120,903
13.00		0.00	0	ELECTROCARDIOLOGY	69.00	159,426
14.00		0.00	0	CLINIC	90.00	1,539,083
15.00		0.00	0	EMERGENCY	91.00	3,809,619

RECLASSIFICATIONS

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet A-6  
Non-CMS Worksheet  
Date/Time Prepared:  
4/30/2014 11:17 am

	Increases			Decreases			
	Cost Center	Line #	Salary	Cost Center	Line #	Salary	
	2.00	3.00	4.00	6.00	7.00	8.00	
16.00		0.00		0 SURGICAL INTENSIVE CARE UNIT	34.00	31,901	16.00
17.00		0.00		0 OCCUPATIONAL THERAPY	67.00	1,139	17.00
	TOTALS		15,994,992	TOTALS		15,994,992	
N - DEPRECIATION RECLASS							
1.00	CAP REL COSTS-BLDG & FIXT	1.00		0 ADMINISTRATIVE & GENERAL	5.00	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00		0 CLINIC	90.00	0	2.00
	TOTALS			0 TOTALS		0	
O - SENGSTACKE CLINIC							
1.00	SENGSTACKE CLINIC	190.04		0 SENGSTACKE CLINIC	190.04	2,508,096	1.00
	TOTALS			0 TOTALS		2,508,096	
Q - INSURANCE RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00		0 CLINIC	90.00	0	1.00
	TOTALS			0 TOTALS		0	
R - PHARMACY SCHOOL							
1.00	ALLIED HEALTH	23.00	226,548	DRUGS CHARGED TO PATIENTS	73.00	226,548	1.00
	TOTALS		226,548	TOTALS		226,548	
S - MEDICAL DIRECTOR							
1.00	ADMINISTRATIVE & GENERAL	5.00	331,549	I&R SERVICES-OTHER PRGM	22.00	331,549	1.00
2.00	DENTISTRY	190.01	484,204	COSTS APPRV OPERATING ROOM	50.00	484,204	2.00
	TOTALS		815,753	TOTALS		815,753	
T - SUPPLY COST							
1.00	OPERATING ROOM	50.00		0 CENTRAL SERVICES & SUPPLY	14.00	0	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00		0	0.00	0	2.00
	TOTALS			0 TOTALS		0	
500.00	Grand Total: Increases		21,228,930	Grand Total: Decreases		25,735,684	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet A-7  
Part I  
Date/Time Prepared:  
4/30/2014 11:17 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	2,717,512	0	0	0	2.00
3.00	Buildings and Fixtures	522,269,978	0	0	0	3.00
4.00	Building Improvements	85,758,281	6,425,955	0	6,425,955	4.00
5.00	Fixed Equipment	156,688,631	2,951,004	0	2,951,004	5.00
6.00	Movable Equipment	9,688,294	2,395,556	0	2,395,556	6.00
7.00	HIT designated Assets	4,436,178	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	781,558,874	11,772,515	0	11,772,515	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	781,558,874	11,772,515	0	11,772,515	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	0	0			1.00
2.00	Land Improvements	2,717,512	0			2.00
3.00	Buildings and Fixtures	522,269,978	0			3.00
4.00	Building Improvements	92,184,236	0			4.00
5.00	Fixed Equipment	159,639,635	0			5.00
6.00	Movable Equipment	12,083,850	0			6.00
7.00	HIT designated Assets	4,436,178	0			7.00
8.00	Subtotal (sum of lines 1-7)	793,331,389	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	793,331,389	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet A-7  
Part II  
Date/Time Prepared:  
4/30/2014 11:17 am

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet A-7  
Part III  
Date/Time Prepared:  
4/30/2014 11:17 am

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	767,434,402	0	767,434,402	0.981928	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	14,124,472	0	14,124,472	0.018072	0	2.00
3.00	Total (sum of lines 1-2)	781,558,874	0	781,558,874	1.000000	0	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	14,264,431	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	8,204,812	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	22,469,243	0	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	32,880,805	0	0	0	47,145,236	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	8,204,812	2.00
3.00	Total (sum of lines 1-2)	32,880,805	0	0	0	55,350,048	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet A-8

Date/Time Prepared:  
4/30/2014 11:17 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00		3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)	B	-2,980,654		OPERATION OF PLANT	7.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-104,049,625				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	B	-26,634		ADMINISTRATIVE & GENERAL	5.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	834,555				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests			0		0.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients	B	-426,035		LABORATORY	60.00	0	16.00
17.00 Sale of drugs to other than patients	B	-404		DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00 Sale of medical records and abstracts	B	-184,702		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3			RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3			PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	A	-3,140,204		CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	A	1,322,327		CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00 Non-physician Anesthetist	A	-1,998,658		NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3			OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)				ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3			SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00	0	33.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
33.01 MISCELLANEOUS INCOME	B	-11,484	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02 MISC INCOME	B	-5,800	CLINIC	90.00	0	33.02
33.03		0		0.00	0	33.03
33.04 COUNTY ADJ. FOR HOSPITAL BOND INT.	A	32,880,805	CAP REL COSTS-BLDG & FIXT	1.00	11	33.04
33.05		0		0.00	0	33.05
33.06 SYSTEM HEALTH & HOSPITAL ADMINSTN.	A	90,212,114	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07 SYSTEM HEALTH & HOSPITAL PHARMCY.	A	27,868,718	DRUGS CHARGED TO PATIENTS	73.00	0	33.07
33.08 SYSTEM HEALTH & HOSPITAL BENEFITS	A	11,338,338	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09 SYSTEM HEALTH & HOSPITAL WAI VER COST	A	525,092	WAI VER OVERHEAD COSTS	18.00	0	33.09
33.10 RESIDENCY PROGRAM REIMBURSEMNT.	B	-355,433	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	33.10
33.11		0		0.00	0	33.11
33.12 TO OFFSET PHYSICIAN PART C TIME	A	-10,511	BURN INTENSIVE CARE UNIT	33.00	0	33.12
33.13 TO OFFSET PHYSICIAN PART C TIME	A	-741,898	ADULTS & PEDIATRICS	30.00	0	33.13
33.14 TO OFFSET PHYSICIAN PART C TIME	A	-198	OCCUPATIONAL THERAPY	67.00	0	33.14
33.15 TO OFFSET PHYSICIAN PART C TIME	A	-11,030	PEDIATRIC INTENSIVE CARE UNIT	34.01	0	33.15
33.16 TO OFFSET PHYSICIAN PART C TIME	A	-5,419	TRAUMA INTENSIVE CARE UNIT	34.02	0	33.16
33.17 TO OFFSET PHYSICIAN PART C TIME	A	-36,532	NEONATAL INTENSIVE CARE UNIT	34.04	0	33.17
33.18 TO OFFSET PHYSICIAN PART C TIME	A	-230,147	OPERATING ROOM	50.00	0	33.18
33.19 TO OFFSET PHYSICIAN PART C TIME	A	-51,480	ANESTHESIOLOGY	53.00	0	33.19
33.20 TO OFFSET PHYSICIAN PART C TIME	A	-158,390	RADIOLOGY-DIAGNOSTIC	54.00	0	33.20
33.21 TO OFFSET PHYSICIAN PART C TIME	A	-200,582	LABORATORY	60.00	0	33.21
33.22 TO OFFSET PHYSICIAN PART C TIME	A	-3,894	RESPIRATORY THERAPY	65.00	0	33.22
33.23 TO OFFSET PHYSICIAN PART C TIME	A	-96,916	ELECTROCARDIOLOGY	69.00	0	33.23
33.24 TO OFFSET PHYSICIAN PART C TIME	A	-366,830	CLINIC	90.00	0	33.24
33.25 PROVIDENT COSTS	A	-1,207,766	DIETARY	10.00	0	33.25
33.26 TO OFFSET PHYSICIAN PART C TIME	A	-180,894	EMERGENCY	91.00	0	33.26
33.27		0		0.00	0	33.27
33.28 PROPERTY TAX ACCRUAL	A	1,136,383	ADMINISTRATIVE & GENERAL	5.00	0	33.28
33.29 PROPERTY TAX ACCRUAL	A	-1,154,803	CLINIC	90.00	0	33.29
33.30 TO REMOVE SENGSTACKE CLINIC FROM C/R	A	-2,570,186	SENGSTACKE CLINIC	190.04	0	33.30
33.31 IHA LOBBYING	A	-2,925	ADMINISTRATIVE & GENERAL	5.00	0	33.31
33.32 COST BELONGING TO PROVIDENT	A	-1,207,766	DIETARY	10.00	0	33.32
33.33 NURSE PRACTITIONER AND PHYS ASST.	A	-2,091,162	ADULTS & PEDIATRICS	30.00	0	33.33
33.34 NURSE PRACTITIONER AND PHYS ASST.	A	-105,930	SURGICAL INTENSIVE CARE UNIT	34.00	0	33.34
33.35 NURSE PRACTITIONER AND PHYS ASST.	A	-132,330	PEDIATRIC INTENSIVE CARE UNIT	34.01	0	33.35
33.36 NURSE PRACTITIONER AND PHYS ASST.	A	-481,400	NEURO INTENSIVE CARE UNIT	34.03	0	33.36
33.37 NURSE PRACTITIONER AND PHYS ASST.	A	-488,528	NEONATAL INTENSIVE CARE UNIT	34.04	0	33.37
33.38 NURSE PRACTITIONER AND PHYS ASST.	A	-956,017	OPERATING ROOM	50.00	0	33.38
33.39 NURSE PRACTITIONER AND PHYS ASST.	A	-133,177	DELIVERY ROOM & LABOR ROOM	52.00	0	33.39
33.40 NURSE PRACTITIONER AND PHYS ASST.	A	-329,341	ELECTROCARDIOLOGY	69.00	0	33.40
33.41		0		0.00	0	33.41

Provider CCN: 140124

Period:  
 From 12/01/2012  
 To 11/30/2013

Worksheet A-8

Date/Time Prepared:  
 4/30/2014 11:17 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
33.42 NURSE PRACTITIONER AND PHYS ASST.	A	-1,901,217	CLINIC	90.00	0	33.42
33.43 NURSE PRACTITIONER AND PHYS ASST.	A	-894,957	EMERGENCY	91.00	0	33.43
33.44 OAK FOREST VACANT SPACE ADJUSTMENT	A	-1,252,785	CAP REL COSTS-BLDG & FIXT	1.00	9	33.44
33.45 WAIVER COSTS	A	-65,925,227	WAIVER PURCHASED PATIENT SERVICES	76.00	0	33.45
33.46 3 YR PENSION AVG	A	649,535	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.46
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-29,342,004				50.00

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

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet A-8-1

Date/Time Prepared:  
4/30/2014 11:17 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	STORE ROOM	299,423	299,470 1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	PAYROLL	175,513	177,080 2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	GENERAL ACCOUNTING	399,139	400,944 3.00
3.01	90.00	CLINIC	0	0	481,504 3.01
4.00	5.00	ADMINISTRATIVE & GENERAL	COUNTY COSTS ALLOCATED TO CC	1,653,893	2,625,753 4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	COUNTY COSTS ALLOCATED TO CC	1,448,488	0 4.01
4.02	194.00	WAIVER ADMINISTRATIVE ONLY C	WAIVER COSTS	25,254,719	24,411,869 4.02
5.00	0		0	29,231,175	28,396,620 5.00

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

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

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

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

6.00	G	O. F. PROV &	100.00	OUTRCH CLINICS	100.00	6.00
7.00	G	SPECIAL FUNDS	100.00	OUTRCH CLINICS	100.00	7.00
8.00	G	COOK CTY GOVNMNT	100.00	BUDGET, COMPTLR	100.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	GVRNMNT AGENCY				100.00

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

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

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

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet A-8-1

Date/Time Prepared:  
4/30/2014 11:17 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	-47	0		1.00
2.00	-1,567	0		2.00
3.00	-1,805	0		3.00
3.01	-481,504	0		3.01
4.00	-971,860	0		4.00
4.01	1,448,488	0		4.01
4.02	842,850	0		4.02
5.00	834,555			5.00

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

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

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	NOT HOSP BASED		6.00
7.00	GOVRNMNT AGENCY		7.00
8.00	TREAS, ST ATRNY		8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet A-8-2  
Date/Time Prepared:  
4/30/2014 11:17 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	21,729,171	87,267	21,641,903	177,200	140,000	1.00
2.00	30.00	ADULTS & PEDIATRICS	37,252,461	23,601,124	13,651,337	177,200	92,660	2.00
3.00	31.00	INTENSIVE CARE UNIT	821,055	154,381	666,674	177,200	4,367	3.00
4.00	33.00	BURN INTENSIVE CARE UNIT	1,340,683	991,225	349,458	208,000	1,671	4.00
5.00	34.00	SURGICAL INTENSIVE CARE UNIT	77,777	43,866	33,911	208,000	136	5.00
6.00	34.01	PEDIATRIC INTENSIVE CARE UNIT	896,646	728,660	167,986	177,200	1,227	6.00
7.00	34.02	TRAUMA INTENSIVE CARE UNIT	2,533,417	2,232,626	300,791	208,000	1,695	7.00
8.00	34.03	NEURO INTENSIVE CARE UNIT	873,733	659,010	214,723	208,000	1,033	8.00
9.00	34.04	NEONATAL INTENSIVE CARE UNIT	3,900,847	2,907,360	993,486	177,200	6,008	9.00
10.00	50.00	OPERATING ROOM	14,668,402	10,972,621	3,695,781	208,000	20,537	10.00
11.00	53.00	ANESTHESIOLOGY	7,357,356	4,216,410	3,140,946	200,300	17,162	11.00
12.00	54.00	RADIOLOGY-DIAGNOSTIC	8,802,579	7,297,662	1,504,917	225,300	7,561	12.00
13.00	60.00	LABORATORY	5,262,621	3,836,692	1,425,929	215,700	10,235	13.00
14.00	65.00	RESPIRATORY THERAPY	3,062,481	2,069,100	993,381	200,300	7,039	14.00
15.00	67.00	OCCUPATIONAL THERAPY	17,480	14,361	3,119	177,200	24	15.00
16.00	69.00	ELECTROCARDIOLOGY	2,881,448	2,052,763	828,685	165,600	4,767	16.00
17.00	90.00	CLINIC	23,236,397	18,857,098	4,379,299	177,200	32,235	17.00
18.00	91.00	EMERGENCY	6,710,597	1,452,632	5,257,965	177,200	32,962	18.00
200.00			141,425,151	82,174,858	59,250,291		381,319	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	11,926,923	596,346	0	0	1,434,794	1.00
2.00	30.00	ADULTS & PEDIATRICS	7,893,919	394,696	0	0	2,459,808	2.00
3.00	31.00	INTENSIVE CARE UNIT	372,035	18,602	0	0	54,215	3.00
4.00	33.00	BURN INTENSIVE CARE UNIT	167,100	8,355	0	0	88,526	4.00
5.00	34.00	SURGICAL INTENSIVE CARE UNIT	13,600	680	0	0	5,136	5.00
6.00	34.01	PEDIATRIC INTENSIVE CARE UNIT	104,531	5,227	0	0	59,206	6.00
7.00	34.02	TRAUMA INTENSIVE CARE UNIT	169,500	8,475	0	0	167,283	7.00
8.00	34.03	NEURO INTENSIVE CARE UNIT	103,300	5,165	0	0	57,693	8.00
9.00	34.04	NEONATAL INTENSIVE CARE UNIT	511,835	25,592	0	0	257,576	9.00
10.00	50.00	OPERATING ROOM	2,053,700	102,685	0	0	968,566	10.00
11.00	53.00	ANESTHESIOLOGY	1,652,668	82,633	0	0	485,812	11.00
12.00	54.00	RADIOLOGY-DIAGNOSTIC	818,987	40,949	0	0	581,241	12.00
13.00	60.00	LABORATORY	1,061,389	53,069	0	0	347,495	13.00
14.00	65.00	RESPIRATORY THERAPY	677,842	33,892	0	0	202,218	14.00
15.00	67.00	OCCUPATIONAL THERAPY	2,045	102	0	0	1,154	15.00
16.00	69.00	ELECTROCARDIOLOGY	379,527	18,976	0	0	190,264	16.00
17.00	90.00	CLINIC	2,746,174	137,309	0	0	1,534,317	17.00
18.00	91.00	EMERGENCY	2,808,109	140,405	0	0	443,106	18.00
200.00			33,463,184	1,673,158	0	0	9,338,410	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	1,429,032	13,355,955	8,285,948	8,373,216		1.00
2.00	30.00	ADULTS & PEDIATRICS	901,408	8,795,327	4,856,010	28,457,134		2.00
3.00	31.00	INTENSIVE CARE UNIT	44,021	416,056	250,618	404,999		3.00
4.00	33.00	BURN INTENSIVE CARE UNIT	23,075	190,175	159,283	1,150,508		4.00
5.00	34.00	SURGICAL INTENSIVE CARE UNIT	2,239	15,839	18,072	61,938		5.00
6.00	34.01	PEDIATRIC INTENSIVE CARE UNIT	11,092	115,623	52,363	781,023		6.00
7.00	34.02	TRAUMA INTENSIVE CARE UNIT	19,861	189,361	111,430	2,344,056		7.00
8.00	34.03	NEURO INTENSIVE CARE UNIT	14,178	117,478	97,245	756,255		8.00
9.00	34.04	NEONATAL INTENSIVE CARE UNIT	65,601	577,436	416,050	3,323,411		9.00
10.00	50.00	OPERATING ROOM	244,035	2,297,735	1,398,046	12,370,667		10.00
11.00	53.00	ANESTHESIOLOGY	207,399	1,860,067	1,280,879	5,497,289		11.00
12.00	54.00	RADIOLOGY-DIAGNOSTIC	99,371	918,358	586,559	7,884,221		12.00
13.00	60.00	LABORATORY	94,155	1,155,544	270,385	4,107,077		13.00
14.00	65.00	RESPIRATORY THERAPY	65,594	743,436	249,945	2,319,045		14.00
15.00	67.00	OCCUPATIONAL THERAPY	206	2,251	868	15,229		15.00
16.00	69.00	ELECTROCARDIOLOGY	54,719	434,246	394,439	2,447,202		16.00
17.00	90.00	CLINIC	289,168	3,035,342	1,343,957	20,201,055		17.00
18.00	91.00	EMERGENCY	347,188	3,155,297	2,102,668	3,555,300		18.00
200.00			3,912,342	37,375,526	21,874,765	104,049,625		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet B  
Part I  
Date/Time Prepared:  
4/30/2014 11:17 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	47,145,236	47,145,236			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	8,204,812		8,204,812		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	113,887,687	382,411	12,652	114,282,750	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	144,488,445	7,085,587	571,725	10,339,484	5.00
6.00 00600	MAINTENANCE & REPAIRS	5,940,908	1,400,504	10,509	1,738,636	6.00
7.00 00700	OPERATION OF PLANT	22,404,432	15,427,235	576,113	2,814,234	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,911,323	351,142	177	69,686	8.00
9.00 00900	HOUSEKEEPING	11,309,819	365,925	5,413	2,402,886	9.00
10.00 01000	DIETARY	3,303,357	20,171	23,438	855,174	10.00
11.00 01100	CAFETERIA	667,962	842,782	136	195,482	11.00
13.00 01300	NURSING ADMINISTRATION	3,431,259	223,766	105,279	846,806	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	3,963,315	1,247,828	255,368	493,682	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	4,258,296	593,557	2,363	1,075,481	16.00
17.00 01700	SOCIAL SERVICE	566,730	72,472	174	165,856	17.00
18.00 01851	WAI VER OVERHEAD COSTS	525,092	51,560	0	153,671	18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	23,970,814	20,812	1,847	5,317,718	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	19,982,017	0	0	5,747,736	22.00
23.00 02300	ALLIED HEALTH	255,221	2,504	0	66,300	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	35,943,499	5,397,419	3,107,198	18,834,548	30.00
31.00 03100	INTENSIVE CARE UNIT	8,092,593	561,888	2,300	2,424,449	31.00
33.00 03300	BURN INTENSIVE CARE UNIT	1,507,822	119,945	1,500	754,990	33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	3,474,653	188,992	0	1,053,779	34.00
34.01 02080	PEDIATRIC INTENSIVE CARE UNIT	1,620,253	133,146	1,568	742,254	34.01
34.02 02180	TRAUMA INTENSIVE CARE UNIT	3,853,705	454,382	78,152	1,675,137	34.02
34.03 02060	NEURO INTENSIVE CARE UNIT	2,171,299	94,947	0	980,601	34.03
34.04 02061	NEONATAL INTENSIVE CARE UNIT	6,209,242	242,114	26,026	2,926,327	34.04
43.00 04300	NURSERY	2,189,272	173,208	0	635,335	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	44,930,696	1,386,362	786,021	8,561,317	50.00
51.00 05100	RECOVERY ROOM	2,331,270	267,513	886	682,126	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	3,385,346	265,049	0	1,025,578	52.00
53.00 05300	ANESTHESIOLOGY	741,775	92,443	219,817	1,737,576	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	18,034,981	1,852,822	550,222	4,540,954	54.00
60.00 06000	LABORATORY	26,353,606	1,540,860	187,617	4,662,598	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	4,688,792	55,245	1,004	332,444	62.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	4,677,562	110,330	241,013	1,869,163	65.00
66.00 06600	PHYSICAL THERAPY	1,288,133	91,902	4,572	315,578	66.00
67.00 06700	OCCUPATIONAL THERAPY	420,032	88,817	0	127,439	67.00
68.00 06800	SPEECH PATHOLOGY	731,848	44,990	14,086	132,318	68.00
69.00 06900	ELECTROCARDIOLOGY	4,645,698	424,816	381,937	1,496,506	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	4,110,078	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	46,513,588	230,015	592,476	584,029	73.00
74.00 07400	RENAL DIALYSIS	2,971,966	46,592	15,555	864,014	74.00
76.00 03950	WAI VER PURCHASED PATIENT SERVICES	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	61,230,760	3,263,862	291,226	16,333,039	90.00
91.00 09100	EMERGENCY	22,944,848	1,417,450	135,299	7,994,506	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
98.00 05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	731,280,042	46,633,365	8,203,669	113,569,437	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.01 19001	DENTISTRY	1,711,311	91,021	1,143	470,912	190.01
190.02 19002	ACHN SATELITTE CLINICS	0	0	0	0	190.02
190.03 19003	SPECIAL FUNDS	828,284	420,850	0	242,401	190.03
190.04 19004	SENGSTACKE CLINIC	0	0	0	0	190.04
194.00 07951	WAI VER ADMINISTRATIVE ONLY COSTS	25,254,719	0	0	0	194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	759,074,356	47,145,236	8,204,812	114,282,750	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet B Part I Date/Time Prepared: 4/30/2014 11:17 am
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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	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	162,485,241				5.00
6.00	00600	MAINTENANCE & REPAIRS	2,475,877	11,566,434			6.00
7.00	00700	OPERATION OF PLANT	11,227,104	4,661,788	57,110,906		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	635,226	106,108	877,659	3,951,321	8.00
9.00	00900	HOUSEKEEPING	3,835,888	110,575	914,608	0	18,945,114
10.00	01000	DIETARY	1,144,482	6,095	50,417	0	17,266
11.00	01100	CAFETERIA	464,740	254,671	2,106,481	0	721,412
13.00	01300	NURSING ADMINISTRATION	1,254,779	67,617	559,288	0	191,541
14.00	01400	CENTRAL SERVICES & SUPPLY	1,623,300	377,068	3,118,868	0	1,068,127
16.00	01600	MEDICAL RECORDS & LIBRARY	1,614,994	179,361	1,483,559	0	508,078
17.00	01700	SOCIAL SERVICE	219,311	21,900	181,139	0	62,035
18.00	01851	WAIVER OVERHEAD COSTS	198,909	15,580	128,870	0	44,134
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	7,983,108	6,289	52,019	0	17,815
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	7,007,678	0	0	0	0
23.00	02300	ALLIED HEALTH	88,250	757	6,258	0	2,143
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	17,235,477	1,630,988	13,490,513	1,043,686	4,620,130
31.00	03100	INTENSIVE CARE UNIT	3,018,051	169,791	1,404,404	159,556	480,970
33.00	03300	BURN INTENSIVE CARE UNIT	649,369	36,245	299,796	120,971	102,672
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,284,823	57,109	472,374	163,432	161,775
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	680,136	40,234	332,789	39,344	113,971
34.02	02180	TRAUMA INTENSIVE CARE UNIT	1,650,858	137,305	1,135,700	180,750	388,946
34.03	02060	NEURO INTENSIVE CARE UNIT	884,302	28,691	237,313	15,079	81,273
34.04	02061	NEONATAL INTENSIVE CARE UNIT	2,561,166	73,162	605,149	143,511	207,247
43.00	04300	NURSERY	816,476	52,340	432,922	50,386	148,264
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	15,160,588	418,930	3,465,125	549,823	1,186,710
51.00	05100	RECOVERY ROOM	893,820	80,837	668,633	175,028	228,988
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,273,534	80,092	662,475	216,157	226,879
53.00	05300	ANESTHESIOLOGY	760,315	27,934	231,055	27,924	79,130
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,803,200	559,884	4,631,014	403,768	1,585,995
60.00	06000	LABORATORY	8,918,243	465,616	3,851,285	0	1,318,959
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,382,889	16,694	138,082	0	47,289
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	1,878,737	33,340	275,764	0	94,442
66.00	06600	PHYSICAL THERAPY	463,057	27,771	229,703	31,766	78,667
67.00	06700	OCCUPATIONAL THERAPY	173,297	26,839	221,993	0	76,027
68.00	06800	SPEECH PATHOLOGY	251,451	13,595	112,448	0	38,511
69.00	06900	ELECTROCARDIOLOGY	1,892,597	128,371	1,061,802	43,780	363,638
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,119,409	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	13,051,377	69,506	574,909	0	196,891
74.00	07400	RENAL DIALYSIS	1,061,682	14,079	116,454	0	39,882
76.00	03950	WAIVER PURCHASED PATIENT SERVICES	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	22,093,314	986,271	8,157,821	26,071	2,793,830
91.00	09100	EMERGENCY	8,849,452	428,324	3,542,828	560,289	1,213,321
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	154,581,266	11,411,757	55,831,517	3,951,321	18,506,958
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
190.01	19001	DENTISTRY	619,445	27,505	227,500	0	77,913
190.02	19002	ACHN SATELITTE CLINICS	0	0	0	0	0
190.03	19003	SPECIAL FUNDS	406,230	127,172	1,051,889	0	360,243
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0
194.00	07951	WAIVER ADMINISTRATIVE ONLY COSTS	6,878,300	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	162,485,241	11,566,434	57,110,906	3,951,321	18,945,114

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet B  
Part I  
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	14.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	5,420,400					10.00
11.00	01100	CAFETERIA	0	5,253,666				11.00
13.00	01300	NURSING ADMINISTRATION	0	56,301	6,736,636			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	57,188	124,270	12,329,014		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	121,723	0	0	9,837,412	16.00
17.00	01700	SOCIAL SERVICE	0	6,224	0	0	0	17.00
18.00	01851	WAIVER OVERHEAD COSTS	0	7,240	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	631,522	0	2,830	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	152,725	0	6,970	0	22.00
23.00	02300	ALLIED HEALTH	0	6,186	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	4,668,024	1,023,237	1,636,701	50,077	1,681,899	30.00
31.00	03100	INTENSIVE CARE UNIT	151,045	139,151	294,518	21,386	183,593	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	30,704	32,707	53,469	11,323	31,276	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	39,542	61,813	129,783	3,735	59,701	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	23,272	40,588	72,237	0	23,280	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	32,181	87,460	155,103	11,624	84,536	34.02
34.03	02060	NEURO INTENSIVE CARE UNIT	58,419	51,724	92,014	7,475	54,374	34.03
34.04	02061	NEONATAL INTENSIVE CARE UNIT	0	146,703	243,698	9,895	222,496	34.04
43.00	04300	NURSERY	0	44,010	95,514	1,329	12,209	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	465,217	793,912	9,599,668	1,451,671	50.00
51.00	05100	RECOVERY ROOM	0	41,464	89,353	0	95,180	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	62,058	130,367	2,044	22,485	52.00
53.00	05300	ANESTHESIOLOGY	0	47,351	32,518	96,436	466,146	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	251,916	89,637	645,628	1,337,924	54.00
60.00	06000	LABORATORY	0	363,008	0	10,850	1,122,321	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	27,021	0	0	77,629	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	116,178	17,764	63,559	14,887	65.00
66.00	06600	PHYSICAL THERAPY	0	22,752	0	62,753	16,306	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,754	0	0	9,372	67.00
68.00	06800	SPEECH PATHOLOGY	0	10,082	0	1,019	5,888	68.00
69.00	06900	ELECTROCARDIOLOGY	0	94,719	61,416	497,530	189,862	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,029,455	51,737	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	108,346	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	332,468	0	0	835,911	73.00
74.00	07400	RENAL DIALYSIS	0	42,834	56,797	5,807	64,184	74.00
76.00	03950	WAIVER PURCHASED PATIENT SERVICES	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	147,138	199,482	1,716,967	129,364	951,854	90.00
91.00	09100	EMERGENCY	270,075	472,472	850,598	27,259	662,345	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,420,400	5,225,278	6,736,636	12,298,016	9,837,412	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	DENTISTRY	0	21,129	0	30,998	0	190.01
190.02	19002	ACHN SATELLITE CLINICS	0	0	0	0	0	190.02
190.03	19003	SPECIAL FUNDS	0	7,259	0	0	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07951	WAIVER ADMINISTRATIVE ONLY COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	5,420,400	5,253,666	6,736,636	12,329,014	9,837,412	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet B  
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Cost Center Description	SOCIAL SERVICE	OTHER GENERAL SERVICE		NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		
		WAI VER OVERHEAD COSTS			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100 CAP REL COSTS-BLDG & FIXT							1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP							2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT							4.00
5.00 00500 ADMINISTRATIVE & GENERAL							5.00
6.00 00600 MAINTENANCE & REPAIRS							6.00
7.00 00700 OPERATION OF PLANT							7.00
8.00 00800 LAUNDRY & LINEN SERVICE							8.00
9.00 00900 HOUSEKEEPING							9.00
10.00 01000 DIETARY							10.00
11.00 01100 CAFETERIA							11.00
13.00 01300 NURSING ADMINISTRATION							13.00
14.00 01400 CENTRAL SERVICES & SUPPLY							14.00
16.00 01600 MEDICAL RECORDS & LIBRARY							16.00
17.00 01700 SOCIAL SERVICE	1,295,841						17.00
18.00 01851 WAI VER OVERHEAD COSTS	0	1,125,056					18.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0				19.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	38,004,774			21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	32,897,126		22.00
23.00 02300 ALLIED HEALTH	0	0	0	0	0		23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS	392,121	0	0	11,380,966	9,851,422		30.00
31.00 03100 INTENSIVE CARE UNIT	31,981	0	0	1,426,815	1,235,058		31.00
33.00 03300 BURN INTENSIVE CARE UNIT	15,921	0	0	305,327	264,292		33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	23,997	0	0	394,240	341,256		34.00
34.01 02080 PEDIATRIC INTENSIVE CARE UNIT	15,921	0	0	167,762	145,216		34.01
34.02 02180 TRAUMA INTENSIVE CARE UNIT	23,997	0	0	0	0		34.02
34.03 02060 NEURO INTENSIVE CARE UNIT	23,997	0	0	204,669	177,163		34.03
34.04 02061 NEONATAL INTENSIVE CARE UNIT	23,997	0	0	768,349	665,087		34.04
43.00 04300 NURSERY	0	0	0	248,288	214,919		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	0	0	0	5,275,272	4,566,302		50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	322,942	279,540		52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	2,171,677	1,879,815		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	1,521,600	1,317,105		54.00
60.00 06000 LABORATORY	0	0	0	158,535	137,229		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0		62.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	805,257	697,035		65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	25,164	21,782		67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	1,182,721	1,023,769		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0		73.00
74.00 07400 RENAL DIALYSIS	47,994	0	0	0	0		74.00
76.00 03950 WAI VER PURCHASED PATIENT SERVICES	0	0	0	0	0		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	455,944	0	0	5,454,777	4,721,683		90.00
91.00 09100 EMERGENCY	239,971	0	0	6,190,413	5,358,453		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART							92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00 05950 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0		98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00 11300 INTEREST EXPENSE							113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,295,841	0	0	38,004,774	32,897,126	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0		190.00
190.01 19001 DENTISTRY	0	0	0	0	0		190.01
190.02 19002 ACHN SATELLITE CLINICS	0	0	0	0	0		190.02
190.03 19003 SPECIAL FUNDS	0	0	0	0	0		190.03
190.04 19004 SENGSTACKE CLINIC	0	0	0	0	0		190.04
194.00 07951 WAI VER ADMINISTRATIVE ONLY COSTS	0	1,125,056	0	0	0		194.00
200.00	Cross Foot Adjustments			0	0		200.00
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	1,295,841	1,125,056	0	38,004,774	32,897,126	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

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Cost Center Description			ALLIED HEALTH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
18.00	01851	WAI VER OVERHEAD COSTS					18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV					22.00
23.00	02300	ALLIED HEALTH	427,619				23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	131,987,905	-21,232,388	110,755,517	30.00
31.00	03100	INTENSIVE CARE UNIT	0	19,797,549	-2,661,873	17,135,676	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	4,338,329	-569,619	3,768,710	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	7,911,004	-735,496	7,175,508	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	4,191,971	-312,978	3,878,993	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	9,949,836	0	9,949,836	34.02
34.03	02060	NEURO INTENSIVE CARE UNIT	0	5,163,340	-381,832	4,781,508	34.03
34.04	02061	NEONATAL INTENSIVE CARE UNIT	0	15,074,169	-1,433,436	13,640,733	34.04
43.00	04300	NURSERY	0	5,114,472	-463,207	4,651,265	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	98,597,614	-9,841,574	88,756,040	50.00
51.00	05100	RECOVERY ROOM	0	5,555,098	0	5,555,098	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,954,546	-602,482	7,352,064	52.00
53.00	05300	ANESTHESIOLOGY	0	8,611,912	-4,051,492	4,560,420	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	44,126,650	-2,838,705	41,287,945	54.00
60.00	06000	LABORATORY	0	49,090,727	-295,764	48,794,963	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	6,767,089	0	6,767,089	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	10,895,031	-1,502,292	9,392,739	65.00
66.00	06600	PHYSICAL THERAPY	0	2,632,960	0	2,632,960	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,200,516	-46,946	1,153,570	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,356,236	0	1,356,236	68.00
69.00	06900	ELECTROCARDIOLOGY	0	13,489,162	-2,206,490	11,282,672	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,081,192	0	1,081,192	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,337,833	0	5,337,833	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	427,619	63,408,789	0	63,408,789	73.00
74.00	07400	RENAL DIALYSIS	0	5,347,840	0	5,347,840	74.00
76.00	03950	WAI VER PURCHASED PATIENT SERVICES	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	128,953,403	-10,176,460	118,776,943	90.00
91.00	09100	EMERGENCY	0	61,157,903	-11,548,866	49,609,037	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	427,619	719,093,076	-70,901,900	648,191,176	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.01	19001	DENTISTRY	0	3,278,877	0	3,278,877	190.01
190.02	19002	ACHN SATELITE CLINICS	0	0	0	0	190.02
190.03	19003	SPECIAL FUNDS	0	3,444,328	0	3,444,328	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	190.04
194.00	07951	WAI VER ADMINSTRATIVE ONLY COSTS	0	33,258,075	0	33,258,075	194.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	427,619	759,074,356	-70,901,900	688,172,456	202.00

Provider CCN: 140124  
 Period: From 12/01/2012 To 11/30/2013  
 Worksheet Non-CMS W  
 Date/Time Prepared: 4/30/2014 11:17 am

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	16	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM. COST	5.00
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	5	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	6	MEALS SERVED	10.00
11.00	CAFETERIA	7	MEALS SERVED	11.00
13.00	NURSING ADMINISTRATION	9	DIRECT NRSING HRS	13.00
14.00	CENTRAL SERVICES & SUPPLY	10	COSTED REQUIS.	14.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS CHARGES	16.00
17.00	SOCIAL SERVICE	13	TIME SPENT	17.00
18.00	WAIVER OVERHEAD COSTS	25	ASSIGNED TIME	18.00
19.00	NONPHYSICIAN ANESTHETISTS	14	ASSIGNED TIME	19.00
21.00	I&R SERVICES-SALARY & FRINGES APPRV	15	ASSIGNED TIME	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	15	ASSIGNED TIME	22.00
23.00	ALLIED HEALTH	23	ASSIGNED TIME	23.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet B  
Part II  
Date/Time Prepared:  
4/30/2014 11:17 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	156,158	382,411	12,652	551,221	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	361,374	7,085,587	571,725	8,018,686	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	1,400,504	10,509	1,411,013	6.00
7.00 00700	OPERATION OF PLANT	0	15,427,235	576,113	16,003,348	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	351,142	177	351,319	8.00
9.00 00900	HOUSEKEEPING	0	365,925	5,413	371,338	9.00
10.00 01000	DIETARY	0	20,171	23,438	43,609	10.00
11.00 01100	CAFETERIA	0	842,782	136	842,918	11.00
13.00 01300	NURSING ADMINISTRATION	56,506	223,766	105,279	385,551	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	1,247,828	255,368	1,503,196	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	593,557	2,363	595,920	16.00
17.00 01700	SOCIAL SERVICE	0	72,472	174	72,646	17.00
18.00 01851	WAIVER OVERHEAD COSTS	0	51,560	0	51,560	18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	20,812	1,847	22,659	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00 02300	ALLIED HEALTH	0	2,504	0	2,504	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	5,397,419	3,107,198	8,504,617	30.00
31.00 03100	INTENSIVE CARE UNIT	0	561,888	2,300	564,188	31.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	119,945	1,500	121,445	33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	188,992	0	188,992	34.00
34.01 02080	PEDIATRIC INTENSIVE CARE UNIT	0	133,146	1,568	134,714	34.01
34.02 02180	TRAUMA INTENSIVE CARE UNIT	0	454,382	78,152	532,534	34.02
34.03 02060	NEURO INTENSIVE CARE UNIT	0	94,947	0	94,947	34.03
34.04 02061	NEONATAL INTENSIVE CARE UNIT	0	242,114	26,026	268,140	34.04
43.00 04300	NURSERY	0	173,208	0	173,208	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	1,386,362	786,021	2,172,383	50.00
51.00 05100	RECOVERY ROOM	0	267,513	886	268,399	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	265,049	0	265,049	52.00
53.00 05300	ANESTHESIOLOGY	0	92,443	219,817	312,260	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	1,852,822	550,222	2,403,044	54.00
60.00 06000	LABORATORY	0	1,540,860	187,617	1,728,477	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	55,245	1,004	56,249	62.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	295,495	110,330	241,013	646,838	65.00
66.00 06600	PHYSICAL THERAPY	0	91,902	4,572	96,474	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	88,817	0	88,817	67.00
68.00 06800	SPEECH PATHOLOGY	0	44,990	14,086	59,076	68.00
69.00 06900	ELECTROCARDIOLOGY	0	424,816	381,937	806,753	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	230,015	592,476	822,491	73.00
74.00 07400	RENAL DIALYSIS	0	46,592	15,555	62,147	74.00
76.00 03950	WAIVER PURCHASED PATIENT SERVICES	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	948,965	3,263,862	291,226	4,504,053	90.00
91.00 09100	EMERGENCY	0	1,417,450	135,299	1,552,749	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
98.00 05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,818,498	46,633,365	8,203,669	56,655,532	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.01 19001	DENTISTRY	0	91,021	1,143	92,164	190.01
190.02 19002	ACHN SATELLITE CLINICS	0	0	0	0	190.02
190.03 19003	SPECIAL FUNDS	0	420,850	0	420,850	190.03
190.04 19004	SENGSTACKE CLINIC	0	0	0	0	190.04
194.00 07951	WAIVER ADMINISTRATIVE ONLY COSTS	0	0	0	0	194.00
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,818,498	47,145,236	8,204,812	57,168,546	551,221

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet B Part II Date/Time Prepared: 4/30/2014 11:17 am				
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.00	6.00	7.00	8.00	9.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00		
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00		
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00		
5.00	00500	ADMINISTRATIVE & GENERAL	8,068,572			5.00		
6.00	00600	MAINTENANCE & REPAIRS	122,950	1,542,352		6.00		
7.00	00700	OPERATION OF PLANT	557,528	621,636	17,196,090	7.00		
8.00	00800	LAUNDRY & LINEN SERVICE	31,545	14,149	264,263	661,612	8.00	
9.00	00900	HOUSEKEEPING	190,487	14,745	275,388	0	863,551	9.00
10.00	01000	DIETARY	56,834	813	15,180	0	787	10.00
11.00	01100	CAFETERIA	23,079	33,960	634,261	0	32,883	11.00
13.00	01300	NURSING ADMINISTRATION	62,311	9,017	168,402	0	8,731	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	80,612	50,281	939,091	0	48,687	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	80,199	23,917	446,699	0	23,159	16.00
17.00	01700	SOCIAL SERVICE	10,891	2,920	54,541	0	2,828	17.00
18.00	01851	WAIVER OVERHEAD COSTS	9,878	2,078	38,803	0	2,012	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	396,434	839	15,663	0	812	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	347,995	0	0	0	0	22.00
23.00	02300	ALLIED HEALTH	4,382	101	1,884	0	98	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	855,898	217,488	4,061,992	174,755	210,593	30.00
31.00	03100	INTENSIVE CARE UNIT	149,874	22,641	422,866	26,716	21,923	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	32,247	4,833	90,269	20,256	4,680	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	63,803	7,615	142,232	27,365	7,374	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	33,775	5,365	100,203	6,588	5,195	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	81,980	18,309	341,959	30,265	17,729	34.02
34.03	02060	NEURO INTENSIVE CARE UNIT	43,914	3,826	71,455	2,525	3,705	34.03
34.04	02061	NEONATAL INTENSIVE CARE UNIT	127,185	9,756	182,210	24,030	9,447	34.04
43.00	04300	NURSERY	40,545	6,979	130,353	8,437	6,758	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	752,861	55,863	1,043,349	92,063	54,092	50.00
51.00	05100	RECOVERY ROOM	44,386	10,779	201,325	29,307	10,438	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	63,243	10,680	199,471	36,193	10,342	52.00
53.00	05300	ANESTHESIOLOGY	37,757	3,725	69,571	4,676	3,607	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	337,841	74,659	1,394,398	67,607	72,292	54.00
60.00	06000	LABORATORY	442,872	62,089	1,159,622	0	60,120	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	68,673	2,226	41,577	0	2,156	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	93,296	4,446	83,033	0	4,305	65.00
66.00	06600	PHYSICAL THERAPY	22,995	3,703	69,164	5,319	3,586	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,606	3,579	66,842	0	3,465	67.00
68.00	06800	SPEECH PATHOLOGY	12,487	1,813	33,858	0	1,755	68.00
69.00	06900	ELECTROCARDIOLOGY	93,985	17,118	319,709	7,330	16,575	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	55,589	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	648,119	9,268	173,105	0	8,975	73.00
74.00	07400	RENAL DIALYSIS	52,722	1,877	35,064	0	1,818	74.00
76.00	03950	WAIVER PURCHASED PATIENT SERVICES	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	1,096,834	131,517	2,456,319	4,365	127,348	90.00
91.00	09100	EMERGENCY	439,456	57,116	1,066,745	93,815	55,305	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,676,068	1,521,726	16,810,866	661,612	843,580	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	DENTISTRY	30,761	3,668	68,500	0	3,551	190.01
190.02	19002	ACHN SATELITTE CLINICS	0	0	0	0	0	190.02
190.03	19003	SPECIAL FUNDS	20,173	16,958	316,724	0	16,420	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07951	WAIVER ADMINISTRATIVE ONLY COSTS	341,570	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	8,068,572	1,542,352	17,196,090	661,612	863,551	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140124		Period: From 12/01/2012 To 11/30/2013		Worksheet B Part II Date/Time Prepared: 4/30/2014 11:17 am	
Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
		10.00	11.00	13.00	14.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	121,349					10.00
11.00	01100		1,568,044				11.00
13.00	01300		16,804	654,902			13.00
14.00	01400		17,069	12,081	2,653,399		14.00
16.00	01600		36,330	0	0	1,211,413	16.00
17.00	01700		1,858	0	0	0	17.00
18.00	01851		2,161	0	0	0	18.00
19.00	01900		0	0	0	0	19.00
21.00	02100		188,489	0	609	0	21.00
22.00	02200		45,583	0	1,500	0	22.00
23.00	02300		1,846	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	104,506	305,398	159,112	10,777	207,037	30.00
31.00	03100	3,382	41,532	28,632	4,603	22,610	31.00
33.00	03300	687	9,762	5,198	2,437	3,852	33.00
34.00	03400	885	18,449	12,617	804	7,352	34.00
34.01	02080	521	12,114	7,023	0	2,867	34.01
34.02	02180	720	26,104	15,078	2,502	10,411	34.02
34.03	02060	1,308	15,438	8,945	1,609	6,696	34.03
34.04	02061	0	43,786	23,691	2,130	27,401	34.04
43.00	04300	0	13,136	9,285	286	1,504	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	138,852	77,180	2,065,998	178,778	50.00
51.00	05100	0	12,376	8,686	0	11,722	51.00
52.00	05200	0	18,522	12,674	440	2,769	52.00
53.00	05300	0	14,133	3,161	20,755	57,407	53.00
54.00	05400	0	75,189	8,714	138,950	164,770	54.00
60.00	06000	0	108,346	0	2,335	138,217	60.00
62.00	06200	0	8,065	0	0	9,560	62.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	34,675	1,727	13,679	1,833	65.00
66.00	06600	0	6,791	0	13,506	2,008	66.00
67.00	06700	0	2,911	0	0	1,154	67.00
68.00	06800	0	3,009	0	219	725	68.00
69.00	06900	0	28,271	5,971	107,076	23,382	69.00
71.00	07100	0	0	0	221,555	6,372	71.00
72.00	07200	0	0	0	0	13,343	72.00
73.00	07300	0	99,231	0	0	102,945	73.00
74.00	07400	0	12,785	5,522	1,250	7,904	74.00
76.00	03950	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	3,294	59,539	166,914	27,841	117,224	90.00
91.00	09100	6,046	141,017	82,691	5,867	81,570	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00	05950	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00							118.00
SUBTOTALS (SUM OF LINES 1-117)		121,349	1,559,571	654,902	2,646,728	1,211,413	
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	0	6,306	0	6,671	0	190.01
190.02	19002	0	0	0	0	0	190.02
190.03	19003	0	2,167	0	0	0	190.03
190.04	19004	0	0	0	0	0	190.04
194.00	07951	0	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		121,349	1,568,044	654,902	2,653,399	1,211,413	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet B  
Part II  
Date/Time Prepared:  
4/30/2014 11:17 am

Cost Center Description	SOCIAL SERVICE	OTHER GENERAL SERVICE		NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		
		WAI VER OVERHEAD COSTS			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500	ADMINISTRATIVE & GENERAL						5.00
6.00 00600	MAINTENANCE & REPAIRS						6.00
7.00 00700	OPERATION OF PLANT						7.00
8.00 00800	LAUNDRY & LINEN SERVICE						8.00
9.00 00900	HOUSEKEEPING						9.00
10.00 01000	DIETARY						10.00
11.00 01100	CAFETERIA						11.00
13.00 01300	NURSING ADMINISTRATION						13.00
14.00 01400	CENTRAL SERVICES & SUPPLY						14.00
16.00 01600	MEDICAL RECORDS & LIBRARY						16.00
17.00 01700	SOCIAL SERVICE	146,484					17.00
18.00 01851	WAI VER OVERHEAD COSTS	0	107,233				18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		651,162		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0			422,810	22.00
23.00 02300	ALLIED HEALTH	0	0				23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	44,326	0				30.00
31.00 03100	INTENSIVE CARE UNIT	3,615	0				31.00
33.00 03300	BURN INTENSIVE CARE UNIT	1,800	0				33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	2,713	0				34.00
34.01 02080	PEDIATRIC INTENSIVE CARE UNIT	1,800	0				34.01
34.02 02180	TRAUMA INTENSIVE CARE UNIT	2,713	0				34.02
34.03 02060	NEURO INTENSIVE CARE UNIT	2,713	0				34.03
34.04 02061	NEONATAL INTENSIVE CARE UNIT	2,713	0				34.04
43.00 04300	NURSERY	0	0				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	0	0				50.00
51.00 05100	RECOVERY ROOM	0	0				51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0				52.00
53.00 05300	ANESTHESIOLOGY	0	0				53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0				54.00
60.00 06000	LABORATORY	0	0				60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62.00
64.00 06400	INTRAVENOUS THERAPY	0	0				64.00
65.00 06500	RESPIRATORY THERAPY	0	0				65.00
66.00 06600	PHYSICAL THERAPY	0	0				66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0				67.00
68.00 06800	SPEECH PATHOLOGY	0	0				68.00
69.00 06900	ELECTROCARDIOLOGY	0	0				69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0				73.00
74.00 07400	RENAL DIALYSIS	5,425	0				74.00
76.00 03950	WAI VER PURCHASED PATIENT SERVICES	0	0				76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000	CLINIC	51,539	0				90.00
91.00 09100	EMERGENCY	27,127	0				91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00 05950	OTHER REIMBURSABLE COST CENTERS	0	0				98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00 11300	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	146,484	0	0	0	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
190.01 19001	DENTISTRY	0	0				190.01
190.02 19002	ACHN SATELLITE CLINICS	0	0				190.02
190.03 19003	SPECIAL FUNDS	0	0				190.03
190.04 19004	SENGSTACKE CLINIC	0	0				190.04
194.00 07951	WAI VER ADMINISTRATIVE ONLY COSTS	0	107,233				194.00
200.00	Cross Foot Adjustments			0	651,162	422,810	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	146,484	107,233	0	651,162	422,810	202.00

ALLOCATION OF CAPITAL RELATED COSTS				Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet B Part II Date/Time Prepared: 4/30/2014 11:17 am
Cost Center Description			ALLIED HEALTH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
			23.00	24.00	25.00	26.00
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
18.00	01851	WAIVER OVERHEAD COSTS				18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
23.00	02300	ALLIED HEALTH	11,135			23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS		14,947,203	0	14,947,203
31.00	03100	INTENSIVE CARE UNIT		1,324,279	0	1,324,279
33.00	03300	BURN INTENSIVE CARE UNIT		301,109	0	301,109
34.00	03400	SURGICAL INTENSIVE CARE UNIT		485,285	0	485,285
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT		313,746	0	313,746
34.02	02180	TRAUMA INTENSIVE CARE UNIT		1,088,386	0	1,088,386
34.03	02060	NEURO INTENSIVE CARE UNIT		261,812	0	261,812
34.04	02061	NEONATAL INTENSIVE CARE UNIT		734,608	0	734,608
43.00	04300	NURSERY		393,556	0	393,556
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM		6,672,726	0	6,672,726
51.00	05100	RECOVERY ROOM		600,709	0	600,709
52.00	05200	DELIVERY ROOM & LABOR ROOM		624,331	0	624,331
53.00	05300	ANESTHESIOLOGY		535,435	0	535,435
54.00	05400	RADIOLOGY-DIAGNOSTIC		4,759,373	0	4,759,373
60.00	06000	LABORATORY		3,724,574	0	3,724,574
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		190,110	0	190,110
64.00	06400	INTRAVENOUS THERAPY		0	0	0
65.00	06500	RESPIRATORY THERAPY		892,850	0	892,850
66.00	06600	PHYSICAL THERAPY		225,069	0	225,069
67.00	06700	OCCUPATIONAL THERAPY		175,989	0	175,989
68.00	06800	SPEECH PATHOLOGY		113,580	0	113,580
69.00	06900	ELECTROCARDIOLOGY		1,433,390	0	1,433,390
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		227,927	0	227,927
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		68,932	0	68,932
73.00	07300	DRUGS CHARGED TO PATIENTS		1,866,952	0	1,866,952
74.00	07400	RENAL DIALYSIS		190,683	0	190,683
76.00	03950	WAIVER PURCHASED PATIENT SERVICES		0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC		8,825,591	0	8,825,591
91.00	09100	EMERGENCY		3,648,076	0	3,648,076
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0	
<b>OTHER REIMBURSABLE COST CENTERS</b>						
98.00	05950	OTHER REIMBURSABLE COST CENTERS		0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	54,626,281	0	54,626,281
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0
190.01	19001	DENTISTRY		213,893	0	213,893
190.02	19002	ACHN SATELLITE CLINICS		0	0	0
190.03	19003	SPECIAL FUNDS		794,462	0	794,462
190.04	19004	SENGSTACKE CLINIC		0	0	0
194.00	07951	WAIVER ADMINSTRATIVE ONLY COSTS		448,803	0	448,803
200.00		Cross Foot Adjustments	11,135	1,085,107	0	1,085,107
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	11,135	57,168,546	0	57,168,546

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet B-1  
Date/Time Prepared:  
4/30/2014 11:17 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,353,620					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		8,204,809				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	19,091	12,652	390,503,199			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	353,732	571,725	35,329,940	-162,485,241	596,589,115	5.00
6.00 00600	MAINTENANCE & REPAIRS	69,917	10,509	5,940,908	0	9,090,557	6.00
7.00 00700	OPERATION OF PLANT	770,170	576,113	9,616,218	0	41,222,014	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	17,530	177	238,118	0	2,332,328	8.00
9.00 00900	HOUSEKEEPING	18,268	5,413	8,210,644	0	14,084,043	9.00
10.00 01000	DIETARY	1,007	23,438	2,922,123	0	4,202,140	10.00
11.00 01100	CAFETERIA	42,074	136	667,962	0	1,706,362	11.00
13.00 01300	NURSING ADMINISTRATION	11,171	105,279	2,893,530	0	4,607,110	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	62,295	255,368	1,686,909	0	5,960,193	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	29,632	2,363	3,674,912	0	5,929,697	16.00
17.00 01700	SOCIAL SERVICE	3,618	174	566,730	0	805,232	17.00
18.00 01851	WAIVER OVERHEAD COSTS	2,574	0	525,092	0	730,323	18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	1,039	1,847	18,170,604	0	29,311,191	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	19,639,973	0	25,729,753	22.00
23.00 02300	ALLIED HEALTH	125	0	226,548	0	324,025	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	269,454	3,107,195	64,357,366	0	63,282,664	30.00
31.00 03100	INTENSIVE CARE UNIT	28,051	2,300	8,284,325	0	11,081,230	31.00
33.00 03300	BURN INTENSIVE CARE UNIT	5,988	1,500	2,579,797	0	2,384,257	33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	9,435	0	3,600,755	0	4,717,424	34.00
34.01 02080	PEDIATRIC INTENSIVE CARE UNIT	6,647	1,568	2,536,278	0	2,497,221	34.01
34.02 02180	TRAUMA INTENSIVE CARE UNIT	22,684	78,152	5,723,931	0	6,061,376	34.02
34.03 02060	NEURO INTENSIVE CARE UNIT	4,740	0	3,350,708	0	3,246,847	34.03
34.04 02061	NEONATAL INTENSIVE CARE UNIT	12,087	26,026	9,999,239	0	9,403,709	34.04
43.00 04300	NURSERY	8,647	0	2,170,935	0	2,997,815	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	69,211	786,021	29,253,957	0	55,664,396	50.00
51.00 05100	RECOVERY ROOM	13,355	886	2,330,818	0	3,281,795	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	13,232	0	3,504,393	0	4,675,973	52.00
53.00 05300	ANESTHESIOLOGY	4,615	219,817	5,937,286	0	2,791,611	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	92,498	550,222	15,516,406	0	24,978,979	54.00
60.00 06000	LABORATORY	76,924	187,617	15,932,064	0	32,744,681	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,758	1,004	1,135,959	0	5,077,485	62.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	5,508	241,013	6,386,918	0	6,898,068	65.00
66.00 06600	PHYSICAL THERAPY	4,588	4,572	1,078,329	0	1,700,185	66.00
67.00 06700	OCCUPATIONAL THERAPY	4,434	0	435,459	0	636,288	67.00
68.00 06800	SPEECH PATHOLOGY	2,246	14,086	452,129	0	923,242	68.00
69.00 06900	ELECTROCARDIOLOGY	21,208	381,937	5,113,550	0	6,948,957	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,110,078	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	11,483	592,476	1,995,623	0	47,920,108	73.00
74.00 07400	RENAL DIALYSIS	2,326	15,555	2,952,331	0	3,898,127	74.00
76.00 03950	WAIVER PURCHASED PATIENT SERVICES	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000	CLINIC	162,941	291,226	55,809,876	0	81,118,887	90.00
91.00 09100	EMERGENCY	70,763	135,299	27,317,168	0	32,492,103	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00 05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00 11300	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,328,066	8,203,666	388,065,811	-162,485,241	567,568,474	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01 19001	DENTISTRY	4,544	1,143	1,609,104	0	2,274,387	190.01
190.02 19002	ACHN SATELITTE CLINICS	0	0	0	0	0	190.02
190.03 19003	SPECIAL FUNDS	21,010	0	828,284	0	1,491,535	190.03
190.04 19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00 07951	WAIVER ADMINISTRATIVE ONLY COSTS	0	0	0	0	25,254,719	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	47,145,236	8,204,812	114,282,750		162,485,241	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet B-1

Date/Time Prepared:  
4/30/2014 11:17 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00				
203.00	Unit cost multiplier (Wkst. B, Part I)	20.030946	1.000000	0.292655		0.272357	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			551,221		8,068,572	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001412		0.013525	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet B-1  
Date/Time Prepared:  
4/30/2014 11:17 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	1,910,880					6.00
7.00	00700	770,170	1,140,710				7.00
8.00	00800	17,530	17,530	2,232,635			8.00
9.00	00900	18,268	18,268	0	1,104,912		9.00
10.00	01000	1,007	1,007	0	1,007	455,107	10.00
11.00	01100	42,074	42,074	0	42,074	0	11.00
13.00	01300	11,171	11,171	0	11,171	0	13.00
14.00	01400	62,295	62,295	0	62,295	0	14.00
16.00	01600	29,632	29,632	0	29,632	0	16.00
17.00	01700	3,618	3,618	0	3,618	0	17.00
18.00	01851	2,574	2,574	0	2,574	0	18.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	1,039	1,039	0	1,039	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	125	125	0	125	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	269,454	269,454	589,719	269,454	391,936	30.00
31.00	03100	28,051	28,051	90,155	28,051	12,682	31.00
33.00	03300	5,988	5,988	68,353	5,988	2,578	33.00
34.00	03400	9,435	9,435	92,345	9,435	3,320	34.00
34.01	02080	6,647	6,647	22,231	6,647	1,954	34.01
34.02	02180	22,684	22,684	102,130	22,684	2,702	34.02
34.03	02060	4,740	4,740	8,520	4,740	4,905	34.03
34.04	02061	12,087	12,087	81,089	12,087	0	34.04
43.00	04300	8,647	8,647	28,470	8,647	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	69,211	69,211	310,669	69,211	0	50.00
51.00	05100	13,355	13,355	98,897	13,355	0	51.00
52.00	05200	13,232	13,232	122,136	13,232	0	52.00
53.00	05300	4,615	4,615	15,778	4,615	0	53.00
54.00	05400	92,498	92,498	228,143	92,498	0	54.00
60.00	06000	76,924	76,924	0	76,924	0	60.00
62.00	06200	2,758	2,758	0	2,758	0	62.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	5,508	5,508	0	5,508	0	65.00
66.00	06600	4,588	4,588	17,949	4,588	0	66.00
67.00	06700	4,434	4,434	0	4,434	0	67.00
68.00	06800	2,246	2,246	0	2,246	0	68.00
69.00	06900	21,208	21,208	24,737	21,208	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	11,483	11,483	0	11,483	0	73.00
74.00	07400	2,326	2,326	0	2,326	0	74.00
76.00	03950	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	162,941	162,941	14,731	162,941	12,354	90.00
91.00	09100	70,763	70,763	316,583	70,763	22,676	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00	05950	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		1,885,326	1,115,156	2,232,635	1,079,358	455,107	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	4,544	4,544	0	4,544	0	190.01
190.02	19002	0	0	0	0	0	190.02
190.03	19003	21,010	21,010	0	21,010	0	190.03
190.04	19004	0	0	0	0	0	190.04
194.00	07951	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		11,566,434	57,110,906	3,951,321	18,945,114	5,420,400	202.00
203.00		6.052936	50.066104	1.769802	17.146265	11.910166	203.00
204.00		1,542,352	17,196,090	661,612	863,551	121,349	204.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 140124			Period: From 12/01/2012 To 11/30/2013		Worksheet B-1 Date/Time Prepared: 4/30/2014 11:17 am	
Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)		
		6.00	7.00	8.00	9.00	10.00		
205.00	Unit cost multiplier (Wkst. B, Part II)	0.807142	15.074901	0.296337	0.781556	0.266638	205.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet B-1  
Date/Time Prepared:  
4/30/2014 11:17 am

Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		11.00	13.00	14.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	6,922,181					11.00
13.00	01300	74,182	4,118,916				13.00
14.00	01400	75,350	75,981	40,413,004			14.00
16.00	01600	160,381	0	0	1,162,636,325		16.00
17.00	01700	8,201	0	0	0	56,160	17.00
18.00	01851	9,539	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	832,087	0	9,278	0	0	21.00
22.00	02200	201,229	0	22,848	0	0	22.00
23.00	02300	8,150	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	1,348,207	1,000,712	164,147	198,741,809	16,994	30.00
31.00	03100	183,344	180,074	70,100	21,698,725	1,386	31.00
33.00	03300	43,094	32,692	37,114	3,696,489	690	33.00
34.00	03400	81,444	79,352	12,243	7,055,975	1,040	34.00
34.01	02080	53,479	44,167	0	2,751,448	690	34.01
34.02	02180	115,236	94,833	38,102	9,991,269	1,040	34.02
34.03	02060	68,151	56,259	24,503	6,426,383	1,040	34.03
34.04	02061	193,295	149,002	32,435	26,296,693	1,040	34.04
43.00	04300	57,987	58,399	4,357	1,442,955	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	612,966	485,414	31,466,522	171,572,065	0	50.00
51.00	05100	54,632	54,632	0	11,249,309	0	51.00
52.00	05200	81,767	79,709	6,701	2,657,498	0	52.00
53.00	05300	62,389	19,882	316,105	55,093,541	0	53.00
54.00	05400	331,922	54,806	2,116,294	158,128,366	0	54.00
60.00	06000	478,296	0	35,564	132,646,348	0	60.00
62.00	06200	35,602	0	0	9,174,876	0	62.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	153,075	10,861	208,340	1,759,533	0	65.00
66.00	06600	29,978	0	205,698	1,927,141	0	66.00
67.00	06700	12,852	0	0	1,107,628	0	67.00
68.00	06800	13,284	0	3,339	695,912	0	68.00
69.00	06900	124,801	37,551	1,630,846	22,439,632	0	69.00
71.00	07100	0	0	3,374,433	6,114,716	0	71.00
72.00	07200	0	0	0	12,805,304	0	72.00
73.00	07300	438,057	0	0	98,795,751	0	73.00
74.00	07400	56,438	34,727	19,034	7,585,867	2,080	74.00
76.00	03950	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	262,836	1,049,790	424,040	112,499,029	19,760	90.00
91.00	09100	622,525	520,073	89,352	78,282,063	10,400	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00	05950	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		6,884,776	4,118,916	40,311,395	1,162,636,325	56,160	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	27,840	0	101,609	0	0	190.01
190.02	19002	0	0	0	0	0	190.02
190.03	19003	9,565	0	0	0	0	190.03
190.04	19004	0	0	0	0	0	190.04
194.00	07951	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		5,253,666	6,736,636	12,329,014	9,837,412	1,295,841	202.00
203.00		0.758961	1.635536	0.305075	0.008461	23.074092	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet B-1

Date/Time Prepared:  
4/30/2014 11:17 am

Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		11.00	13.00	14.00	16.00	17.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	1,568,044	654,902	2,653,399	1,211,413	146,484	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.226525	0.158999	0.065657	0.001042	2.608333	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet B-1

Date/Time Prepared:  
4/30/2014 11:17 am

Cost Center Description	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	INTERNS & RESIDENTS		ALLIED HEALTH (ASSIGNED TIME)	
	WAI VER OVERHEAD COSTS		SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
	(ASSIGNED TIME)		18.00	19.00		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
18.00 01851	WAI VER OVERHEAD COSTS	100,000				18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0			19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0		45,308		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0			45,308	22.00
23.00 02300	ALLIED HEALTH	0				10,000 23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0		13,568	13,568	0 30.00
31.00 03100	INTENSIVE CARE UNIT	0		1,701	1,701	0 31.00
33.00 03300	BURN INTENSIVE CARE UNIT	0		364	364	0 33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0		470	470	0 34.00
34.01 02080	PEDIATRIC INTENSIVE CARE UNIT	0		200	200	0 34.01
34.02 02180	TRAUMA INTENSIVE CARE UNIT	0		0	0	0 34.02
34.03 02060	NEURO INTENSIVE CARE UNIT	0		244	244	0 34.03
34.04 02061	NEONATAL INTENSIVE CARE UNIT	0		916	916	0 34.04
43.00 04300	NURSERY	0		296	296	0 43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	0	6,289	6,289	0 50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	385	385	0 52.00
53.00 05300	ANESTHESIOLOGY	0	0	2,589	2,589	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	1,814	1,814	0 54.00
60.00 06000	LABORATORY	0	0	189	189	0 60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0 62.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	0	0	960	960	0 65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	30	30	0 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	1,410	1,410	0 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	10,000 73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0 74.00
76.00 03950	WAI VER PURCHASED PATIENT SERVICES	0	0	0	0	0 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	6,503	6,503	0 90.00
91.00 09100	EMERGENCY	0	0	7,380	7,380	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
98.00 05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0 98.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	45,308	45,308	10,000 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
190.01 19001	DENTISTRY	0	0	0	0	0 190.01
190.02 19002	ACHN SATELITTE CLINICS	0	0	0	0	0 190.02
190.03 19003	SPECIAL FUNDS	0	0	0	0	0 190.03
190.04 19004	SENGSTACKE CLINIC	0	0	0	0	0 190.04
194.00 07951	WAI VER ADMINSTRATIVE ONLY COSTS	100,000	0	0	0	0 194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,125,056	0	38,004,774	32,897,126	427,619 202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet B-1

Date/Time Prepared:  
4/30/2014 11:17 am

Cost Center Description		OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	INTERNS & RESIDENTS		ALLIED HEALTH (ASSIGNED TIME)	
		WAIVER OVERHEAD COSTS		SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
		(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	
		18.00	19.00	21.00	22.00	23.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	11.250560	0.000000	838.809349	726.077646	42.761900	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	107,233	0	651,162	422,810	11,135	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.072330	0.000000	14.371899	9.331906	1.113500	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet C Part I Date/Time Prepared: 4/30/2014 11:17 am	
			Title XVIII	Hospital	PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		110,755,517	4,856,010	115,611,527	30.00
31.00	03100 INTENSIVE CARE UNIT		17,135,676	250,618	17,386,294	31.00
33.00	03300 BURN INTENSIVE CARE UNIT		3,768,710	159,283	3,927,993	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT		7,175,508	18,072	7,193,580	34.00
34.01	02080 PEDIATRIC INTENSIVE CARE UNIT		3,878,993	52,363	3,931,356	34.01
34.02	02180 TRAUMA INTENSIVE CARE UNIT		9,949,836	111,430	10,061,266	34.02
34.03	02060 NEURO INTENSIVE CARE UNIT		4,781,508	97,245	4,878,753	34.03
34.04	02061 NEONATAL INTENSIVE CARE UNIT		13,640,733	416,050	14,056,783	34.04
43.00	04300 NURSERY		4,651,265	0	4,651,265	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		88,756,040	1,398,046	90,154,086	50.00
51.00	05100 RECOVERY ROOM		5,555,098	0	5,555,098	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		7,352,064	0	7,352,064	52.00
53.00	05300 ANESTHESIOLOGY		4,560,420	1,280,879	5,841,299	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		41,287,945	586,559	41,874,504	54.00
60.00	06000 LABORATORY		48,794,963	270,385	49,065,348	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		6,767,089	0	6,767,089	62.00
64.00	06400 INTRAVENOUS THERAPY		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	9,392,739	249,945	9,642,684	65.00
66.00	06600 PHYSICAL THERAPY	0	2,632,960	0	2,632,960	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,153,570	868	1,154,438	67.00
68.00	06800 SPEECH PATHOLOGY	0	1,356,236	0	1,356,236	68.00
69.00	06900 ELECTROCARDIOLOGY		11,282,672	394,439	11,677,111	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1,081,192	0	1,081,192	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		5,337,833	0	5,337,833	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		63,408,789	0	63,408,789	73.00
74.00	07400 RENAL DIALYSIS		5,347,840	0	5,347,840	74.00
76.00	03950 WAIVER PURCHASED PATIENT SERVICES		0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC		118,776,943	1,343,957	120,120,900	90.00
91.00	09100 EMERGENCY		49,609,037	2,102,668	51,711,705	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		11,452,339		11,452,339	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
98.00	05950 OTHER REIMBURSABLE COST CENTERS		0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		659,643,515	13,588,817	673,232,332	200.00
201.00	Less Observation Beds		11,452,339		11,452,339	201.00
202.00	Total (see instructions)		648,191,176	13,588,817	661,779,993	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet C Part I Date/Time Prepared: 4/30/2014 11:17 am
		Title XVIIII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
9.00	10.00					
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	180,719,478		180,719,478	30.00
31.00	03100	INTENSIVE CARE UNIT	21,698,725		21,698,725	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	3,696,489		3,696,489	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,055,975		7,055,975	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	2,751,448		2,751,448	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	9,991,269		9,991,269	34.02
34.03	02060	NEURO INTENSIVE CARE UNIT	6,426,383		6,426,383	34.03
34.04	02061	NEONATAL INTENSIVE CARE UNIT	26,296,693		26,296,693	34.04
43.00	04300	NURSERY	1,442,955		1,442,955	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	99,669,295	71,902,770	171,572,065	50.00
51.00	05100	RECOVERY ROOM	4,115,084	7,134,225	11,249,309	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,602,649	54,849	2,657,498	52.00
53.00	05300	ANESTHESIOLOGY	36,975,059	18,118,482	55,093,541	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	39,988,254	118,140,112	158,128,366	54.00
60.00	06000	LABORATORY	41,959,760	90,686,588	132,646,348	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	7,365,088	1,809,788	9,174,876	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	18,296	1,741,237	1,759,533	65.00
66.00	06600	PHYSICAL THERAPY	771,833	1,155,308	1,927,141	66.00
67.00	06700	OCCUPATIONAL THERAPY	304,857	802,771	1,107,628	67.00
68.00	06800	SPEECH PATHOLOGY	5,114	690,798	695,912	68.00
69.00	06900	ELECTROCARDIOLOGY	10,991,830	11,447,802	22,439,632	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,188,640	2,926,076	6,114,716	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,802,005	4,003,299	12,805,304	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	57,080,703	41,715,048	98,795,751	73.00
74.00	07400	RENAL DIALYSIS	72,624	7,513,243	7,585,867	74.00
76.00	03950	WAIVER PURCHASED PATIENT SERVICES	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	949,310	111,549,719	112,499,029	90.00
91.00	09100	EMERGENCY	12,889,600	65,392,463	78,282,063	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	79,577	17,942,754	18,022,331	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)	587,908,993	574,727,332	1,162,636,325	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	587,908,993	574,727,332	1,162,636,325	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet C Part I Date/Time Prepared: 4/30/2014 11:17 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital
		11.00		PPS
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
33.00	03300	BURN INTENSIVE CARE UNIT		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT		34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT		34.02
34.03	02060	NEURO INTENSIVE CARE UNIT		34.03
34.04	02061	NEONATAL INTENSIVE CARE UNIT		34.04
43.00	04300	NURSERY		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	0.525459	50.00
51.00	05100	RECOVERY ROOM	0.493817	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.766536	52.00
53.00	05300	ANESTHESIOLOGY	0.106025	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.264813	54.00
60.00	06000	LABORATORY	0.369896	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.737567	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	5.480252	65.00
66.00	06600	PHYSICAL THERAPY	1.366252	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.042261	67.00
68.00	06800	SPEECH PATHOLOGY	1.948861	68.00
69.00	06900	ELECTROCARDIOLOGY	0.520379	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.176818	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.416845	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.641817	73.00
74.00	07400	RENAL DIALYSIS	0.704974	74.00
76.00	03950	WAIVER PURCHASED PATIENT SERVICES	0.000000	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000	CLINIC	1.067751	90.00
91.00	09100	EMERGENCY	0.660582	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.635453	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet C  
Part I  
Date/Time Prepared:  
4/30/2014 11:17 am

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		110,755,517	4,856,010	115,611,527	30.00
31.00	03100 INTENSIVE CARE UNIT		17,135,676	250,618	17,386,294	31.00
33.00	03300 BURN INTENSIVE CARE UNIT		3,768,710	159,283	3,927,993	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT		7,175,508	18,072	7,193,580	34.00
34.01	02080 PEDIATRIC INTENSIVE CARE UNIT		3,878,993	52,363	3,931,356	34.01
34.02	02180 TRAUMA INTENSIVE CARE UNIT		9,949,836	111,430	10,061,266	34.02
34.03	02060 NEURO INTENSIVE CARE UNIT		4,781,508	97,245	4,878,753	34.03
34.04	02061 NEONATAL INTENSIVE CARE UNIT		13,640,733	416,050	14,056,783	34.04
43.00	04300 NURSERY		4,651,265	0	4,651,265	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		88,756,040	1,398,046	90,154,086	50.00
51.00	05100 RECOVERY ROOM		5,555,098	0	5,555,098	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		7,352,064	0	7,352,064	52.00
53.00	05300 ANESTHESIOLOGY		4,560,420	1,280,879	5,841,299	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		41,287,945	586,559	41,874,504	54.00
60.00	06000 LABORATORY		48,794,963	270,385	49,065,348	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		6,767,089	0	6,767,089	62.00
64.00	06400 INTRAVENOUS THERAPY		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	9,392,739	249,945	9,642,684	65.00
66.00	06600 PHYSICAL THERAPY	0	2,632,960	0	2,632,960	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,153,570	868	1,154,438	67.00
68.00	06800 SPEECH PATHOLOGY	0	1,356,236	0	1,356,236	68.00
69.00	06900 ELECTROCARDIOLOGY		11,282,672	394,439	11,677,111	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1,081,192	0	1,081,192	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		5,337,833	0	5,337,833	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		63,408,789	0	63,408,789	73.00
74.00	07400 RENAL DIALYSIS		5,347,840	0	5,347,840	74.00
76.00	03950 WAIVER PURCHASED PATIENT SERVICES		0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC		118,776,943	1,343,957	120,120,900	90.00
91.00	09100 EMERGENCY		49,609,037	2,102,668	51,711,705	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		11,452,339		11,452,339	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
98.00	05950 OTHER REIMBURSABLE COST CENTERS		0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		659,643,515	13,588,817	673,232,332	200.00
201.00	Less Observation Beds		11,452,339		11,452,339	201.00
202.00	Total (see instructions)		648,191,176	13,588,817	661,779,993	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet C  
Part I  
Date/Time Prepared:  
4/30/2014 11:17 am

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	180,719,478		180,719,478		30.00
31.00	03100	INTENSIVE CARE UNIT	21,698,725		21,698,725		31.00
33.00	03300	BURN INTENSIVE CARE UNIT	3,696,489		3,696,489		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,055,975		7,055,975		34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	2,751,448		2,751,448		34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	9,991,269		9,991,269		34.02
34.03	02060	NEURO INTENSIVE CARE UNIT	6,426,383		6,426,383		34.03
34.04	02061	NEONATAL INTENSIVE CARE UNIT	26,296,693		26,296,693		34.04
43.00	04300	NURSERY	1,442,955		1,442,955		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	99,669,295	71,902,770	171,572,065	0.517311	50.00
51.00	05100	RECOVERY ROOM	4,115,084	7,134,225	11,249,309	0.493817	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,602,649	54,849	2,657,498	2.766536	52.00
53.00	05300	ANESTHESIOLOGY	36,975,059	18,118,482	55,093,541	0.082776	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	39,988,254	118,140,112	158,128,366	0.261104	54.00
60.00	06000	LABORATORY	41,959,760	90,686,588	132,646,348	0.367858	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	7,365,088	1,809,788	9,174,876	0.737567	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	18,296	1,741,237	1,759,533	5.338200	65.00
66.00	06600	PHYSICAL THERAPY	771,833	1,155,308	1,927,141	1.366252	66.00
67.00	06700	OCCUPATIONAL THERAPY	304,857	802,771	1,107,628	1.041478	67.00
68.00	06800	SPEECH PATHOLOGY	5,114	690,798	695,912	1.948861	68.00
69.00	06900	ELECTROCARDIOLOGY	10,991,830	11,447,802	22,439,632	0.502801	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,188,640	2,926,076	6,114,716	0.176818	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,802,005	4,003,299	12,805,304	0.416845	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	57,080,703	41,715,048	98,795,751	0.641817	73.00
74.00	07400	RENAL DIALYSIS	72,624	7,513,243	7,585,867	0.704974	74.00
76.00	03950	WAIVER PURCHASED PATIENT SERVICES	0	0	0	0.000000	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	949,310	111,549,719	112,499,029	1.055804	90.00
91.00	09100	EMERGENCY	12,889,600	65,392,463	78,282,063	0.633722	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	79,577	17,942,754	18,022,331	0.635453	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	587,908,993	574,727,332	1,162,636,325		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	587,908,993	574,727,332	1,162,636,325		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet C Part I Date/Time Prepared: 4/30/2014 11:17 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
33.00	03300	BURN INTENSIVE CARE UNIT		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT		34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT		34.02
34.03	02060	NEURO INTENSIVE CARE UNIT		34.03
34.04	02061	NEONATAL INTENSIVE CARE UNIT		34.04
43.00	04300	NURSERY		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
76.00	03950	WAIVER PURCHASED PATIENT SERVICES	0.000000	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet D Part I Date/Time Prepared: 4/30/2014 11:17 am
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Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Hospital 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	ADULTS & PEDIATRICS	14,947,203	0	14,947,203	90,320	165.49	30.00
31.00	INTENSIVE CARE UNIT	1,324,279		1,324,279	7,508	176.38	31.00
33.00	BURN INTENSIVE CARE UNIT	301,109		301,109	1,207	249.47	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	485,285		485,285	2,430	199.71	34.00
34.01	PEDIATRIC INTENSIVE CARE UNIT	313,746		313,746	964	325.46	34.01
34.02	TRAUMA INTENSIVE CARE UNIT	1,088,386		1,088,386	2,357	461.77	34.02
34.03	NEURO INTENSIVE CARE UNIT	261,812		261,812	2,222	117.83	34.03
34.04	NEONATAL INTENSIVE CARE UNIT	734,608		734,608	9,073	80.97	34.04
43.00	NURSERY	393,556		393,556	1,800	218.64	43.00
200.00	Total (lines 30-199)	19,849,984		19,849,984	117,881		200.00

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

INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	9,469	1,567,025	30.00
31.00	INTENSIVE CARE UNIT	1,110	195,782	31.00
33.00	BURN INTENSIVE CARE UNIT	271	67,606	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	264	52,723	34.00
34.01	PEDIATRIC INTENSIVE CARE UNIT	0	0	34.01
34.02	TRAUMA INTENSIVE CARE UNIT	154	71,113	34.02
34.03	NEURO INTENSIVE CARE UNIT	200	23,566	34.03
34.04	NEONATAL INTENSIVE CARE UNIT	0	0	34.04
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	11,468	1,977,815	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet D Part II Date/Time Prepared: 4/30/2014 11:17 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	6,672,726	171,572,065	0.038892	8,113,025	315,532	50.00
51.00	05100 RECOVERY ROOM	600,709	11,249,309	0.053400	233,595	12,474	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	624,331	2,657,498	0.234932	0	0	52.00
53.00	05300 ANESTHESIOLOGY	535,435	55,093,541	0.009719	2,936,699	28,542	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,759,373	158,128,366	0.030098	4,345,264	130,784	54.00
60.00	06000 LABORATORY	3,724,574	132,646,348	0.028079	4,810,577	135,076	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	190,110	9,174,876	0.020721	818,169	16,953	62.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	892,850	1,759,533	0.507436	2,690	1,365	65.00
66.00	06600 PHYSICAL THERAPY	225,069	1,927,141	0.116789	108,105	12,625	66.00
67.00	06700 OCCUPATIONAL THERAPY	175,989	1,107,628	0.158888	39,032	6,202	67.00
68.00	06800 SPEECH PATHOLOGY	113,580	695,912	0.163210	699	114	68.00
69.00	06900 ELECTROCARDIOLOGY	1,433,390	22,439,632	0.063878	2,186,987	139,700	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	227,927	6,114,716	0.037275	207,304	7,727	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	68,932	12,805,304	0.005383	312,444	1,682	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,866,952	98,795,751	0.018897	5,855,211	110,646	73.00
74.00	07400 RENAL DIALYSIS	190,683	7,585,867	0.025137	6,932	174	74.00
76.00	03950 WAIVER PURCHASED PATIENT SERVICES	0	0	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	8,825,591	112,499,029	0.078450	46,173	3,622	90.00
91.00	09100 EMERGENCY	3,648,076	78,282,063	0.046602	1,600,930	74,607	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,480,650	18,022,331	0.082156	10,226	840	92.00
OTHER REIMBURSABLE COST CENTERS							
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (lines 50-199)	36,256,947	902,556,910		31,634,062	998,665	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140124		Period: From 12/01/2012 To 11/30/2013		Worksheet D Part III Date/Time Prepared: 4/30/2014 11:17 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
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	0	0	0	0	34.02
34.03	02060	NEURO INTENSIVE CARE UNIT	0	0	0	0	0	34.03
34.04	02061	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	34.04
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	90,320	0.00	9,469	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	7,508	0.00	1,110	0	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	1,207	0.00	271	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	2,430	0.00	264	0	0	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	964	0.00	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	2,357	0.00	154	0	0	34.02
34.03	02060	NEURO INTENSIVE CARE UNIT	2,222	0.00	200	0	0	34.03
34.04	02061	NEONATAL INTENSIVE CARE UNIT	9,073	0.00	0	0	0	34.04
43.00	04300	NURSERY	1,800	0.00	0	0	0	43.00
200.00		Total (lines 30-199)	117,881		11,468	0	0	200.00
Cost Center Description			PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost				
			12.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0				30.00
31.00	03100	INTENSIVE CARE UNIT	0	0				31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0				33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0				34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0				34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	0				34.02
34.03	02060	NEURO INTENSIVE CARE UNIT	0	0				34.03
34.04	02061	NEONATAL INTENSIVE CARE UNIT	0	0				34.04
43.00	04300	NURSERY	0	0				43.00
200.00		Total (lines 30-199)	0	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet D  
Part IV  
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Cost Center Description		Title XVIII				Hospital	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	427,619	0	427,619	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950 WAIVER PURCHASED PATIENT SERVICES	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00	Total (lines 50-199)	0	0	427,619	0	427,619	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet D  
Part IV  
Date/Time Prepared:  
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	171,572,065	0.000000	0.000000	8,113,025	50.00
51.00	05100	RECOVERY ROOM	0	11,249,309	0.000000	0.000000	233,595	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,657,498	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	55,093,541	0.000000	0.000000	2,936,699	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	158,128,366	0.000000	0.000000	4,345,264	54.00
60.00	06000	LABORATORY	0	132,646,348	0.000000	0.000000	4,810,577	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	9,174,876	0.000000	0.000000	818,169	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,759,533	0.000000	0.000000	2,690	65.00
66.00	06600	PHYSICAL THERAPY	0	1,927,141	0.000000	0.000000	108,105	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,107,628	0.000000	0.000000	39,032	67.00
68.00	06800	SPEECH PATHOLOGY	0	695,912	0.000000	0.000000	699	68.00
69.00	06900	ELECTROCARDIOLOGY	0	22,439,632	0.000000	0.000000	2,186,987	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,114,716	0.000000	0.000000	207,304	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,805,304	0.000000	0.000000	312,444	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	427,619	98,795,751	0.004328	0.004328	5,855,211	73.00
74.00	07400	RENAL DIALYSIS	0	7,585,867	0.000000	0.000000	6,932	74.00
76.00	03950	WAIWER PURCHASED PATIENT SERVICES	0	0	0.000000	0.000000	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	112,499,029	0.000000	0.000000	46,173	90.00
91.00	09100	EMERGENCY	0	78,282,063	0.000000	0.000000	1,600,930	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	18,022,331	0.000000	0.000000	10,226	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00
200.00		Total (lines 50-199)	427,619	902,556,910			31,634,062	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet D  
Part IV  
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Cost Center Description			Title XVIII			Hospital		PPS
			Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 1/1	Outpatient Program Charges on/after 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 1/1	
			11.00	12.00	12.01	13.00	13.01	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	1,554,132	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	258,714	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	608,208	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,434,274	0	0	0	54.00
60.00	06000	LABORATORY	0	409,235	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	68,107	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	135,193	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	394	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	43,460	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,034,915	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	136,015	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	91,176	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,341	3,023,607	0	13,086	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	WAIVER PURCHASED PATIENT SERVICES	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	14,753,671	0	0	0	90.00
91.00	09100	EMERGENCY	0	2,486,865	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	952,638	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00		Total (lines 50-199)	25,341	32,990,604	0	13,086	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet D  
Part IV  
Date/Time Prepared:  
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Cost Center Description		Title XVIII				Hospital	PPS
		PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
		21.00	22.00	23.00	24.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
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
60.00	06000 LABORATORY	0	0	0	0		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0		62.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0		74.00
76.00	03950 WAIVER PURCHASED PATIENT SERVICES	0	0	0	0		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
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
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0	0		98.00
200.00	Total (Lines 50-199)	0	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet D Part V Date/Time Prepared: 4/30/2014 11:17 am
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)
		PPS Reimbursed Services (see inst.) before 1/1	PPS Reimbursed Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	1.00	2.00	2.01	3.00	4.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	0.517311	1,554,132	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0.493817	258,714	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2.766536	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.082776	608,208	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.261104	7,434,274	0	0	0	0	54.00
60.00 06000 LABORATORY	0.367858	409,235	0	0	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.737567	68,107	0	0	0	0	62.00
64.00 06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	5.338200	135,193	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	1.366252	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	1.041478	394	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	1.948861	43,460	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.502801	1,034,915	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.176818	136,015	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.416845	91,176	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.641817	3,023,607	0	0	167,844	0	73.00
74.00 07400 RENAL DIALYSIS	0.704974	0	0	0	0	0	74.00
76.00 03950 WAIVER PURCHASED PATIENT SERVICES	0.000000	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	1.055804	14,753,671	0	0	0	0	90.00
91.00 09100 EMERGENCY	0.633722	2,486,865	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.635453	952,638	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00 05950 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	0	98.00
200.00		Subtotal (see instructions)	32,990,604	0	0	167,844	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 +/- line 201)	32,990,604	0	0	167,844	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet D Part V Date/Time Prepared: 4/30/2014 11:17 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs					
	PPS Services (see inst.) before 1/1	PPS Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	5.00	5.01	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	803,970	0	0	0		50.00
51.00 05100 RECOVERY ROOM	127,757	0	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00 05300 ANESTHESIOLOGY	50,345	0	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,941,119	0	0	0		54.00
60.00 06000 LABORATORY	150,540	0	0	0		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	50,233	0	0	0		62.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	721,687	0	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	410	0	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	84,697	0	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	520,356	0	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	24,050	0	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	38,006	0	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,940,602	0	0	107,725		73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0		74.00
76.00 03950 WAIVER PURCHASED PATIENT SERVICES	0	0	0	0		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	15,576,985	0	0	0		90.00
91.00 09100 EMERGENCY	1,575,981	0	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	605,357	0	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
98.00 05950 OTHER REIMBURSABLE COST CENTERS	0	0	0	0		98.00
200.00 Subtotal (see instructions)	24,212,095	0	0	107,725		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0		201.00
202.00 Net Charges (line 200 +/- line 201)	24,212,095	0	0	107,725		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet D Part V Date/Time Prepared: 4/30/2014 11:17 am
	Title XIX	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)
		PPS Reimbursed Services (see inst.) before 1/1	PPS Reimbursed Services (see inst.) on/after 1/1	Reimbursed Services Subject To Ded. & Coins. (see inst.)	Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	1.00	2.00	2.01	3.00	4.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	0.517311	0	0	7,345,077	0	0	50.00
51.00 05100 RECOVERY ROOM	0.493817	0	0	839,087	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2.766536	0	0	34,066	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.082776	0	0	2,254,824	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.261104	0	0	17,658,344	0	0	54.00
60.00 06000 LABORATORY	0.367858	0	0	11,753,605	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.737567	0	0	514,027	0	0	62.00
64.00 06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	5.338200	0	0	342,119	0	0	65.00
66.00 06600 PHYSICAL THERAPY	1.366252	0	0	111,652	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	1.041478	0	0	90,738	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	1.948861	0	0	110,556	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.502801	0	0	1,172,810	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.176818	0	0	1,232,917	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.416845	0	0	463,179	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.641817	0	0	8,924,784	0	0	73.00
74.00 07400 RENAL DIALYSIS	0.704974	0	0	1,769,585	0	0	74.00
76.00 03950 WAIVER PURCHASED PATIENT SERVICES	0.000000	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	1.055804	0	0	17,007,782	0	0	90.00
91.00 09100 EMERGENCY	0.633722	0	0	11,687,986	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.635453	0	0	3,575,649	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00 05950 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	0	98.00
200.00	Subtotal (see instructions)	0	0	86,888,787	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	86,888,787		0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet D Part V Date/Time Prepared: 4/30/2014 11:17 am
	Title XIX	Hospital	Cost

Cost Center Description	Costs					
	PPS Services (see inst.) before 1/1	PPS Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	5.00	5.01	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	3,799,689	0		50.00
51.00 05100 RECOVERY ROOM	0	0	414,355	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	94,245	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0	186,645	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	4,610,664	0		54.00
60.00 06000 LABORATORY	0	0	4,323,658	0		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	379,129	0		62.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0	1,826,300	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0	152,545	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	94,502	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0	215,458	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	589,690	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	218,002	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	193,074	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	5,728,078	0		73.00
74.00 07400 RENAL DIALYSIS	0	0	1,247,511	0		74.00
76.00 03950 WAIVER PURCHASED PATIENT SERVICES	0	0	0	0		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	17,956,884	0		90.00
91.00 09100 EMERGENCY	0	0	7,406,934	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	2,272,157	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
98.00 05950 OTHER REIMBURSABLE COST CENTERS	0	0	0	0		98.00
200.00 Subtotal (see instructions)	0	0	51,709,520	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	51,709,520	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet D-1 Date/Time Prepared: 4/30/2014 11:17 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		90,320	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		90,320	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		81,373	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		9,469	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
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		115,611,527	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		115,611,527	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		115,611,527	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,280.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		12,120,509	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)		12,120,509	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet D-1 Date/Time Prepared: 4/30/2014 11:17 am	
Title XVIII			Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	17,386,294	7,508	2,315.70	1,110	2,570,427	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT	3,927,993	1,207	3,254.34	271	881,926	45.00
46.00 SURGICAL INTENSIVE CARE UNIT	7,193,580	2,430	2,960.32	264	781,524	46.00
46.01 PEDIATRIC INTENSIVE CARE UNIT	3,931,356	964	4,078.17	0	0	46.01
46.02 TRAUMA INTENSIVE CARE UNIT	10,061,266	2,357	4,268.67	154	657,375	46.02
46.03 NEURO INTENSIVE CARE UNIT	4,878,753	2,222	2,195.66	200	439,132	46.03
46.04 NEONATAL INTENSIVE CARE UNIT	14,056,783	9,073	1,549.30	0	0	46.04
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					14,608,977	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					32,059,870	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,977,815	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,024,006	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					3,001,821	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					29,058,049	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)					8,947	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,280.02	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					11,452,339	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140124		Period: From 12/01/2012 To 11/30/2013		Worksheet D-1 Date/Time Prepared: 4/30/2014 11:17 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	14,947,203	115,611,527	0.129288	11,452,339	1,480,650	90.00
91.00	Nursing School cost	0	115,611,527	0.000000	11,452,339	0	91.00
92.00	Allied health cost	0	115,611,527	0.000000	11,452,339	0	92.00
93.00	All other Medical Education	0	115,611,527	0.000000	11,452,339	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet D-1 Date/Time Prepared: 4/30/2014 11:17 am
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		90,320	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		90,320	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		81,373	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		26,461	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		1,800	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
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)		110,755,517	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)		110,755,517	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		110,755,517	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,226.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		32,448,066	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)		32,448,066	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet D-1 Date/Time Prepared: 4/30/2014 11:17 am		
Cost Center Description			Title XIX		Hospital Cost		
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00	NURSERY (title V & XIX only)	4,651,265	1,800	2,584.04	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	17,135,676	7,508	2,282.32	3,234	7,381,023	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	3,768,710	1,207	3,122.38	344	1,074,099	45.00
46.00	SURGICAL INTENSIVE CARE UNIT	7,175,508	2,430	2,952.88	680	2,007,958	46.00
46.01	PEDIATRIC INTENSIVE CARE UNIT	3,878,993	964	4,023.85	582	2,341,881	46.01
46.02	TRAUMA INTENSIVE CARE UNIT	9,949,836	2,357	4,221.40	1,320	5,572,248	46.02
46.03	NEURO INTENSIVE CARE UNIT	4,781,508	2,222	2,151.89	120	258,227	46.03
46.04	NEONATAL INTENSIVE CARE UNIT	13,640,733	9,073	1,503.44	7,413	11,145,001	46.04
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					49,165,464	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					111,393,967	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					8,947	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,226.26	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					10,971,348	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140124		Period: From 12/01/2012 To 11/30/2013		Worksheet D-1 Date/Time Prepared: 4/30/2014 11:17 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet D-3 Date/Time Prepared: 4/30/2014 11:17 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		20,189,786	30.00
31.00	03100	INTENSIVE CARE UNIT		2,670,369	31.00
33.00	03300	BURN INTENSIVE CARE UNIT		811,422	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		764,006	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT		0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT		477,400	34.02
34.03	02060	NEURO INTENSIVE CARE UNIT		1,127,215	34.03
34.04	02061	NEONATAL INTENSIVE CARE UNIT		0	34.04
43.00	04300	NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.525459	8,113,025	50.00
51.00	05100	RECOVERY ROOM	0.493817	233,595	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.766536	0	52.00
53.00	05300	ANESTHESIOLOGY	0.106025	2,936,699	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.264813	4,345,264	54.00
60.00	06000	LABORATORY	0.369896	4,810,577	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.737567	818,169	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	5.480252	2,690	65.00
66.00	06600	PHYSICAL THERAPY	1.366252	108,105	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.042261	39,032	67.00
68.00	06800	SPEECH PATHOLOGY	1.948861	699	68.00
69.00	06900	ELECTROCARDIOLOGY	0.520379	2,186,987	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.176818	207,304	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.416845	312,444	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.641817	5,855,211	73.00
74.00	07400	RENAL DIALYSIS	0.704974	6,932	74.00
76.00	03950	WAIVER PURCHASED PATIENT SERVICES	0.000000	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	1.067751	46,173	90.00
91.00	09100	EMERGENCY	0.660582	1,600,930	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.635453	10,226	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	0	98.00
200.00		Total (sum of lines 50-94 and 96-98)		31,634,062	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		31,634,062	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet D-3 Date/Time Prepared: 4/30/2014 11:17 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		64,881,999	30.00
31.00	03100	INTENSIVE CARE UNIT		8,113,181	31.00
33.00	03300	BURN INTENSIVE CARE UNIT		862,116	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		1,703,913	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT		1,438,278	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT		3,312,036	34.02
34.03	02060	NEURO INTENSIVE CARE UNIT		301,886	34.03
34.04	02061	NEONATAL INTENSIVE CARE UNIT		16,830,110	34.04
43.00	04300	NURSERY		989,454	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.517311	29,863,425	15,448,678 50.00
51.00	05100	RECOVERY ROOM	0.493817	976,716	482,319 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.766536	1,511,017	4,180,283 52.00
53.00	05300	ANESTHESIOLOGY	0.082776	11,159,443	923,734 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.261104	12,981,457	3,389,510 54.00
60.00	06000	LABORATORY	0.367858	14,839,422	5,458,800 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.737567	2,239,791	1,651,996 62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	5.338200	5,669	30,262 65.00
66.00	06600	PHYSICAL THERAPY	1.366252	282,754	386,313 66.00
67.00	06700	OCCUPATIONAL THERAPY	1.041478	124,043	129,188 67.00
68.00	06800	SPEECH PATHOLOGY	1.948861	1,870	3,644 68.00
69.00	06900	ELECTROCARDIOLOGY	0.502801	2,557,186	1,285,756 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.176818	2,940,026	519,850 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.416845	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.641817	23,732,474	15,231,905 73.00
74.00	07400	RENAL DIALYSIS	0.704974	11,029	7,775 74.00
76.00	03950	WAIVER PURCHASED PATIENT SERVICES	0.000000	0	0 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	1.055804	7,744	8,176 90.00
91.00	09100	EMERGENCY	0.633722	43,039	27,275 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.635453	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0 98.00
200.00		Total (sum of lines 50-94 and 96-98)		103,277,105	49,165,464 200.00
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)		103,277,105	202.00

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

Provider CCN: 140124

Period:  
 From 12/01/2012  
 To 11/30/2013

Worksheet D-5  
 Part I  
 Date/Time Prepared:  
 4/30/2014 11:17 am

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

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

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet D-5  
Part I  
Date/Time Prepared:  
4/30/2014 11:17 am

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

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

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet D-5  
Part I  
Date/Time Prepared:  
4/30/2014 11:17 am

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

APPORTIONMENT OF COST FOR THE SERVICES OF TEACHING PHYSICIANS

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet D-5  
Part II  
Date/Time Prepared:  
4/30/2014 11:17 am

Cost Center Description		Hospital		PPS	
		Hospital Staff	Medical School Faculty	Total (col 1 + col 2)	
		1.00	2.00	3.00	
1.00	Adjusted Cost of Physician's Direct Medical and Surgical Services	0	0		1.00
2.00	Total Inpatient Days and Outpatient Visit Days	0	0		2.00
3.00	Average Per Diem (line 1 ÷ line 2)	0.00	0.00		3.00
<b>Health Care Program Reimbursable Days</b>					
4.00	Title V - Inpatient	0	0		4.00
5.00	Title V - Outpatient	0	0		5.00
6.00	Title XVIII - Part A	0	0		6.00
7.00	Title XVIII - Part B	0	0		7.00
8.00	Title XIX - Inpatient	0	0		8.00
9.00	Title XIX - Outpatient	0	0		9.00
10.00	Inpatient and Outpatient Kidney Acquisition	0	0		10.00
11.00	Inpatient and Outpatient Liver Acquisition	0	0		11.00
12.00	Inpatient and Outpatient Heart Acquisition	0	0		12.00
13.00	Inpatient and Outpatient Lung Acquisition	0	0		13.00
14.00	Inpatient and Outpatient Pancreas Acquisition	0	0		14.00
15.00	Inpatient and Outpatient Intestine Acquisition	0	0		15.00
16.00	Inpatient and Outpatient Islet Acquisition	0	0		16.00
17.00	OTHER ORGAN ACQUISITION	0	0		17.00
<b>Health Care Program Reimbursable Cost</b>					
18.00	Title V - Inpatient (line 3 x line 4)	0	0	0	18.00
19.00	Title V - Outpatient (line 3 x line 5)	0	0	0	19.00
20.00	Title XVIII - Part A (line 3 x line 6)	0	0	0	20.00
21.00	Title XVIII - Part B (line 3 x line 7)	0	0	0	21.00
22.00	Title XIX - Inpatient (line 3 x line 8)	0	0	0	22.00
23.00	Title XIX - Outpatient (line 3 x line 9)	0	0	0	23.00
24.00	Inpatient and Outpatient Kidney Acquisition (line 3 x line 10)	0	0	0	24.00
25.00	Inpatient and Outpatient Liver Acquisition (line 3 x line 11)	0	0	0	25.00
26.00	Inpatient and Outpatient Heart Acquisition (line 3 x line 12)	0	0	0	26.00
27.00	Inpatient and Outpatient Lung Acquisition (line 3 x line 13)	0	0	0	27.00
28.00	Inpatient and Outpatient Pancreas Acquisition (line 3 x line 14)	0	0	0	28.00
29.00	Inpatient and Outpatient Intestine Acquisition (line 3 x line 15)	0	0	0	29.00
30.00	Inpatient and Outpatient Islet Acquisition (line 3 x line 16)	0	0	0	30.00
31.00	Inpatient and Outpatient Other Organ Acquisition (line 3 x line 17)	0	0	0	31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet E Part A Date/Time Prepared: 4/30/2014 11:17 am	
		Title XVIII	Hospital		PPS
		0	before 1/1	on/after 1/1	2.00
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER PPS</b>					
1.00	DRG Amounts Other than Outlier Payments		0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013 (see instructions)		14,665,872		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		2,291,712		1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI (see instructions)		0		1.03
2.00	Outlier payments for discharges. (see instructions)		6,666,651		2.00
2.01	Outlier reconciliation amount		0		2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0		2.02
3.00	Managed Care Simulated Payments		960,741		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		444.49		4.00
<b>Indirect Medical Education Adjustment</b>					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		522.08		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		36.60		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		-85.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		400.48		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		449.80		10.00
11.00	FTE count for residents in dental and podiatric programs.		12.60		11.00
12.00	Current year allowable FTE (see instructions)		413.08		12.00
13.00	Total allowable FTE count for the prior year.		411.98		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.		409.95		14.00
15.00	Sum of lines 12 through 14 divided by 3.		411.67		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		411.67		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.926163		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.909127		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.909127		21.00
22.00	IME payment adjustment (see instructions)		7,242,067		22.00
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>					
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)		49.32		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)		0		28.00
29.00	Total IME payment ( sum of lines 22 and 28)		7,242,067		29.00
<b>Disproportionate Share Adjustment</b>					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		13.37		30.00
31.00	Percentage of Medicaid patient days (see instructions)		52.90		31.00
32.00	Sum of lines 30 and 31		66.27		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet E Part A Date/Time Prepared: 4/30/2014 11:17 am	
		Title XVIII	Hospital		PPS
		0	before 1/1	on/after 1/1	2.00
33.00	Allowable disproportionate share percentage (see instructions)		43.89	1.01	33.00
34.00	Disproportionate share adjustment (see instructions)		6,688,309		34.00
			Prior to October 1 before 1/1		On/After October 1
		0	1.00	1.01	2.00
<b>Uncompensated Care Adjustment</b>					
35.00	Total uncompensated care amount (see instructions)				0 35.00
35.01	Factor 3 (see instructions)				0.000000000 35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)				13,192,957 35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)				2,204,847 35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		2,204,847		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0		46.00
47.00	Subtotal (see instructions)		39,759,458		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		39,759,458		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		3,072,595		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		2,171,602		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)		25,341		58.00
59.00	Total (sum of amounts on lines 49 through 58)		45,028,996		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		45,028,996		61.00
62.00	Deductibles billed to program beneficiaries		2,011,956		62.00
63.00	Coinurance billed to program beneficiaries		80,803		63.00
64.00	Allowable bad debts (see instructions)		518,588		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		337,082		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,156		66.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet E  
Part A  
Date/Time Prepared:  
4/30/2014 11:17 am

		Title XVIII	Hospital	PPS	
			Prior to October 1 before 1/1		On/After October 1
		0	1.00	1.01	2.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		43,273,319		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
70.92	Bundled Model 1 discount amount		0		70.92
70.93	HVBP incentive payment (see instructions)		0		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		0		70.94
70.95	Recovery of Accelerated Depreciation		0		70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		43,273,319		71.00
71.01	Sequestration adjustment (see instructions)		579,862		71.01
72.00	Interim payments		41,266,409		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) line 71 minus lines 71.01, 72 and 73		1,427,048		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		624,844		75.00
<b>TO BE COMPLETED BY CONTRACTOR</b>					
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 DSH PAYMENT PERCENTAGE		Provider CCN: 140124		Period: From 12/01/2012 To 11/30/2013		Worksheet DSH	
		Title XVIII		Hospital		Date/Time Prepared: 4/30/2014 11:17 am	
		PPS					
		Original .mcrcx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	13.37	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	52.90	0.00			52.90	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	66.27	0.00			52.90	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	Urban				Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	444.49	0.00			444.49	5.00
6.00	Disproportionate Share Payment Percentage (transfer to Worksheet E, Part A, line 33)	43.89	0.00			32.86	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes				No	9.00
10.00	S-2, Line 45	Yes				Yes	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	13.37	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	41,902	0			41,902	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	6,500	0			6,500	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	9,750	0			9,750	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	58,152	0			58,152	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	108,934	0			108,934	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	985	0			985	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	109,919	0			109,919	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	52.90	0.00			52.90	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140124		Period: From 12/01/2012 To 11/30/2013		Worksheet DSH Date/Time Prepared: 4/30/2014 11:17 am	
		Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
<b>CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE</b>							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	43.89		0.00	True	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	False	29.00
30.00	Line 28 or 29 as applicable		43.89		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		43.89		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
<b>DETERMINATION OF PROVIDER TYPE</b>							
32.00	Does the hospital qualify under the Pickle amendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet DSH Date/Time Prepared: 4/30/2014 11:17 am
		Title XVIII	Hospital	PPS

		Revised Percentage 6.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE			
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	32.86	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00	29.00
30.00	Line 28 or 29 as applicable	32.86	30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	32.86	31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet E Part B Date/Time Prepared: 4/30/2014 11:17 am
		Title XVIII	Hospital	PPS
		before 1/1	on/after 1/1	
		1.00	1.01	
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)	107,725		1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	24,199,009	0	2.00
3.00	PPS payments	11,257,805	0	3.00
4.00	Outlier payment (see instructions)	2,388,496	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	0.000	5.00
6.00	Line 2 times line 5	0	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	13,086		9.00
10.00	Organ acquisitions	0		10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	107,725		11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges	167,844		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)	167,844		14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	167,844		15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis 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)	167,844		18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	60,119		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)	107,725		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)	13,659,387		24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)	3,100,256		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)	10,666,856		27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	1,647,325		28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0		29.00
30.00	Subtotal (sum of lines 27 through 29)	12,314,181		30.00
31.00	Primary payer payments	0		31.00
32.00	Subtotal (line 30 minus line 31)	12,314,181		32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0		33.00
34.00	Allowable bad debts (see instructions)	985,812		34.00
35.00	Adjusted reimbursable bad debts (see instructions)	640,778		35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	97,503		36.00
37.00	Subtotal (see instructions)	12,954,959		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	Partial or full credits received from manufacturers for replaced devices (see instructions)	0		39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0		39.99
40.00	Subtotal (see instructions)	12,954,959		40.00
40.01	Sequestration adjustment (see instructions)	173,596		40.01
41.00	Interim payments	12,561,966		41.00
42.00	Tentative settlement (for contractors use only)	0		42.00
43.00	Balance due provider/program (see instructions)	219,397		43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0		44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)	0		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0		91.00
92.00	The rate used to calculate the Time Value of Money	0.00		92.00
93.00	Time Value of Money (see instructions)	0		93.00
94.00	Total (sum of lines 91 and 93)	0		94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet E Part B Date/Time Prepared: 4/30/2014 11:17 am
	Title XVIII	Hospital	PPS
WORKSHEET OVERRIDE VALUES			Overrides
			1.00
112.00 Override of Ancillary service charges (line 12)			0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet E-1  
Part I  
Date/Time Prepared:  
4/30/2014 11:17 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		40,981,205		12,506,592	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	05/20/2013	236,299	05/20/2013	42,775	3.01	
3.02		11/19/2013	48,905	11/19/2013	12,599	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		285,204		55,374	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)		41,266,409		12,561,966	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		1,427,048		219,397	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		42,693,457		12,781,363	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet E-1 Part II Date/Time Prepared: 4/30/2014 11:17 am
		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			23,153 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			11,468 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			597 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			107,134 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			1,162,636,325 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			292,919,218 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)			958,715 8.00
9.00	Sequestration adjustment amount (see instructions)			19,174 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			939,541 10.00
<b>INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			939,541 32.00
				Overrides
				1.00
<b>CONTRACTOR OVERRIDES</b>				
108.00	Override of HIT payment			0 108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet E-3 Part VII Date/Time Prepared: 4/30/2014 11:17 am	
		Title XIX	Hospital	Cost	
		Inpatient	Outpatient		
		1.00	2.00		
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services	111,393,967			1.00
2.00	Medical and other services		51,709,520		2.00
3.00	Organ acquisition (certified transplant centers only)	0			3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	111,393,967	51,709,520		4.00
5.00	Inpatient primary payer payments	0			5.00
6.00	Outpatient primary payer payments		0		6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	111,393,967	51,709,520		7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges	0			8.00
9.00	Ancillary service charges	103,277,105	86,888,787		9.00
10.00	Organ acquisition charges, net of revenue	0			10.00
11.00	Incentive from target amount computation	0			11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	103,277,105	86,888,787		12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0		13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	0		14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000		15.00
16.00	Total customary charges (see instructions)	103,277,105	86,888,787		16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	35,179,267		17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	8,116,862	0		18.00
19.00	Interns and Residents (see instructions)	0	0		19.00
20.00	Cost of Teaching Physicians (see instructions)	0	0		20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	103,277,105	51,709,520		21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments	0	0		22.00
23.00	Outlier payments	0	0		23.00
24.00	Program capital payments	0			24.00
25.00	Capital exception payments (see instructions)	0			25.00
26.00	Routine and Ancillary service other pass through costs	0	0		26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0		27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0			28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	103,277,105	51,709,520		29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)	8,116,862	0		30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	103,277,105	51,709,520		31.00
32.00	Deductibles	0	0		32.00
33.00	Coinurance	0	0		33.00
34.00	Allowable bad debts (see instructions)	0	0		34.00
35.00	Utilization review	0			35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	103,277,105	51,709,520		36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0		37.00
38.00	Subtotal (line 36 ± line 37)	103,277,105	51,709,520		38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0			39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	103,277,105	51,709,520		40.00
41.00	Interim payments	0	0		41.00
42.00	Balance due provider/program (line 40 minus 41)	103,277,105	51,709,520		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	0	0		43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet E-4 Date/Time Prepared: 4/30/2014 11:17 am	
		Title XVII	Hospital	PPS	
				1.00	
<b>COMPUTATION OF TOTAL DIRECT GME AMOUNT</b>					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			526.48	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			65.83	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			-60.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			400.65	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			453.40	6.00
7.00	Enter the lesser of line 5 or line 6			400.65	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	196.60	211.97	408.57	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.	173.73	187.31	361.04	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		11.81		10.00
11.00	Total weighted FTE count	173.73	199.12		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	179.27	193.90		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	178.38	182.99		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	177.13	192.00		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	177.13	192.00		17.00
18.00	Per resident amount	92,923.50	92,136.74		18.00
19.00	Approved amount for resident costs	16,459,540	17,690,254	34,149,794	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)			52.75	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)			34,149,794	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
<b>COMPUTATION OF PROGRAM PATIENT LOAD</b>					
26.00	Inpatient Days (see instructions)	11,468	597		26.00
27.00	Total Inpatient Days (see instructions)	107,134	107,134		27.00
28.00	Ratio of inpatient days to total inpatient days	0.107044	0.005572		28.00
29.00	Program direct GME amount	3,655,531	190,283		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		26,887		30.00
31.00	Net Program direct GME amount			3,818,927	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet E-4 Date/Time Prepared: 4/30/2014 11:17 am
		Title XVIII	Hospital	PPS
				1.00
<b>DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)</b>				
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)			7,585,867 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)			66,608 35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0 36.00
<b>APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY</b>				
<b>Part A Reasonable Cost</b>				
37.00	Reasonable cost (see instructions)			32,059,870 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)			32,059,870 41.00
<b>Part B Reasonable Cost</b>				
42.00	Reasonable cost (see instructions)			24,319,820 42.00
43.00	Primary payer payments (see instructions)			0 43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			24,319,820 44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			56,379,690 45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.568642 46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.431358 47.00
<b>ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B</b>				
48.00	Total program GME payment (line 31)			3,818,927 48.00
49.00	Part A Medicare GME payment (line 46 x 48) (Title XVIII only) (see instructions)			2,171,602 49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			1,647,325 50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)      Provider CCN: 140124      Period: From 12/01/2012 To 11/30/2013      Worksheet G  
 Date/Time Prepared: 4/30/2014 11:17 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	1,434,754	0	0	0	1.00
2.00	Temporary investments	768,382,116	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	69,895,363	0	0	0	4.00
5.00	Other receivable	67,920,138	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-73,949,441	0	0	0	6.00
7.00	Inventory	2,626,473	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	714,107	0	0	0	9.00
10.00	Due from other funds	-91,951,074	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	745,072,436	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	2,717,512	0	0	0	13.00
14.00	Accumulated depreciation	-1,646,483	0	0	0	14.00
15.00	Buildings	522,269,978	0	0	0	15.00
16.00	Accumulated depreciation	-233,477,787	0	0	0	16.00
17.00	Leasehold improvements	92,184,236	0	0	0	17.00
18.00	Accumulated depreciation	-24,958,818	0	0	0	18.00
19.00	Fixed equipment	19,667,433	0	0	0	19.00
20.00	Accumulated depreciation	-15,420,015	0	0	0	20.00
21.00	Automobiles and trucks	934,396	0	0	0	21.00
22.00	Accumulated depreciation	-762,126	0	0	0	22.00
23.00	Major movable equipment	155,557,835	0	0	0	23.00
24.00	Accumulated depreciation	-130,801,856	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	386,264,305	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	1,131,336,741	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	62,480,177	0	0	0	37.00
38.00	Salaries, wages, and fees payable	18,713,315	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	-28,452,416	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	52,741,076	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	52,741,076	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	1,078,595,665				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)	1,078,595,665	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	1,131,336,741	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet G-1

Date/Time Prepared:  
4/30/2014 11:17 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		896,666,580		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		156,389,181			2.00
3.00	Total (sum of line 1 and line 2)		1,053,055,761		0	3.00
4.00	INVESTMENTS IN CAPITAL ASSETS	25,539,904		0		4.00
5.00		0		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)		25,539,904		0	10.00
11.00	Subtotal (line 3 plus line 10)		1,078,595,665		0	11.00
12.00	ROUNDING	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)		1,078,595,665		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	INVESTMENTS IN CAPITAL ASSETS		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	ROUNDING		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
4/30/2014 11:17 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	182,162,432		182,162,432	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	182,162,432		182,162,432	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	21,698,725		21,698,725	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT	3,696,489		3,696,489	13.00
14.00	SURGICAL INTENSIVE CARE UNIT	7,055,975		7,055,975	14.00
14.01	PEDIATRIC INTENSIVE CARE UNIT	2,751,448		2,751,448	14.01
14.02	TRAUMA INTENSIVE CARE UNIT	9,991,269		9,991,269	14.02
14.03	NEURO INTENSIVE CARE UNIT	6,426,383		6,426,383	14.03
14.04	NEONATAL INTENSIVE CARE UNIT	26,296,693		26,296,693	14.04
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	77,916,982		77,916,982	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	260,079,414		260,079,414	17.00
18.00	Ancillary services	313,911,090	379,842,393	693,753,483	18.00
19.00	Outpatient services	13,918,487	194,884,937	208,803,424	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEE CAPITATION & SENGSTACKE	0	31,130,875	31,130,875	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	587,908,991	605,858,205	1,193,767,196	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		788,416,360		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		788,416,360		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140124

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet G-3

Date/Time Prepared:  
4/30/2014 11:17 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,193,767,196	1.00
2.00	Less contractual allowances and discounts on patients' accounts	672,897,767	2.00
3.00	Net patient revenues (line 1 minus line 2)	520,869,429	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	788,416,360	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-267,546,931	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	2,138	6.00
7.00	Income from investments	24,577	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	2,980,654	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	426,035	16.00
17.00	Revenue from sale of drugs to other than patients	404	17.00
18.00	Revenue from sale of medical records and abstracts	184,702	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	233,648,276	23.00
24.00		0	24.00
24.01	MI SCCELLANEOUS INCOME	1,822,572	24.01
24.02	WAI VER REVENUE	178,183,193	24.02
24.03	EHR INCENTIVE REVENUE	6,663,561	24.03
25.00	Total other income (sum of lines 6-24)	423,936,112	25.00
26.00	Total (line 5 plus line 25)	156,389,181	26.00
27.00	ROUNDING	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)	156,389,181	29.00

ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

Provider CCN: 140124

Period:

Worksheet I-1

Component CCN: 142313

From 12/01/2012  
To 11/30/2013

Date/Time Prepared:  
4/30/2014 11:17 am

Renal Dialysis

		Total Costs	Basis	Statistics	FTEs per 2080 Hours	
		1.00	2.00	3.00	4.00	
1.00	Registered Nurses	914,692	Hours of Service	20,073.00	9.65	1.00
2.00	Licensed Practical Nurses	177,775	Hours of Service	6,563.00	3.16	2.00
3.00	Nurses Aides	59,271	Hours of Service	3,554.00	1.71	3.00
4.00	Technicians	59,795	Hours of Service	2,152.00	1.03	4.00
5.00	Social Workers	0	Hours of Service	0.00	0.00	5.00
6.00	Dieticians	0	Hours of Service	0.00	0.00	6.00
7.00	Physicians	1,224,223	Accumulated Cost			7.00
8.00	Non-patient Care Salary	516,575	Accumulated Cost			8.00
9.00	Subtotal (sum of lines 1-8)	2,952,331				9.00
10.00	Employee Benefits	0	Salary			10.00
11.00	Capital Related Costs-Bldgs. & Fixtures	0	Square Feet			11.00
12.00	Capital Related Costs-Mov. Equip.	0	Percentage of Time			12.00
13.00	Machine Costs & Repairs	0	Percentage of Time			13.00
14.00	Supplies	19,635	Requisitions			14.00
15.00	Drugs	0	Requisitions			15.00
16.00	Other	0	Accumulated Cost			16.00
17.00	Subtotal (sum of lines 9-16)*	2,971,966				17.00
18.00	Capital Related Costs-Bldgs. & Fixtures	46,592	Square Feet			18.00
19.00	Capital Related Costs-Mov. Equip.	15,555	Percentage of Time			19.00
20.00	Employee Benefits Department	864,014	Salary			20.00
21.00	Administrative & General	1,061,682	Accumulated Cost			21.00
22.00	Maint./Repairs-Oper-Housekeeping	170,415	Square Feet			22.00
23.00	Medical Education Program Costs	0				23.00
24.00	Central Service & Supplies	5,807	Requisitions			24.00
25.00	Pharmacy	0	Requisitions			25.00
26.00	Other Allocated Costs	211,809	Accumulated Cost			26.00
27.00	Subtotal (sum of lines 17-26)*	5,347,840				27.00
28.00	Laboratory (see instructions)	0	Charges	0		28.00
29.00	Respiratory Therapy (see instructions)	0	Charges	0		29.00
30.00	Other (see instructions)	0	Charges	0		30.00
31.00	Total costs (sum of lines 27-30)	5,347,840				31.00

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

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES

Provider CCN: 140124

Period: From 12/01/2012

Worksheet 1-2

Component CCN: 142313

To 11/30/2013

Date/Time Prepared: 4/30/2014 11:17 am

		Capital Related Costs		Direct Patient Care Salary		Employee Benefits Department	Drugs	
		Bui l di ng	Equip ment	RNs	Other			
		1.00	2.00	3.00	4.00			
1.00	Total Renal Department Costs	217,007	15,555	914,692	296,841	864,014	0	1.00
MAINTENANCE								
2.00	Hemodialysis	151,400	10,852	638,157	207,098	602,800	0	2.00
3.00	Intermittent Peritoneal	0	0	0	0	0	0	3.00
TRAINING								
4.00	Hemodialysis	0	0	0	0	0	0	4.00
5.00	Intermittent Peritoneal	0	0	0	0	0	0	5.00
6.00	CAPD	0	0	0	0	0	0	6.00
7.00	CCDP	0	0	0	0	0	0	7.00
HOME								
8.00	Hemodialysis	0	0	0	0	0	0	8.00
9.00	Intermittent Peritoneal	0	0	0	0	0	0	9.00
10.00	CAPD	0	0	0	0	0	0	10.00
11.00	CCDP	0	0	0	0	0	0	11.00
OTHER BILLABLE SERVICES								
12.00	Inpatient Dialysis	65,607	4,703	276,535	89,743	261,214	0	12.00
13.00	Method II Home Patient	0	0	0	0	0	0	13.00
14.00	EPO (include in Renal Department)							14.00
15.00	ARANESP (include in Renal Department)							15.00
16.00	Other	0	0	0	0	0	0	16.00
17.00	Total (sum of lines 2-16)	217,007	15,555	914,692	296,841	864,014	0	17.00
18.00	Medical Educational Program Costs							18.00
19.00	Total Renal Costs (line 17 + line 18)							19.00
		Medical Supplies	Routine Ancillary Services	Subtotal (sum of col s. 1-8)	Overhead	Total (col. 9 + col. 10)		
		7.00	8.00	9.00	10.00	11.00		
1.00	Total Renal Department Costs	25,442	0	2,333,551	3,014,289	5,347,840		1.00
MAINTENANCE								
2.00	Hemodialysis	17,750	0	1,628,057	2,102,990	3,731,047		2.00
3.00	Intermittent Peritoneal	0	0	0	0	0		3.00
TRAINING								
4.00	Hemodialysis	0	0	0	0	0		4.00
5.00	Intermittent Peritoneal	0	0	0	0	0		5.00
6.00	CAPD	0	0	0	0	0		6.00
7.00	CCDP	0	0	0	0	0		7.00
HOME								
8.00	Hemodialysis	0	0	0	0	0		8.00
9.00	Intermittent Peritoneal	0	0	0	0	0		9.00
10.00	CAPD	0	0	0	0	0		10.00
11.00	CCDP	0	0	0	0	0		11.00
OTHER BILLABLE SERVICES								
12.00	Inpatient Dialysis	7,692	0	705,494	911,299	1,616,793		12.00
13.00	Method II Home Patient	0	0	0	0	0		13.00
14.00	EPO (include in Renal Department)							14.00
15.00	ARANESP (include in Renal Department)							15.00
16.00	Other	0	0	0	0	0		16.00
17.00	Total (sum of lines 2-16)	25,442	0	2,333,551	3,014,289	5,347,840		17.00
18.00	Medical Educational Program Costs					0		18.00
19.00	Total Renal Costs (line 17 + line 18)					5,347,840		19.00

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140124

Period: From 12/01/2012

Worksheet 1-3

Component CCN: 142313

To 11/30/2013

Date/Time Prepared: 4/30/2014 11:17 am

		Capital Related Costs		Direct Patient Care Salary			
		Building (Square Feet)	Equipment (% of Time)	RNs (Hours)	Other (Hours)	Employee Benefits Department (Salary)	
		0	1.00	2.00	3.00	4.00	5.00
1.00	Total Renal Department Costs	217,007	15,555	914,692	296,841	864,014	1.00
<b>MAINTENANCE</b>							
2.00	Hemodialysis	3,840	3,840.00	3,840.00	3,840.00	3,840	2.00
3.00	Intermittent Peritoneal	0	0.00	0.00	0.00	0	3.00
<b>TRAINING</b>							
4.00	Hemodialysis	0	0.00	0.00	0.00	0	4.00
5.00	Intermittent Peritoneal	0	0.00	0.00	0.00	0	5.00
6.00	CAPD	0	0.00	0.00	0.00	0	6.00
7.00	CCDP	0	0.00	0.00	0.00	0	7.00
<b>HOME</b>							
8.00	Hemodialysis	0	0.00	0.00	0.00	0	8.00
9.00	Intermittent Peritoneal	0	0.00	0.00	0.00	0	9.00
10.00	CAPD	0	0.00	0.00	0.00	0	10.00
11.00	CCDP	0	0.00	0.00	0.00	0	11.00
<b>OTHER BILLABLE SERVICES</b>							
12.00	Inpatient Dialysis Treatments	1,664	1,664.00	1,664.00	1,664.00	1,664	12.00
13.00	Method II Home Patient	0	0.00	0.00	0.00	0	13.00
14.00	EPO						14.00
15.00	ARANESP						15.00
16.00	Other	0	0.00	0.00	0.00	0	16.00
17.00	Total Statistical Basis	5,504	5,504.00	5,504.00	5,504.00	5,504	17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)	39.427144	2.826126	166.186773	53.931868	156.979288	18.00
		Drugs (Requist.)	Medical Supplies (Requist.)	Routine Ancillary Services (Charges)	Subtotal	Overhead (Accum. Cost)	
		6.00	7.00	8.00	9.00	10.00	
1.00	Total Renal Department Costs	0	25,442	0	2,333,551	3,014,289	1.00
<b>MAINTENANCE</b>							
2.00	Hemodialysis	0	3,840	0			2.00
3.00	Intermittent Peritoneal	0	0	0			3.00
<b>TRAINING</b>							
4.00	Hemodialysis	0	0	0			4.00
5.00	Intermittent Peritoneal	0	0	0			5.00
6.00	CAPD	0	0	0			6.00
7.00	CCDP	0	0	0			7.00
<b>HOME</b>							
8.00	Hemodialysis	0	0	0			8.00
9.00	Intermittent Peritoneal	0	0	0			9.00
10.00	CAPD	0	0	0			10.00
11.00	CCDP	0	0	0			11.00
<b>OTHER BILLABLE SERVICES</b>							
12.00	Inpatient Dialysis Treatments	0	1,664	0			12.00
13.00	Method II Home Patient	0	0	0			13.00
14.00	EPO	0					14.00
15.00	ARANESP	0					15.00
16.00	Other	0	0	0			16.00
17.00	Total Statistical Basis	0	5,504	0		2,333,551	17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)	0.000000	4.622456	0.000000		1.291718	18.00

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

Provider CCN: 140124

Period: From 12/01/2012 To 11/30/2013

Worksheet 1-4

Component CCN: 142313

Date/Time Prepared: 4/30/2014 11:17 am

		Rate 0			Renal Dialysis	
		Number of Total Treatments	Total Cost (from Wkst. 1-2, col. 11)	Average Cost of Program Treatments (col. 2 ÷ col. 1)	Number of Program Treatments	Number of Program Treatments (prior to Jan. 1)
		1.00	2.00	3.00	4.00	4.01
1.00	Maintenance - Hemodialysis	3,840	3,731,047	971.63	0	23
2.00	Maintenance - Peritoneal Dialysis	0	0	0.00	0	0
3.00	Training - Hemodialysis	0	0	0.00	0	0
4.00	Training - Peritoneal Dialysis	0	0	0.00	0	0
5.00	Training - Continuous Ambulatory Peritoneal Dialysis	0	0	0.00	0	0
6.00	Training - Continuous Cycling Peritoneal Dialysis	0	0	0.00	0	0
7.00	Home Program - Hemodialysis	0	0	0.00	0	0
8.00	Home Program - Peritoneal Dialysis	0	0	0.00	0	0
		Patient Weeks			Patient Weeks	Patient Weeks (prior to Jan. 1)
		1.00	2.00	3.00	4.00	4.01
9.00	Home Program - Continuous Ambulatory Peritoneal Dialysis	0	0	0.00	0	0
10.00	Home Program - Continuous Cycling Peritoneal Dialysis	0	0	0.00	0	0
11.00	Totals (sum of lines 1-8, columns 1 and 4) (sum of lines 1-10, columns 2, 5, and 6)	3,840	3,731,047		0	23
12.00	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3))	3,840				
		Number of Program Treatments (on/after Jan. 1)	Total Program Expenses (see instructions)	Total Program Payment	Total Program Payment (prior to Jan. 1)	Total Program Payment (on/after Jan. 1)
		4.02	5.00	6.00	6.01	6.02
1.00	Maintenance - Hemodialysis	248	263,312	0	5,551	61,057
2.00	Maintenance - Peritoneal Dialysis	0	0	0	0	0
3.00	Training - Hemodialysis	0	0	0	0	0
4.00	Training - Peritoneal Dialysis	0	0	0	0	0
5.00	Training - Continuous Ambulatory Peritoneal Dialysis	0	0	0	0	0
6.00	Training - Continuous Cycling Peritoneal Dialysis	0	0	0	0	0
7.00	Home Program - Hemodialysis	0	0	0	0	0
8.00	Home Program - Peritoneal Dialysis	0	0	0	0	0
		Patient Weeks (on/after Jan. 1)			(prior to Jan. 1)	(on/after Jan. 1)
		4.02	5.00	6.00	6.01	6.02
9.00	Home Program - Continuous Ambulatory Peritoneal Dialysis	0	0	0	0	0
10.00	Home Program - Continuous Cycling Peritoneal Dialysis	0	0	0	0	0
11.00	Totals (sum of lines 1-8, columns 1 and 4) (sum of lines 1-10, columns 2, 5, and 6)	248	263,312	0	5,551	61,057
12.00	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3))					
		Average Payment Rate (col. 6 ÷ col. 4)	Average Payment Rate (col. 6.01 ÷ col. 4.01)	Average Payment Rate (col. 6.02 ÷ col. 4.02)		
		7.00	7.01	7.02		
1.00	Maintenance - Hemodialysis	250.00	241.35	246.20		
2.00	Maintenance - Peritoneal Dialysis	0.00	0.00	0.00		
3.00	Training - Hemodialysis	0.00	0.00	0.00		
4.00	Training - Peritoneal Dialysis	0.00	0.00	0.00		
5.00	Training - Continuous Ambulatory Peritoneal Dialysis	0.00	0.00	0.00		
6.00	Training - Continuous Cycling Peritoneal Dialysis	0.00	0.00	0.00		
7.00	Home Program - Hemodialysis	0.00	0.00	0.00		
8.00	Home Program - Peritoneal Dialysis	0.00	0.00	0.00		

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

Provider CCN: 140124  
Component CCN: 142313

Period:  
From 12/01/2012  
To 11/30/2013

Worksheet 1-4  
Date/Time Prepared:  
4/30/2014 11:17 am

		Rate 0			Renal Dialysis	
		7.00	7.01	7.02		
9.00	Home Program - Continuous Ambulatory Peritoneal Dialysis	0.00	0.00	0.00		9.00
10.00	Home Program - Continuous Cycling Peritoneal Dialysis	0.00	0.00	0.00		10.00
11.00	Totals (sum of lines 1-8, columns 1 and 4) (sum of lines 1-10, columns 2, 5, and 6)					11.00
12.00	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3))					12.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B		Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet I-5 Date/Time Prepared: 4/30/2014 11:17 am
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		1.00	2.00	
<b>PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B</b>				
1.00	Total expenses related to care of program beneficiaries (see instructions)	263,312		1.00
2.00	Total payment due (from Wkst. 1-4, col. 6, line 11) (see instructions)	0	0	2.00
2.01	Total payment due (from Wkst. 1-4, col. 6.01, line 11) (see instructions)	5,551	5,551	2.01
2.02	Total payment due (from Wkst. 1-4, col. 6.02, line 11) (see instructions)	61,057	61,057	2.02
2.03	Total payment due (see instructions)	66,608	66,608	2.03
2.04	Outlier payments	0		2.04
3.00	Deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.00
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.03
4.00	Coinsurance billed to Medicare (Part B) patients	13,222	13,222	4.00
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	4.01
4.02	Coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	4.02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)	13,222	13,222	4.03
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries	0	0	5.00
5.01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012			5.01
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013			5.02
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014			5.03
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014	0	0	5.04
5.05	Total bad debts (sum of line 5 through line 5.04)	0	0	5.05
6.00	Allowable bad debts (see instructions)	0		6.00
7.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0		7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)	13,222	13,222	8.00
9.00	Program payment (see instructions)	0	53,286	9.00
10.00	Unrecovered from Medicare (Part B) patients (see instructions)	250,090	196,804	10.00
11.00	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)	0		11.00
<b>PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE</b>				
12.00	Total allowable expenses (see instructions)	3,731,047		12.00
13.00	Total composite costs (from Wkst. 1-4, col. 2, line 11)	3,731,047		13.00
14.00	Facility specific composite cost percentage (line 13 divided by line 12)	1.000000		14.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140124	Period: From 12/01/2012 To 11/30/2013	Worksheet L Parts I-III Date/Time Prepared: 4/30/2014 11:17 am
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		1,349,429	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		874,105	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		293.52	3.00
4.00	Number of interns & residents (see instructions)		411.67	4.00
5.00	Indirect medical education percentage (see instructions)		48.56	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)		655,283	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		13.37	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		52.90	8.00
9.00	Sum of lines 7 and 8		66.27	9.00
10.00	Allowable disproportionate share percentage (see instructions)		14.36	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		193,778	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		3,072,595	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
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
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
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