

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).

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

FORM APPROVED
OMB NO. 0938-0050
Worksheet S
Parts I-III
Date/Time Prepared:
5/13/2015 3:49 pm

PART I - COST REPORT STATUS

Provider use only
1. Electronically filed cost report
2. Manually submitted cost report
3. If this is an amended report enter the number of times the provider resubmitted this cost report
4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only
5. 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. Initial Report for this Provider CCN
9. Final Report for this Provider CCN

10. NPR Date:
11. Contractor's Vendor Code: 4
12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 5/13/2015 Time: 3:49 pm

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 12/01/2013 and ending 11/30/2014 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.

Encryption Information

ECR: Date: 5/13/2015 Time: 3:49 pm
V3KnoTwpvLkCGZvoC7HhmNerrjwj0
.d72L0jGgcYidUBTx:yyoQim557wc
qkL119xpIS0bDuAM
PI: Date: 5/13/2015 Time: 3:49 pm
R.X4uEL9vyyG2:8gTXJRTV11L8IAo0
iAcPx0Lqw0t.R7IRwewwMZruwMMVU
DFsE0xas670y2rne

(Signed)

Douglas L. Howell
Officer or Administrator of Provider(s)

DEPUTY CHIEF EXECUTIVE OFFICER

Title

05/13/2015

Date

	Title v	Title xviii		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-300,176	506,389	432,700	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	-300,176	506,389	432,700	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 140124		Period: From 12/01/2013 To 11/30/2014		Worksheet S-2 Part I Date/Time Prepared: 5/13/2015 3:48 pm			
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 1901 WEST HARRISON STREET			PO Box:						1.00		
2.00	City: CHICAGO			State: IL		Zip Code: 60612-3714		County: COOK		2.00		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		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)						12/01/2013		11/30/2014		20.00	
21.00	Type of Control (see instructions)								9		21.00	
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						Y	N		22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						Y	Y		22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							1		N	23.00	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
				1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			41,152	9,000	0	0	12,292	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0	0		25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet S-2 Part I Date/Time Prepared: 5/13/2015 3:48 pm		
		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)(iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	Y			40.00
		V	XVII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N			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			47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N			48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. 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, § 2148? If yes, complete Wkst. D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	Y				60.00
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140124		Period: From 12/01/2013 To 11/30/2014		Worksheet S-2 Part I Date/Time Prepared: 5/13/2015 3:48 pm	
		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 Nonprovider Settings</u>							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00	
				Unweighted FTEs 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 nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovi der Si te	Unweighted 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 12/01/2013 To 11/30/2014	Worksheet S-2 Part I Date/Time Prepared: 5/13/2015 3:48 pm		
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	267.84	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
				1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS 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 an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, 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 fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)				0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, 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 fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)				0	76.00
				1.00		
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N		81.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet S-2 Part I Date/Time Prepared: 5/13/2015 3:48 pm	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. 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 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				109.00
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N	110.00
				1.00	2.00
				3.00	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, §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 1.00	Losses 2.00	Insurance 3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,393,147	12,035,000		0118.01
				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
DO NOT USE THIS LINE					
119.00	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	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet S-2 Part I Date/Time Prepared: 5/13/2015 3:48 pm	
		1.00	2.00		
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y		140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: COOK COUNTY	Contractor's Name:		Contractor's Number: 00131	
142.00	Street: 118 NORTH CLARK STREET	PO Box:			
143.00	City: CHI CAGO	State: IL		Zip Code: 60602	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y		144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are the 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, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		149.00
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
					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
		Name	County	State	Zip Code
		0	1.00	2.00	3.00
					4.00
					5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)				
					0.00
					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
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
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet S-2 Part I Date/Time Prepared: 5/13/2015 3:48 pm
		Beginning 1.00	Ending 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
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet S-2 Part II Date/Time Prepared: 5/13/2015 3:48 pm	
		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	06/15/2015	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	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/08/2015	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 12/01/2013 To 11/30/2014	Worksheet S-2 Part II Date/Time Prepared: 5/13/2015 3:48 pm	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			Y	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			Y	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			Y	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LEO	JANCI LA		41.00
42.00	Enter the employer/company name of the cost report preparer.	COOK COUNTY HEALTH & HOSPITAL SYSTEM			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	312-864-4778	LJANCI LA@COOKCOUNTYHHS.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet S-2
Part II
Date/Time Prepared:
5/13/2015 3:48 pm

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	04/08/2015	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ADMINISTRATIVE COORDINATOR III	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

VOLUNTARY CONTACT INFORMATION	Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet S-2 Part V Date/Time Prepared: 5/13/2015 3:48 pm
-------------------------------	----------------------	---	---

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

HFS Supplemental Information		Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet S-2 Part IX Date/Time Prepared: 5/13/2015 3:48 pm
		Title V	Title XIX	
		1.00	2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient	Outpatient	
		1.00	2.00	
CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
RCE DISALLOWANCE				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
PASS THROUGH COST				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet S-3
Part I
Date/Time Prepared:
5/13/2015 3:48 pm

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	310	113,150	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)		310	113,150	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	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)		448	163,520	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)		448				27.00
28.00 Observation Bed Days					3,667	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 12/01/2013
To 11/30/2014

Worksheet S-3
Part I
Date/Time Prepared:
5/13/2015 3:48 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	8,963	24,361	72,961			1.00
2.00 HMO and other (see instructions)	1,300	21,292				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)	8,963	24,361	72,961			7.00
8.00 INTENSIVE CARE UNIT	1,111	3,270	6,919			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT	133	387	1,201			10.00
11.00 SURGICAL INTENSIVE CARE UNIT	411	711	2,574			11.00
11.01 PEDIATRIC INTENSIVE CARE UNIT	0	495	926			11.01
11.02 TRAUMA INTENSIVE CARE UNIT	431	1,666	2,720			11.02
11.03 NEURO INTENSIVE CARE	130	126	2,509			11.03
11.04 NEONATAL INTENSIVE CARE UNIT	0	8,328	9,482			11.04
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		1,808	2,070			13.00
14.00 Total (see instructions)	11,179	41,152	101,362	462.69	4,822.23	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)				462.69	4,822.23	27.00
28.00 Observation Bed Days		8,063	11,730			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	566	930			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 12/01/2013
To 11/30/2014

Worksheet S-3
Part I
Date/Time Prepared:
5/13/2015 3:48 pm

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	2,316	7,263	20,608	1.00
2.00 HMO and other (see instructions)			273	3,931		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						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	2,316	7,263	20,608	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 12/01/2013 To 11/30/2014		Worksheet S-3 Part II Date/Time Prepared: 5/13/2015 3:48 pm		
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)			
	1.00	2.00	3.00	4.00	5.00	6.00			
PART II - WAGE DATA									
SALARIES									
1.00	Total salaries (see instructions)	200.00	391,888,098	-2,083,063	389,805,035	9,369,008.00	41.61		
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00		
3.00	Non-physician anesthetist Part B		2,053,266	0	2,053,266	28,302.00	72.55		
4.00	Physician-Part A - Administrative		28,788,523	0	28,788,523	245,302.00	117.36		
4.01	Physicians - Part A - Teaching		15,585,061	0	15,585,061	134,282.00	116.06		
5.00	Physician-Part B		61,951,329	0	61,951,329	568,555.00	108.96		
6.00	Non-physician-Part B		0	0	0	0.00	0.00		
7.00	Interns & residents (in an approved program)	21.00	22,951,665	-3,147,772	19,803,893	899,891.00	22.01		
7.01	Contracted interns and residents (in an approved programs)		6,799,495	0	6,799,495	298,616.00	22.77		
8.00	Home office personnel		0	0	0	0.00	0.00		
9.00	SNF	44.00	0	0	0	0.00	0.00		
10.00	Excluded area salaries (see instructions)		5,560,340	8,901,099	14,461,439	444,378.00	32.54		
OTHER WAGES & RELATED COSTS									
11.00	Contract labor: Direct Patient Care		15,372,732	0	15,372,732	391,699.00	39.25		
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00		
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00		
14.00	Home office salaries & wage-related costs		48,559,051	0	48,559,051	925,955.00	52.44		
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00		
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00		
WAGE-RELATED COSTS									
17.00	Wage-related costs (core) (see instructions)		67,464,080	0	67,464,080		17.00		
18.00	Wage-related costs (other) (see instructions)		0	0	0		18.00		
19.00	Excluded areas		3,924,150	0	3,924,150		19.00		
20.00	Non-physician anesthetist Part A		0	0	0		20.00		
21.00	Non-physician anesthetist Part B		547,524	0	547,524		21.00		
22.00	Physician Part A - Administrative		9,026,227	0	9,026,227		22.00		
22.01	Physician Part A - Teaching		4,886,883	0	4,886,883		22.01		
23.00	Physician Part B		19,435,213	0	19,435,213		23.00		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		24.00		
25.00	Interns & residents (in an approved program)		9,712,546	0	9,712,546		25.00		
OVERHEAD COSTS - DIRECT SALARIES									
26.00	Employee Benefits Department	4.00	3,154,079	0	3,154,079	38,764.00	81.37		
27.00	Administrative & General	5.00	26,058,479	293,826	26,352,305	660,429.00	39.90		
28.00	Administrative & General under contract (see inst.)		13,175,577	0	13,175,577	186,222.00	70.75		
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	29.00		
30.00	Operation of Plant	7.00	16,309,031	0	16,309,031	428,058.00	38.10		
31.00	Laundry & Linen Service	8.00	241,277	0	241,277	9,700.00	24.87		
32.00	Housekeeping	9.00	8,172,401	0	8,172,401	406,473.00	20.11		
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	33.00		
34.00	Dietary	10.00	3,038,254	-12,265	3,025,989	133,583.00	22.65		
35.00	Dietary under contract (see instructions)		0	0	0	0.00	35.00		
36.00	Cafeteria	11.00	665,538	0	665,538	38,015.00	17.51		
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	37.00		
38.00	Nursing Administration	13.00	3,045,913	0	3,045,913	75,867.00	40.15		
39.00	Central Services and Supply	14.00	1,315,125	0	1,315,125	65,953.00	19.94		
40.00	Pharmacy	15.00	0	0	0	0.00	40.00		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet S-3
Part II
Date/Time Prepared:
5/13/2015 3:48 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjus ted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00 3,649,080	-50,905	3,598,175	153,119.00	23.50	41.00
42.00	Social Service	17.00 566,737	0	566,737	7,320.00	77.42	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 12/01/2013
To 11/30/2014

Worksheet S-3
Part III
Date/Time Prepared:
5/13/2015 3:48 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	295,722,859	1,064,709	296,787,568	7,625,584.00	38.92	1.00
2.00	Excluded area salaries (see instructions)	5,560,340	8,901,099	14,461,439	444,378.00	32.54	2.00
3.00	Subtotal salaries (line 1 minus line 2)	290,162,519	-7,836,390	282,326,129	7,181,206.00	39.31	3.00
4.00	Subtotal other wages & related costs (see inst.)	63,931,783	0	63,931,783	1,317,654.00	48.52	4.00
5.00	Subtotal wage-related costs (see inst.)	76,490,307	0	76,490,307	0.00	27.09	5.00
6.00	Total (sum of lines 3 thru 5)	430,584,609	-7,836,390	422,748,219	8,498,860.00	49.74	6.00
7.00	Total overhead cost (see instructions)	79,391,491	230,656	79,622,147	2,203,503.00	36.13	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet S-3 Part IV Date/Time Prepared: 5/13/2015 3:48 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			0 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		42,201,888	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		47,321,503	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
TAXES				
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
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			0 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement		844,432	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		100,467,784	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED - MALPRACTICE EXP		20,310,155	25.00

WAGE INDEX PENSION COST SCHEDULE		Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet S-3 Part IV Exhibit 3 Date/Time Prepared: 5/13/2015 3:48 pm
				1.00
Step 1: Determine the 3-Year Averaging Period				
1.00	Wage Index fiscal year ending.		2018	1.00
		From	To	
		1.00	2.00	
2.00	Provider cost reporting period used for Wage Index year shown on line 1.	12/01/2013	11/30/2014	2.00
3.00	Midpoint of provider's cost reporting period shown on line 2. (adjust response to first of month)	06/01/2014		3.00
4.00	Date beginning the 3-year averaging period. (subtract 18 months from midpoint shown on line 3)	12/01/2012		4.00
5.00	Date ending the of the 3-year averaging period. (add 18 months to midpoint shown on line 3)	11/30/2015		5.00
Step 2: Adjust Averaging Period for a New Plan(See Instructions) (Leave lines 6 through 8 blank if the provider has not elected to use an adjusted averaging period)				
6.00	Effective date of pension plan			6.00
7.00	First day of the provider cost reporting period containing the pension plan effective date.			7.00
8.00	Starting date of the adjusted averaging period. (date on line 7 if first of the month, otherwise to first of the month immediately preceding or following the date in line 7). If this date occurs after the period shown on line 2 (Step 1), stop here and see instructions. No cost is reportable for a period which is excluded from the averaging period.			8.00
Step 3: Average Pension Contribution During the Averaging Period				
9.00	Beginning date of averaging period from line 4 or line 8.	12/01/2012		9.00
10.00	Ending date of averaging period from line 5	11/30/2015		10.00
		Deposit Date	Contributions	
		1.00	2.00	
11.00	Enter provider contributions made during the averaging period shown on lines 9 & 10. Add additional lines as necessary if more than 15 contributions are made during the cost reporting period. (Data may be grouped within the averaging period to agree with documentation records (enter beginning date of grouped date range))			11.00
11.01		05/31/2013	41,552,353	11.01
11.02		05/31/2014	42,670,834	11.02
11.03		05/31/2015	42,670,834	11.03
				1.00
12.00	Total number of months included in the averaging period		36	12.00
13.00	Total contributions made during averaging period		126,894,021	13.00
14.00	Average monthly contribution. (line 13 divided by line 12)		3,524,834	14.00
15.00	Number of months in provider cost reporting period shown on line 2.		12	15.00
16.00	Average pension contributions. (line 14 multiplied by line 15)		42,298,008	16.00
Step 4: Total Pension Cost for Wage Index				
17.00	Annual prefunding installment from line 8 of pension prefunding worksheet, if applicable.		0	17.00
18.00	Reportable prefunding installment. (line 17 multiplied by line 15 divided by 12)		0	18.00
19.00	Total Pension Cost for Wage Index. (line 16 plus line 18)		42,298,008	19.00
		Prepared By	Date	
		1.00	2.00	
Prepared By and Date Prepared				
100.00				100.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet S-3
Part V
Date/Time Prepared:
5/13/2015 3:48 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	15,372,732	105,599,603	1.00
2.00	Hospital	15,372,732	104,770,472	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	829,131	17.00
18.00	Other	0	0	18.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet S-5

Date/Time Prepared:
5/13/2015 3:48 pm

		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	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.							
	1.00	2.00	3.00	4.00	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 12/01/2013 To 11/30/2014	Worksheet S-10 Date/Time Prepared: 5/13/2015 3:48 pm
---	--	----------------------	---	--

				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.549738	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			180,455,420	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			358,193,319	6.00
7.00	Medicaid cost (line 1 times line 6)			196,912,479	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)			16,457,059	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP			6,362,977	9.00
10.00	Stand-alone SCHIP charges			6,324,479	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)			3,476,806	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			107,279,539	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			84,431,314	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			46,415,102	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			16,457,059	19.00
				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	228,967,889	0	228,967,889	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	125,872,349	0	125,872,349	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	125,872,349	0	125,872,349	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			182,089,957	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			1,108,081	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			180,981,876	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			99,492,615	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			225,364,964	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			241,822,023	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet A
Date/Time Prepared:
5/13/2015 3:48 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	17,028,047	17,028,047	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	5,908,007	5,908,007	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,154,079	102,509,998	105,664,077	108,259,444	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	26,058,479	71,090,943	97,149,422	60,263,280	5.00
7.00	00700	OPERATION OF PLANT	16,309,031	16,889,620	33,198,651	33,198,651	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	241,277	1,986,508	2,227,785	2,227,785	8.00
9.00	00900	HOUSEKEEPING	8,172,401	1,032,515	9,204,916	9,794,983	9.00
10.00	01000	DIETARY	3,038,254	5,561,636	8,599,890	7,891,937	10.00
11.00	01100	CAFETERIA	665,538	0	665,538	665,538	11.00
13.00	01300	NURSING ADMINISTRATION	3,045,913	33,937	3,079,850	3,079,850	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,315,125	-63,308	1,251,817	1,251,817	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,649,080	503,629	4,152,709	4,101,804	16.00
17.00	01700	SOCIAL SERVICE	566,737	0	566,737	566,737	17.00
18.00	01851	WAI VER OVERHEAD COSTS	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	2,053,267	2,053,267	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	22,951,665	4,325,678	27,277,343	24,129,571	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	593,282	507,700	1,100,982	24,242,164	22.00
23.00	02300	ALLIED HEALTH	0	0	249,569	249,569	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	67,651,444	7,447,703	75,099,147	66,889,919	30.00
31.00	03100	INTENSIVE CARE UNIT	8,324,524	54,176	8,378,700	8,319,089	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	3,003,727	28,468	3,032,195	2,927,696	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	3,542,001	15,242	3,557,243	3,596,641	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	2,653,860	5,890	2,659,750	2,623,122	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	5,731,479	621,166	6,352,645	6,330,972	34.02
34.03	02400	NEURO INTENSIVE CARE	4,012,813	31,893	4,044,706	3,436,354	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	10,000,179	21,312	10,021,491	9,719,725	34.04
43.00	04300	NURSERY	2,276,763	11,541	2,288,304	2,288,304	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	30,284,482	11,966,385	42,250,867	47,194,583	50.00
51.00	05100	RECOVERY ROOM	2,146,925	75	2,147,000	2,147,000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,532,516	4,745	3,537,261	3,580,361	52.00
53.00	05300	ANESTHESIOLOGY	9,495,881	87,885	9,583,766	5,046,645	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,565,148	11,789,608	28,354,756	28,225,815	54.00
60.00	06000	LABORATORY	15,809,849	15,645,054	31,454,903	31,171,692	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,074,186	3,249,580	4,323,766	4,323,766	62.00
65.00	06500	RESPIRATORY THERAPY	6,541,413	558,018	7,099,431	7,006,902	65.00
66.00	06600	PHYSICAL THERAPY	1,315,081	145,744	1,460,825	1,460,825	66.00
67.00	06700	OCCUPATIONAL THERAPY	501,787	75	501,862	501,862	67.00
68.00	06800	SPEECH PATHOLOGY	555,572	313,613	869,185	869,185	68.00
69.00	06900	ELECTROCARDIOLOGY	5,219,404	2,243,872	7,463,276	7,257,324	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	5,169,864	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	292,029	-2,889,258	-2,597,229	-590,488	73.00
74.00	07400	RENAL DIALYSIS	3,076,967	7,460	3,084,427	3,166,706	74.00
76.00	03950	WAI VER PURCHASED PATIENT SERVICES	0	0	0	223,681,445	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	62,139,408	37,457,761	99,597,169	82,906,700	90.00
91.00	09100	EMERGENCY	30,819,459	2,411	30,821,870	28,508,468	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	386,327,758	293,199,275	679,527,033	892,672,928	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.01	19001	DENTISTRY	2,233,123	94,882	2,328,005	2,371,226	190.01
190.02	19002	ACHN SATELLITE CLINICS	0	0	0	0	190.02
190.03	19003	SPECIAL FUNDS	0	0	0	776,614	190.03
190.04	19004	SENGSTACKE CLINIC	2,083,063	-116,335	1,966,728	1,966,728	190.04
194.00	07951	WAI VER ADMINISTRATIVE ONLY COSTS	1,244,154	467,390,522	468,634,676	254,668,946	194.00
200.00		TOTAL (SUM OF LINES 118-199)	391,888,098	760,568,344	1,152,456,442	1,152,456,442	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet A
Date/Time Prepared:
5/13/2015 3:48 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	41,367,766	58,395,813	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	12,580,310	18,488,317	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	11,966,028	120,225,472	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	113,712,477	173,975,757	5.00
7.00	00700	OPERATION OF PLANT	-3,129,696	30,068,955	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,227,785	8.00
9.00	00900	HOUSEKEEPING	0	9,794,983	9.00
10.00	01000	DIETARY	-232,743	7,659,194	10.00
11.00	01100	CAFETERIA	0	665,538	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,079,850	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,251,817	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-168,203	3,933,601	16.00
17.00	01700	SOCIAL SERVICE	0	566,737	17.00
18.00	01851	WAIVER OVERHEAD COSTS	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-2,053,267	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	24,129,571	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	-8,557,891	15,684,273	22.00
23.00	02300	ALLIED HEALTH	0	249,569	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-30,498,516	36,391,403	30.00
31.00	03100	INTENSIVE CARE UNIT	-438,664	7,880,425	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	-1,114,471	1,813,225	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	-110,339	3,486,302	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	-860,677	1,762,445	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	-2,244,426	4,086,546	34.02
34.03	02400	NEURO INTENSIVE CARE	-1,070,822	2,365,532	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	-3,665,092	6,054,633	34.04
43.00	04300	NURSERY	0	2,288,304	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-12,916,582	34,278,001	50.00
51.00	05100	RECOVERY ROOM	0	2,147,000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-126,802	3,453,559	52.00
53.00	05300	ANESTHESIOLOGY	-3,835,493	1,211,152	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-8,399,083	19,826,732	54.00
60.00	06000	LABORATORY	-4,523,659	26,648,033	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	4,323,766	62.00
65.00	06500	RESPIRATORY THERAPY	-1,919,949	5,086,953	65.00
66.00	06600	PHYSICAL THERAPY	0	1,460,825	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	501,862	67.00
68.00	06800	SPEECH PATHOLOGY	0	869,185	68.00
69.00	06900	ELECTROCARDIOLOGY	-2,775,705	4,481,619	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,169,864	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	43,098,170	42,507,682	73.00
74.00	07400	RENAL DIALYSIS	-215,826	2,950,880	74.00
76.00	03950	WAIVER PURCHASED PATIENT SERVICES	-223,681,445	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-21,077,413	61,829,287	90.00
91.00	09100	EMERGENCY	-4,516,930	23,991,538	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-115,408,943	777,263,985	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	DENTISTRY	0	2,371,226	190.01
190.02	19002	ACHN SATELITE CLINICS	0	0	190.02
190.03	19003	SPECIAL FUNDS	0	776,614	190.03
190.04	19004	SENGSTACKE CLINIC	-1,966,728	0	190.04
194.00	07951	WAIVER ADMINISTRATIVE ONLY COSTS	13,416,144	268,085,090	194.00
200.00		TOTAL (SUM OF LINES 118-199)	-103,959,527	1,048,496,915	200.00

COST CENTERS USED IN COST REPORT		Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet Non-CMS W Date/Time Prepared: 5/13/2015 3:48 pm
Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
18.00	WAI VER 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
INPATIENT ROUTINE SERVICE COST CENTERS				
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	PEDIATRIC INTENSIVE CARE UNIT	34.01
34.02	TRAUMA INTENSIVE CARE UNIT	02180	TRAUMA INTENSIVE CARE UNIT	34.02
34.03	NEURO INTENSIVE CARE	02400		34.03
34.04	NEONATAL INTENSIVE CARE UNIT	02060	NEONATAL INTENSIVE CARE UNIT	34.04
43.00	NURSERY	04300		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELL	06200		62.00
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	WAI VER PURCHASED PATIENT SERVICES	03950		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS				
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	WAI VER ADMINISTRATIVE ONLY COSTS	07951		194.00
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet A-6
Date/Time Prepared:
5/13/2015 3:48 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
A - TO RECLASS FRINGE BENEFITS TO EHW						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,595,367	1.00	
	TOTALS		0	2,595,367		
B - SERVICE CONTRACTS						
1.00	HOUSEKEEPING	9.00	0	590,067	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	105,621	2.00	
	TOTALS		0	695,688		
C - SAL OF NON RESIDENTS MOVED TO OTHER						
1.00	I&R SERVICES-OTHER PRGM	22.00	1,474,894	0	1.00	
	COSTS APPRV					
	TOTALS		1,474,894	0		
D - TRANSFER MOONLIGHTING TO ER						
1.00	EMERGENCY	91.00	1,459,950	0	1.00	
	TOTALS		1,459,950	0		
E - TO RECLASSIFY I/R OTHER COST						
1.00	I&R SERVICES-OTHER PRGM	22.00	0	6,360,897	1.00	
	COSTS APPRV					
2.00	TRAUMA INTENSIVE CARE UNIT	34.02	0	28,188	2.00	
3.00	CLINIC	90.00	0	3,593	3.00	
	TOTALS		0	6,392,678		
F - TO ALLOCATE PEDS ALGY & PSYCH TO INP						
1.00	ADULTS & PEDIATRICS	30.00	117,198	4,862	1.00	
	TOTALS		117,198	4,862		
G - TO TRANSFER DIETARY SAL TO CLINIC						
1.00	CLINIC	90.00	12,265	0	1.00	
	TOTALS		12,265	0		
H - TO ALLOCATE REGISTRY AND IN-HOUSE NSG						
1.00	INTENSIVE CARE UNIT	31.00	0	96,116	1.00	
2.00	BURN INTENSIVE CARE UNIT	33.00	0	30,143	2.00	
3.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	39,398	3.00	
4.00	PEDIATRIC INTENSIVE CARE UNIT	34.01	0	1,586	4.00	
5.00	TRAUMA INTENSIVE CARE UNIT	34.02	0	150,982	5.00	
6.00	NEONATAL INTENSIVE CARE UNIT	34.04	0	26,970	6.00	
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	43,100	7.00	
8.00	EMERGENCY	91.00	0	122,103	8.00	
	TOTALS		0	510,398		
I - TO RECLASS NON-PHY ANESTH TO PRP GRP						
1.00	NONPHYSICIAN ANESTHETISTS	19.00	2,053,267	0	1.00	
	TOTALS		2,053,267	0		
J - TO RECLASS HEKTOEN COST TO RESRCH.						
1.00	SPECIAL FUNDS	190.03	776,614	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		776,614	0		
K - TO RECLASS COST OF IMPLANTS						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	5,169,864	1.00	
	TOTALS		0	5,169,864		
M - TO RECLASS HBP TEACHING TIME						
1.00	I&R SERVICES-OTHER PRGM	22.00	15,503,902	0	1.00	
	COSTS APPRV					
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
	TOTALS		15,503,902	0		
N - DEPRECIATION RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	16,702,863	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,908,007	2.00	
	TOTALS		0	22,610,870		

RECLASSIFICATIONS

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet A-6

Date/Time Prepared:
5/13/2015 3:48 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
O - SENGSTACKE CLINIC					
1.00	SENGSTACKE CLINIC	190.04	0	2,083,063	1.00
	TOTALS		0	2,083,063	
Q - INSURANCE RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,970,437	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	325,184	2.00
	TOTALS		0	2,295,621	
R - PHARMACY SCHOOL					
1.00	ALLIED HEALTH	23.00	220,863	28,706	1.00
	TOTALS		220,863	28,706	
S - MEDICAL DIRECTOR					
1.00	ADMINISTRATIVE & GENERAL	5.00	329,160	0	1.00
2.00	DENTISTRY	190.01	43,221	0	2.00
3.00	RENAL DIALYSIS	74.00	82,279	0	3.00
4.00		0.00	0	0	4.00
	TOTALS		454,660	0	
T - SUPPLY COST					
1.00	OPERATING ROOM	50.00	0	12,189,456	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,267,000	2.00
	TOTALS		0	14,456,456	
U - RECLASS SALARY FROM OTHER TO SALARY					
1.00		0.00	0	0	1.00
6.00	WAI VER ADMINISTRATIVE ONLY COSTS	194.00	9,943,464	0	6.00
7.00	WAI VER PURCHASED PATIENT SERVICES	76.00	0	223,681,445	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	377,033	8.00
	TOTALS		9,943,464	224,058,478	
V - STRATEGIC MANAGEMENT					
1.00	WAI VER ADMINISTRATIVE ONLY COSTS	194.00	0	149,284	1.00
	TOTALS		0	149,284	
500.00	Grand Total: Increases		32,017,077	281,051,335	500.00

RECLASSIFICATIONS

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet A-6
Date/Time Prepared:
5/13/2015 3:48 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - TO RECLASS FRINGE BENEFITS TO EHW						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,595,367	0	1.00
	TOTALS		0	2,595,367		
B - SERVICE CONTRACTS						
1.00	DIETARY	10.00	0	695,688	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	695,688		
C - SAL OF NON RESIDENTS MOVED TO OTHER						
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	1,474,894	0	0	1.00
	TOTALS		1,474,894	0		
D - TRANSFER MOONLIGHTING TO ER						
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	1,459,950	0	0	1.00
	TOTALS		1,459,950	0		
E - TO RECLASSIFY I/R OTHER COST						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,414,367	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	3,950,602	0	2.00
3.00	LABORATORY	60.00	0	27,709	0	3.00
	TOTALS		0	6,392,678		
F - TO ALLOCATE PEDS ALGY & PSYCH TO INP						
1.00	CLINIC	90.00	117,198	4,862	0	1.00
	TOTALS		117,198	4,862		
G - TO TRANSFER DIETARY SAL TO CLINIC						
1.00	DIETARY	10.00	12,265	0	0	1.00
	TOTALS		12,265	0		
H - TO ALLOCATE REGSTRY AND IN-HOUSE NSG						
1.00	ADULTS & PEDIATRICS	30.00	0	510,398	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
	TOTALS		0	510,398		
I - TO RECLASS NON-PHY ANESTH TO PRP GRP						
1.00	ANESTHESIOLOGY	53.00	2,053,267	0	0	1.00
	TOTALS		2,053,267	0		
J - TO RECLASS HEKTOEN COST TO RESRCH.						
1.00	ADMINISTRATIVE & GENERAL	5.00	35,334	0	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	677,279	0	0	2.00
3.00	ANESTHESIOLOGY	53.00	18,461	0	0	3.00
4.00	CLINIC	90.00	34,850	0	0	4.00
5.00	DRUGS CHARGED TO PATIENTS	73.00	10,690	0	0	5.00
	TOTALS		776,614	0		
K - TO RECLASS COST OF IMPLANTS						
1.00	OPERATING ROOM	50.00	0	5,169,864	0	1.00
	TOTALS		0	5,169,864		
M - TO RECLASS HBP TEACHING TIME						
1.00	ADULTS & PEDIATRICS	30.00	3,193,009	0	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	155,727	0	0	2.00
3.00	BURN INTENSIVE CARE UNIT	33.00	134,642	0	0	3.00
4.00	PEDIATRIC INTENSIVE CARE UNIT	34.01	38,214	0	0	4.00
5.00	TRAUMA INTENSIVE CARE UNIT	34.02	200,843	0	0	5.00
6.00	NEURO INTENSIVE CARE	34.03	608,352	0	0	6.00
7.00	NEONATAL INTENSIVE CARE UNIT	34.04	328,736	0	0	7.00
8.00	OPERATING ROOM	50.00	2,047,732	0	0	8.00
9.00	ANESTHESIOLOGY	53.00	2,465,393	0	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	505,974	0	0	10.00
11.00	LABORATORY	60.00	255,502	0	0	11.00
12.00	RESPIRATORY THERAPY	65.00	92,529	0	0	12.00
13.00	ELECTROCARDIOLOGY	69.00	205,952	0	0	13.00
14.00	CLINIC	90.00	1,324,937	0	0	14.00
15.00	EMERGENCY	91.00	3,895,455	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	16.00	50,905	0	0	16.00
	TOTALS		15,503,902	0		
N - DEPRECIATION RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	19,640,552	9	1.00
2.00	CLINIC	90.00	0	2,970,318	9	2.00
	TOTALS		0	22,610,870		

RECLASSIFICATIONS

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet A-6

Date/Time Prepared:
5/13/2015 3:48 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
O - SENGSTACKE CLINIC						
1.00	SENGSTACKE CLINIC	190.04	2,083,063	0	0	1.00
	TOTALS		2,083,063	0		
Q - INSURANCE RECLASS						
1.00	CLINIC	90.00	0	2,295,621	0	1.00
2.00		0.00	0	0	12	2.00
	TOTALS		0	2,295,621		
R - PHARMACY SCHOOL						
1.00	DRUGS CHARGED TO PATIENTS	73.00	220,863	28,706	0	1.00
	TOTALS		220,863	28,706		
S - MEDICAL DIRECTOR						
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	198,511	0	0	1.00
2.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	212,928	0	0	2.00
3.00	CLINIC	90.00	15,077	0	0	3.00
4.00	OPERATING ROOM	50.00	28,144	0	0	4.00
	TOTALS		454,660	0		
T - SUPPLY COST						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	14,456,456	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	14,456,456		
U - RECLASS SALARY FROM OTHER TO SALARY						
1.00		0.00	0	0	0	1.00
6.00	CLINIC	90.00	9,943,464	0	0	6.00
7.00	WAI VER ADMINISTRATIVE ONLY COSTS	194.00	0	224,058,478	0	7.00
8.00		0.00	0	0	0	8.00
	TOTALS		9,943,464	224,058,478		
V - STRATEGIC MANAGEMENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	149,284	0	1.00
	TOTALS		0	149,284		
500.00	Grand Total : Decreases		34,100,140	278,968,272		500.00

RECLASSIFICATIONS

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
5/13/2015 3:48 pm

		Increases			Decreases				
Cost Center		Line #	Salary	Other	Cost Center	Line #	Salary	Other	
2.00		3.00	4.00	5.00	6.00	7.00	8.00	9.00	
A - TO RECLASS FRINGE BENEFITS TO EHW									
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,595,367	ADMINISTRATIVE & GENERAL	5.00	0	2,595,367	1.00
	TOTALS		0	2,595,367	TOTALS		0	2,595,367	
B - SERVICE CONTRACTS									
1.00	HOUSEKEEPING	9.00	0	590,067	DIETARY	10.00	0	695,688	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	105,621		0.00	0	0	2.00
	TOTALS		0	695,688	TOTALS		0	695,688	
C - SAL OF NON RESIDENTS MOVED TO OTHER									
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	1,474,894	0	I&R SERVICES-SALARY & FRINGES APPRV	21.00	1,474,894	0	1.00
	TOTALS		1,474,894	0	TOTALS		1,474,894	0	
D - TRANSFER MOONLIGHTING TO ER									
1.00	EMERGENCY	91.00	1,459,950	0	I&R SERVICES-SALARY & FRINGES APPRV	21.00	1,459,950	0	1.00
	TOTALS		1,459,950	0	TOTALS		1,459,950	0	
E - TO RECLASSIFY I/R OTHER COST									
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	6,360,897	ADMINISTRATIVE & GENERAL	5.00	0	2,414,367	1.00
2.00	TRAUMA INTENSIVE CARE UNIT	34.02	0	28,188	ADULTS & PEDIATRICS	30.00	0	3,950,602	2.00
3.00	CLINIC	90.00	0	3,593	LABORATORY	60.00	0	27,709	3.00
	TOTALS		0	6,392,678	TOTALS		0	6,392,678	
F - TO ALLOCATE PEDS ALGY & PSYCH TO INP									
1.00	ADULTS & PEDIATRICS	30.00	117,198	4,862	CLINIC	90.00	117,198	4,862	1.00
	TOTALS		117,198	4,862	TOTALS		117,198	4,862	
G - TO TRANSFER DIETARY SAL TO CLINIC									
1.00	CLINIC	90.00	12,265	0	DIETARY	10.00	12,265	0	1.00
	TOTALS		12,265	0	TOTALS		12,265	0	
H - TO ALLOCATE REGISTRY AND IN-HOUSE NSG									
1.00	INTENSIVE CARE UNIT	31.00	0	96,116	ADULTS & PEDIATRICS	30.00	0	510,398	1.00
2.00	BURN INTENSIVE CARE UNIT	33.00	0	30,143		0.00	0	0	2.00
3.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	39,398		0.00	0	0	3.00
4.00	PEDIATRIC INTENSIVE CARE UNIT	34.01	0	1,586		0.00	0	0	4.00
5.00	TRAUMA INTENSIVE CARE UNIT	34.02	0	150,982		0.00	0	0	5.00
6.00	NEONATAL INTENSIVE CARE UNIT	34.04	0	26,970		0.00	0	0	6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	43,100		0.00	0	0	7.00
8.00	EMERGENCY	91.00	0	122,103		0.00	0	0	8.00
	TOTALS		0	510,398	TOTALS		0	510,398	
I - TO RECLASS NON-PHY ANESTH TO PRP GRP									
1.00	NONPHYSICIAN ANESTHETISTS	19.00	2,053,267	0	ANESTHESIOLOGY	53.00	2,053,267	0	1.00
	TOTALS		2,053,267	0	TOTALS		2,053,267	0	
J - TO RECLASS HEKTOEN COST TO RESRCH.									
1.00	SPECIAL FUNDS	190.03	776,614	0	ADMINISTRATIVE & GENERAL	5.00	35,334	0	1.00
2.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	677,279	0	2.00
3.00		0.00	0	0	ANESTHESIOLOGY	53.00	18,461	0	3.00
4.00		0.00	0	0	CLINIC	90.00	34,850	0	4.00
5.00		0.00	0	0	DRUGS CHARGED TO PATIENTS	73.00	10,690	0	5.00
	TOTALS		776,614	0	TOTALS		776,614	0	
K - TO RECLASS COST OF IMPLANTS									
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	5,169,864	OPERATING ROOM	50.00	0	5,169,864	1.00
	TOTALS		0	5,169,864	TOTALS		0	5,169,864	
M - TO RECLASS HBP TEACHING TIME									
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	15,503,902	0	ADULTS & PEDIATRICS	30.00	3,193,009	0	1.00
2.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	155,727	0	2.00
3.00		0.00	0	0	BURN INTENSIVE CARE UNIT	33.00	134,642	0	3.00
4.00		0.00	0	0	PEDIATRIC INTENSIVE CARE UNIT	34.01	38,214	0	4.00
5.00		0.00	0	0	TRAUMA INTENSIVE CARE UNIT	34.02	200,843	0	5.00
6.00		0.00	0	0	NEURO INTENSIVE CARE	34.03	608,352	0	6.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet A-7
Part I
Date/Time Prepared:
5/13/2015 3:48 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	2,717,512	0	0	0	0	2.00
3.00	Buildings and Fixtures	522,269,978	743,817	0	743,817	0	3.00
4.00	Building Improvements	92,184,236	1,690,307	0	1,690,307	0	4.00
5.00	Fixed Equipment	159,693,636	2,134,849	0	2,134,849	0	5.00
6.00	Movable Equipment	12,083,850	0	0	0	5,751,614	6.00
7.00	HIT designated Assets	4,436,178	6,196,231	0	6,196,231	0	7.00
8.00	Subtotal (sum of lines 1-7)	793,385,390	10,765,204	0	10,765,204	5,751,614	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	793,385,390	10,765,204	0	10,765,204	5,751,614	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0				1.00
2.00	Land Improvements	2,717,512	0				2.00
3.00	Buildings and Fixtures	523,013,795	0				3.00
4.00	Building Improvements	93,874,543	0				4.00
5.00	Fixed Equipment	161,828,485	0				5.00
6.00	Movable Equipment	6,332,236	0				6.00
7.00	HIT designated Assets	10,632,409	0				7.00
8.00	Subtotal (sum of lines 1-7)	798,398,980	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	798,398,980	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet A-7
Part II
Date/Time Prepared:
5/13/2015 3:48 pm

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 12/01/2013
To 11/30/2014

Worksheet A-7
Part III
Date/Time Prepared:
5/13/2015 3:48 pm

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	781,380,334	0	781,380,334	0.978750	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	16,964,645	0	16,964,645	0.021250	0	2.00
3.00	Total (sum of lines 1-2)	798,344,979	0	798,344,979	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	13,981,445	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	6,789,926	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	20,771,371	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	44,089,184	325,184	0	0	58,395,813	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,698,391	0	0	0	18,488,317	2.00
3.00	Total (sum of lines 1-2)	55,787,575	325,184	0	0	76,884,130	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet A-8

Date/Time Prepared:
5/13/2015 3:48 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst.	A-7 Ref.
			3.00	4.00	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00		0 1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP 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	-3,129,696	OPERATION OF PLANT	7.00		0 9.00
10.00 Provider-based physician adjustment	A-8-2	-98,984,509				0 10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	B	-60,487	ADMINISTRATIVE & GENERAL	5.00		0 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	19,978,289				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	-468,384	LABORATORY	60.00		0 16.00
17.00 Sale of drugs to other than patients		0		0.00		0 17.00
18.00 Sale of medical records and abstracts	B	-168,203	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		0RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	A	-2,058,179	CAP REL COSTS-BLDG & FIXT	1.00		9 26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	A	881,919	CAP REL COSTS-MVBLE EQUIP	2.00		9 27.00
28.00 Non-physician Anesthetist	A	-2,053,267	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		0OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00		0 32.00
33.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00		0 33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet A-8

Date/Time Prepared:
5/13/2015 3:48 pm

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	
33.01 MISCELLANEOUS INCOME	B	-41,321	ADMINISTRATIVE & GENERAL	5.00	0 33.01
33.02 REMOVE COSTS RELATED TO PROVIDENT	A	-232,743	DIETARY	10.00	0 33.02
33.03 COUNTY ADJ. FOR HOSPITAL BOND INT.	A	11,698,391	CAP REL COSTS-MVBLE EQUIP	2.00	11 33.03
33.04 COUNTY ADJ. FOR HOSPITAL BOND INT.	A	42,260,919	CAP REL COSTS-BLDG & FIXT	1.00	11 33.04
33.05 COUNTY ADJ. FOR HOSPITAL BOND INT.	A	9,991,328	ADMINISTRATIVE & GENERAL	5.00	0 33.05
33.06 SYSTEM HEALTH & HOSPITAL ADMINSTN.	A	95,989,587	ADMINISTRATIVE & GENERAL	5.00	0 33.06
33.07 SYSTEM HEALTH & HOSPITAL PHARMCY.	A	43,098,170	DRUGS CHARGED TO PATIENTS	73.00	0 33.07
33.08 SYSTEM HEALTH & HOSPITAL BENEFITS	A	12,457,400	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.08
33.09 SYSTEM HEALTH & HOSPITAL WAI VER COST	A	180,173	WAI VER ADMINSTRATIVE ONLY COSTS	194.00	0 33.09
33.10 RESIDENCY PROGRAM REIMBURSEMNT.	B	-791,158	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0 33.10
33.11 MISCELLANEOUS INCOME	B	-7,953	CLINIC	90.00	0 33.11
33.12 TO OFFSET PHYSICIAN PART C TIME	A	-5,620	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0 33.12
33.13 TO OFFSET PHYSICIAN PART C TIME	A	-718,288	ADULTS & PEDIATRICS	30.00	0 33.13
33.14 TO OFFSET PHYSICIAN PART C TIME	A	-12,917	BURN INTENSIVE CARE UNIT	33.00	0 33.14
33.15 TO OFFSET PHYSICIAN PART C TIME	A	-15,842	PEDIATRIC INTENSIVE CARE UNIT	34.01	0 33.15
33.16 TO OFFSET PHYSICIAN PART C TIME	A	-104,137	NEONATAL INTENSIVE CARE UNIT	34.04	0 33.16
33.17 TO OFFSET PHYSICIAN PART C TIME	A	-70,804	OPERATING ROOM	50.00	0 33.17
33.18 TO OFFSET PHYSICIAN PART C TIME	A	-87,668	ANESTHESIOLOGY	53.00	0 33.18
33.19 TO OFFSET PHYSICIAN PART C TIME	A	-85,568	RADIOLOGY-DIAGNOSTIC	54.00	0 33.19
33.20 TO OFFSET PHYSICIAN PART C TIME	A	-38,977	LABORATORY	60.00	0 33.20
33.21 TO OFFSET PHYSICIAN PART C TIME	A	-6,456	RESPIRATORY THERAPY	65.00	0 33.21
33.22 TO OFFSET PHYSICIAN PART C TIME	A	-33,770	ELECTROCARDIOLOGY	69.00	0 33.22
33.23 TO OFFSET PHYSICIAN PART C TIME	A	-113,172	CLINIC	90.00	0 33.23
33.24 TO OFFSET PHYSICIAN PART C TIME	A	-160,134	EMERGENCY	91.00	0 33.24
33.25		0		0.00	0 33.25
33.26 POST CLOSING JOURNAL ENTRIES	A	1,828,265	CAP REL COSTS-BLDG & FIXT	1.00	11 33.26
33.27 POST CLOSING JOURNAL ENTRIES	A	355,893	ADMINISTRATIVE & GENERAL	5.00	0 33.27
33.28		0		0.00	0 33.28
33.29 NURSE PRACTITIONER AND PHYS ASST.	A	-215,826	RENAL DIALYSIS	74.00	0 33.29
33.30 TO REMOVE SENGSTACKE CLINIC FROM C/R	A	-1,966,728	SENGSTACKE CLINIC	190.04	0 33.30
33.31 IHA LOBBYING	A	-141,937	ADMINISTRATIVE & GENERAL	5.00	0 33.31
33.32		0		0.00	0 33.32
33.33 NURSE PRACTITIONER AND PHYS ASST.	A	-1,897,494	ADULTS & PEDIATRICS	30.00	0 33.33
33.34 NURSE PRACTITIONER AND PHYS ASST.	A	-110,339	SURGICAL INTENSIVE CARE UNIT	34.00	0 33.34
33.35 NURSE PRACTITIONER AND PHYS ASST.	A	-122,665	PEDIATRIC INTENSIVE CARE UNIT	34.01	0 33.35
33.36 NURSE PRACTITIONER AND PHYS ASST.	A	-470,627	NEURO INTENSIVE CARE	34.03	0 33.36
33.37 NURSE PRACTITIONER AND PHYS ASST.	A	-422,961	NEONATAL INTENSIVE CARE UNIT	34.04	0 33.37
33.38 NURSE PRACTITIONER AND PHYS ASST.	A	-870,106	OPERATING ROOM	50.00	0 33.38
33.39 NURSE PRACTITIONER AND PHYS ASST.	A	-126,802	DELIVERY ROOM & LABOR ROOM	52.00	0 33.39

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	
33.40 NURSE PRACTITIONER AND PHYS ASST.	A	-395,155	ELECTROCARDIOLOGY	69.00	0 33.40
33.41 NURSE PRACTITIONER AND PHYS ASST.	A	-118,545	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.41
33.42 NURSE PRACTITIONER AND PHYS ASST.	A	-1,667,457	CLINIC	90.00	0 33.42
33.43 NURSE PRACTITIONER AND PHYS ASST.	A	-863,551	EMERGENCY	91.00	0 33.43
33.44 OAK FOREST VACANT SPACE ADJUSTMENT	A	-663,239	CAP REL COSTS-BLDG & FIXT	1.00	9 33.44
33.45 WAIVER COSTS	A	-223,681,445	WAI VER PURCHASED PATIENT SERVICES	76.00	0 33.45
33.46 3 YR PENSION AVG	A	-372,827	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.46
33.47		0		0.00	0 33.47
33.48		0		0.00	0 33.48
33.49		0		0.00	0 33.49
33.50		0		0.00	0 33.50
33.51		0		0.00	0 33.51
33.52		0		0.00	0 33.52
33.53		0		0.00	0 33.53
33.54		0		0.00	0 33.54
33.55 HOSPITAL INSURANCES	A	877,096	ADMINISTRATIVE & GENERAL	5.00	0 33.55
33.56 OTHER ADJUSTMENTS (SPECIFY (3))		0		0.00	0 33.56
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-103,959,527			50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet A-8-1

Date/Time Prepared:
5/13/2015 3:48 pm

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	225,456	225,456 1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	PAYROLL	148,481	149,664 2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	GENERAL ACCOUNTING	309,968	310,787 3.00
3.01	194.00	WAI VER ADMINISTRATIVE ONLY C	COUNTY COSTS ALLOCATED TO CC	13,235,971	0 3.01
4.00	5.00	ADMINISTRATIVE & GENERAL	COUNTY COSTS ALLOCATED TO CC	14,990,164	8,245,844 4.00
4.01	0.00			0	0 4.01
4.02	0.00			0	0 4.02
5.00	0		0	28,910,040	8,931,751 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 12/01/2013
To 11/30/2014

Worksheet A-8-1

Date/Time Prepared:
5/13/2015 3:48 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	0	0		1.00
2.00	-1,183	0		2.00
3.00	-819	0		3.00
3.01	13,235,971	0		3.01
4.00	6,744,320	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
5.00	19,978,289			5.00

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

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

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

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested 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	GOVERNMENT AGENCY		7.00
8.00	TREAS, STATE		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 12/01/2013
To 11/30/2014

Worksheet A-8-2

Date/Time Prepared:
5/13/2015 3:48 pm

	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	20,789,548	121,712	20,561,692	177,200	136,237	1.00
2.00	30.00	ADULTS & PEDIATRICS	36,598,752	23,405,295	13,193,457	177,200	91,599	2.00
3.00	31.00	INTENSIVE CARE UNIT	697,778	282,036	415,742	177,200	2,704	3.00
4.00	33.00	BURN INTENSIVE CARE UNIT	1,293,017	929,195	363,822	208,000	1,663	4.00
5.00	34.00	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	5.00
6.00	34.01	PEDIATRIC INTENSIVE CARE UNIT	856,694	665,689	191,005	177,200	1,424	6.00
7.00	34.02	TRAUMA INTENSIVE CARE UNIT	2,516,666	2,030,271	486,395	208,000	2,386	7.00
8.00	34.03	NEURO INTENSIVE CARE	638,999	562,306	76,693	208,000	335	8.00
9.00	34.04	NEONATAL INTENSIVE CARE UNIT	3,804,690	2,808,459	996,230	177,200	7,017	9.00
10.00	50.00	OPERATING ROOM	14,405,395	10,436,129	3,969,266	208,000	21,552	10.00
11.00	53.00	ANESTHESIOLOGY	5,444,251	2,639,492	2,804,759	200,300	15,602	11.00
12.00	54.00	RADIOLOGY-DIAGNOSTIC	9,204,349	7,686,294	1,518,054	225,300	7,255	12.00
13.00	60.00	LABORATORY	5,046,800	3,826,061	1,220,739	215,700	9,123	13.00
14.00	65.00	RESPIRATORY THERAPY	2,699,875	1,686,066	1,013,809	200,300	7,438	14.00
15.00	67.00	OCCUPATIONAL THERAPY	0	0	0	177,200	0	15.00
16.00	69.00	ELECTROCARDIOLOGY	2,676,851	2,057,739	619,112	165,600	3,608	16.00
17.00	90.00	CLINIC	21,754,300	18,312,667	3,441,633	177,200	26,146	17.00
18.00	91.00	EMERGENCY	6,593,982	1,435,412	5,158,570	177,200	32,209	18.00
200.00			135,021,947	78,884,823	56,030,978		366,298	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	11,606,344	580,317	0	0	1,437,850	1.00
2.00	30.00	ADULTS & PEDIATRICS	7,803,530	390,177	0	0	2,531,249	2.00
3.00	31.00	INTENSIVE CARE UNIT	230,360	11,518	0	0	48,260	3.00
4.00	33.00	BURN INTENSIVE CARE UNIT	166,300	8,315	0	0	89,428	4.00
5.00	34.00	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	5.00
6.00	34.01	PEDIATRIC INTENSIVE CARE UNIT	121,314	6,066	0	0	59,251	6.00
7.00	34.02	TRAUMA INTENSIVE CARE UNIT	238,600	11,930	0	0	174,058	7.00
8.00	34.03	NEURO INTENSIVE CARE	33,500	1,675	0	0	44,195	8.00
9.00	34.04	NEONATAL INTENSIVE CARE UNIT	597,794	29,890	0	0	263,141	9.00
10.00	50.00	OPERATING ROOM	2,155,200	107,760	0	0	996,308	10.00
11.00	53.00	ANESTHESIOLOGY	1,502,443	75,122	0	0	376,536	11.00
12.00	54.00	RADIOLOGY-DIAGNOSTIC	785,842	39,292	0	0	636,593	12.00
13.00	60.00	LABORATORY	946,073	47,304	0	0	349,048	13.00
14.00	65.00	RESPIRATORY THERAPY	716,265	35,813	0	0	186,729	14.00
15.00	67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	15.00
16.00	69.00	ELECTROCARDIOLOGY	287,252	14,363	0	0	185,137	16.00
17.00	90.00	CLINIC	2,227,438	111,372	0	0	1,504,574	17.00
18.00	91.00	EMERGENCY	2,743,959	137,198	0	0	456,054	18.00
200.00			32,162,214	1,608,112	0	0	9,338,411	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	1,422,091	13,028,435	7,533,257	7,761,113		1.00
2.00	30.00	ADULTS & PEDIATRICS	912,488	8,716,018	4,477,439	27,882,734		2.00
3.00	31.00	INTENSIVE CARE UNIT	28,754	259,114	156,628	438,664		3.00
4.00	33.00	BURN INTENSIVE CARE UNIT	25,163	191,463	172,359	1,101,554		4.00
5.00	34.00	SURGICAL INTENSIVE CARE UNIT	0	0	0	0		5.00
6.00	34.01	PEDIATRIC INTENSIVE CARE UNIT	13,210	134,524	56,481	722,170		6.00
7.00	34.02	TRAUMA INTENSIVE CARE UNIT	33,640	272,240	214,155	2,244,426		7.00
8.00	34.03	NEURO INTENSIVE CARE	5,304	38,804	37,889	600,195		8.00
9.00	34.04	NEONATAL INTENSIVE CARE UNIT	68,902	666,696	329,534	3,137,994		9.00
10.00	50.00	OPERATING ROOM	274,523	2,429,723	1,539,543	11,975,672		10.00
11.00	53.00	ANESTHESIOLOGY	193,983	1,696,426	1,108,333	3,747,825		11.00
12.00	54.00	RADIOLOGY-DIAGNOSTIC	104,992	890,834	627,220	8,313,515		12.00
13.00	60.00	LABORATORY	84,429	1,030,502	190,237	4,016,298		13.00
14.00	65.00	RESPIRATORY THERAPY	70,117	786,382	227,427	1,913,493		14.00
15.00	67.00	OCCUPATIONAL THERAPY	0	0	0	0		15.00
16.00	69.00	ELECTROCARDIOLOGY	42,819	330,071	289,041	2,346,780		16.00
17.00	90.00	CLINIC	238,031	2,465,469	976,164	19,288,831		17.00
18.00	91.00	EMERGENCY	356,778	3,100,737	2,057,833	3,493,245		18.00
200.00			3,875,224	36,037,438	19,993,540	98,984,509		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet B
Part I
Date/Time Prepared:
5/13/2015 3:48 pm

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	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	58,395,813	58,395,813			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	18,488,317		18,488,317		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	120,225,472	477,124	40,754	120,743,350	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	173,975,757	8,808,869	2,067,169	12,511,783	5.00
7.00 00700	OPERATION OF PLANT	30,068,955	20,833,193	1,492,241	4,669,488	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	2,227,785	438,824	414	69,081	8.00
9.00 00900	HOUSEKEEPING	9,794,983	447,485	7,330	2,339,865	9.00
10.00 01000	DIETARY	7,659,194	25,208	58,450	866,380	10.00
11.00 01100	CAFETERIA	665,538	1,053,227	120	190,552	11.00
13.00 01300	NURSING ADMINISTRATION	3,079,850	274,184	276,652	872,084	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,251,817	1,481,988	527,402	376,537	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	3,933,601	733,359	3,387	1,030,204	16.00
17.00 01700	SOCIAL SERVICE	566,737	90,568	406	162,264	17.00
18.00 01851	WAI VER OVERHEAD COSTS	0	0	0	0	18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	24,129,571	26,009	5,029	5,670,112	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	15,684,273	0	0	4,974,278	22.00
23.00 02300	ALLIED HEALTH	249,569	3,129	0	63,236	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	36,391,403	6,745,171	5,562,820	18,294,977	30.00
31.00 03100	INTENSIVE CARE UNIT	7,880,425	702,193	3,259	2,338,833	31.00
33.00 03300	BURN INTENSIVE CARE UNIT	1,813,225	149,896	0	821,456	33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	3,486,302	236,184	0	1,014,121	34.00
34.01 02080	PEDIATRIC INTENSIVE CARE UNIT	1,762,445	166,393	3,085	748,893	34.01
34.02 02180	TRAUMA INTENSIVE CARE UNIT	4,086,546	567,843	416,022	1,583,493	34.02
34.03 02400	NEURO INTENSIVE CARE	2,365,532	118,655	0	974,741	34.03
34.04 02060	NEONATAL INTENSIVE CARE UNIT	6,054,633	302,571	51,779	2,769,060	34.04
43.00 04300	NURSERY	2,288,304	216,458	0	651,867	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	34,278,001	1,732,541	1,777,308	8,895,380	50.00
51.00 05100	RECOVERY ROOM	2,147,000	334,312	2,344	614,693	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	3,453,559	331,233	0	1,011,405	52.00
53.00 05300	ANESTHESIOLOGY	1,211,152	115,526	797,890	600,868	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	19,826,732	2,287,541	833,230	4,597,950	54.00
60.00 06000	LABORATORY	26,648,033	1,925,518	565,487	4,453,412	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	4,323,766	69,040	4,163	307,553	62.00
65.00 06500	RESPIRATORY THERAPY	5,086,953	137,880	560,011	1,846,399	65.00
66.00 06600	PHYSICAL THERAPY	1,460,825	114,425	7,014	376,525	66.00
67.00 06700	OCCUPATIONAL THERAPY	501,862	110,995	0	143,668	67.00
68.00 06800	SPEECH PATHOLOGY	869,185	55,448	19,096	159,067	68.00
69.00 06900	ELECTROCARDIOLOGY	4,481,619	529,918	1,287,582	1,435,416	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	5,169,864	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	42,507,682	287,451	949,763	5,626,941	73.00
74.00 07400	RENAL DIALYSIS	2,950,880	58,226	40,721	904,533	74.00
76.00 03950	WAI VER PURCHASED PATIENT SERVICES	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	61,829,287	3,958,451	762,037	14,520,692	90.00
91.00 09100	EMERGENCY	23,991,538	1,744,656	362,291	8,126,695	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	777,263,985	57,691,692	18,485,256	116,614,502	772,427,955
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.01 19001	DENTISTRY	2,371,226	113,749	3,061	651,747	190.01
190.02 19002	ACHN SATELITTE CLINICS	0	0	0	0	190.02
190.03 19003	SPECIAL FUNDS	776,614	525,938	0	222,355	190.03
190.04 19004	SENGSTACKE CLINIC	0	0	0	0	190.04
194.00 07951	WAI VER ADMINISTRATIVE ONLY COSTS	268,085,090	64,434	0	3,254,746	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)	1,048,496,915	58,395,813	18,488,317	120,743,350	1,048,496,915

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet B Part I Date/Time Prepared: 5/13/2015 3:48 pm		
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
			5.00	7.00	8.00	9.00	10.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	197,363,578				5.00
7.00	00700	OPERATION OF PLANT	13,232,143	70,296,020			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	634,456	1,090,921	4,461,481		8.00
9.00	00900	HOUSEKEEPING	2,919,329	1,112,453	0	16,621,445	9.00
10.00	01000	DIETARY	1,996,335	62,667	0	15,297	10,683,531
11.00	01100	CAFETERIA	442,766	2,618,335	0	639,137	0
13.00	01300	NURSING ADMINISTRATION	1,044,116	681,623	0	166,385	0
14.00	01400	CENTRAL SERVICES & SUPPLY	843,531	3,684,239	0	899,324	0
16.00	01600	MEDICAL RECORDS & LIBRARY	1,321,861	1,823,139	0	445,029	0
17.00	01700	SOCIAL SERVICE	190,138	225,154	0	54,960	0
18.00	01851	WAI VER OVERHEAD COSTS	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	6,917,237	64,659	0	15,783	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	4,790,367	0	0	0	0
23.00	02300	ALLIED HEALTH	73,260	7,779	0	1,899	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	15,534,856	16,768,575	1,178,436	4,093,214	7,164,105
31.00	03100	INTENSIVE CARE UNIT	2,533,255	1,745,660	180,157	426,117	505,485
33.00	03300	BURN INTENSIVE CARE UNIT	645,696	372,643	136,590	90,962	103,179
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,098,339	587,156	184,533	143,325	133,382
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	621,636	413,654	44,424	100,973	73,211
34.02	02180	TRAUMA INTENSIVE CARE UNIT	1,542,927	1,411,663	204,087	344,588	109,463
34.03	02400	NEURO INTENSIVE CARE	802,067	294,978	17,026	72,004	193,789
34.04	02060	NEONATAL INTENSIVE CARE UNIT	2,128,232	752,194	162,040	183,611	0
43.00	04300	NURSERY	731,969	538,117	56,892	131,355	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,825,047	4,307,116	620,811	1,051,369	0
51.00	05100	RECOVERY ROOM	718,454	831,104	197,626	202,873	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,112,157	823,449	244,065	201,004	0
53.00	05300	ANESTHESIOLOGY	631,982	287,199	31,529	70,105	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,387,322	5,686,854	455,899	1,388,164	0
60.00	06000	LABORATORY	7,789,518	4,786,860	0	1,168,475	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,090,899	171,635	0	41,896	0
65.00	06500	RESPIRATORY THERAPY	1,769,556	342,772	0	83,671	0
66.00	06600	PHYSICAL THERAPY	454,210	284,461	35,868	69,437	0
67.00	06700	OCCUPATIONAL THERAPY	175,425	275,935	0	67,356	0
68.00	06800	SPEECH PATHOLOGY	255,720	137,843	0	33,648	0
69.00	06900	ELECTROCARDIOLOGY	1,793,507	1,317,382	49,432	321,574	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,198,804	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	11,448,490	714,606	0	174,436	0
74.00	07400	RENAL DIALYSIS	916,949	144,751	0	35,334	0
76.00	03950	WAI VER PURCHASED PATIENT SERVICES	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	18,798,863	9,840,756	29,437	2,402,133	1,325,730
91.00	09100	EMERGENCY	7,936,237	4,337,236	632,629	1,058,721	1,075,187
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	133,347,656	68,545,568	4,461,481	16,194,159	10,683,531
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
190.01	19001	DENTISTRY	728,062	282,781	0	69,027	0
190.02	19002	ACHN SATELITTE CLINICS	0	0	0	0	0
190.03	19003	SPECIAL FUNDS	353,600	1,307,487	0	319,158	0
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0
194.00	07951	WAI VER ADMINSTRATIVE ONLY COSTS	62,934,260	160,184	0	39,101	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	197,363,578	70,296,020	4,461,481	16,621,445	10,683,531

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet B
Part I
Date/Time Prepared:
5/13/2015 3:48 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11.00	13.00	14.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	5,609,675					11.00
13.00	01300	60,577	6,455,471				13.00
14.00	01400	52,661	91,285	9,208,784			14.00
16.00	01600	122,260	0	0	9,412,840		16.00
17.00	01700	5,845	0	0	0	1,296,072	17.00
18.00	01851	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	718,529	0	0	0	0	21.00
22.00	02200	155,448	0	0	0	0	22.00
23.00	02300	6,210	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,001,513	1,389,207	12,882	1,434,506	392,191	30.00
31.00	03100	142,101	237,172	0	158,999	31,986	31.00
33.00	03300	36,365	51,986	222	29,894	15,924	33.00
34.00	03400	62,827	107,772	0	59,639	24,001	34.00
34.01	02080	42,184	63,331	0	20,852	15,924	34.01
34.02	02180	85,328	124,816	292	90,131	24,001	34.02
34.03	02400	54,824	89,782	6,546	57,960	24,001	34.03
34.04	02060	141,823	201,378	6,408	225,892	24,001	34.04
43.00	04300	48,848	84,431	0	13,325	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	451,855	661,624	3,527,746	1,440,964	0	50.00
51.00	05100	41,417	71,700	0	103,629	0	51.00
52.00	05200	64,118	110,826	0	28,395	0	52.00
53.00	05300	43,703	72,817	20,255	450,775	0	53.00
54.00	05400	255,144	0	320,862	1,227,059	0	54.00
60.00	06000	353,002	0	1,721	1,123,986	0	60.00
62.00	06200	26,360	0	0	76,537	0	62.00
65.00	06500	124,511	186,831	65,872	6,646	0	65.00
66.00	06600	27,497	0	53,835	19,816	0	66.00
67.00	06700	11,051	0	0	12,393	0	67.00
68.00	06800	12,252	0	1,084	9,522	0	68.00
69.00	06900	94,938	142,472	491,732	214,328	0	69.00
71.00	07100	0	0	4,511,185	117,827	0	71.00
72.00	07200	0	0	0	124,861	0	72.00
73.00	07300	395,516	0	18,639	832,086	0	73.00
74.00	07400	46,002	57,676	1,281	42,644	48,003	74.00
76.00	03950	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	79,193	1,434,258	130,885	892,611	456,027	90.00
91.00	09100	494,606	757,313	2,795	597,563	240,013	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		5,258,508	5,936,677	9,174,242	9,412,840	1,296,072	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	32,170	0	34,542	0	0	190.01
190.02	19002	0	0	0	0	0	190.02
190.03	19003	7,262	0	0	0	0	190.03
190.04	19004	0	0	0	0	0	190.04
194.00	07951	311,735	518,794	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		5,609,675	6,455,471	9,208,784	9,412,840	1,296,072	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet B
Part I
Date/Time Prepared:
5/13/2015 3:48 pm

Cost Center Description	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		ALLIED HEALTH	
	WAI VER OVERHEAD COSTS		SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
	18.00		19.00	21.00		
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
18.00 01851	WAI VER OVERHEAD COSTS	0				18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0			19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	37,546,929		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	25,604,366	22.00
23.00 02300	ALLIED HEALTH	0	0	0	0	405,082 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	0	9,027,060	6,155,819	0 30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	1,407,868	960,067	0 31.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	256,271	174,759	0 33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	446,041	304,169	0 34.00
34.01 02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	159,764	108,948	0 34.01
34.02 02180	TRAUMA INTENSIVE CARE UNIT	0	0	0	0	0 34.02
34.03 02400	NEURO INTENSIVE CARE	0	0	115,160	78,531	0 34.03
34.04 02060	NEONATAL INTENSIVE CARE UNIT	0	0	705,556	481,140	0 34.04
43.00 04300	NURSERY	0	0	217,344	148,213	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	6,199,971	4,227,945	0 50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	514,975	351,177	0 52.00
53.00 05300	ANESTHESIOLOGY	0	0	2,605,691	1,776,898	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	1,664,950	1,135,379	0 54.00
60.00 06000	LABORATORY	0	0	539,304	367,768	0 60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0 62.00
65.00 06500	RESPIRATORY THERAPY	0	0	836,124	570,178	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	1,061,578	723,921	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	87,586	59,728	405,082 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
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	4,508,259	3,074,316	0 90.00
91.00 09100	EMERGENCY	0	0	6,434,346	4,387,771	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	36,787,848	25,086,727	405,082 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
190.01 19001	DENTISTRY	0	0	655,275	446,851	0 190.01
190.02 19002	ACHN SATELLITE CLINICS	0	0	0	0	0 190.02
190.03 19003	SPECIAL FUNDS	0	0	103,806	70,788	0 190.03
190.04 19004	SENGSTACKE CLINIC	0	0	0	0	0 190.04
194.00 07951	WAI VER ADMINISTRATIVE ONLY COSTS	0	0	0	0	0 194.00
200.00	Cross Foot Adjustments	0	0	0	0	0 200.00
201.00	Negative Cost Centers	0	0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	0	0	37,546,929	25,604,366	405,082 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet B
Part I
Date/Time Prepared:
5/13/2015 3:48 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
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				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	131,146,735	-15,182,879	115,963,856	30.00
31.00	03100	INTENSIVE CARE UNIT	19,253,577	-2,367,935	16,885,642	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	4,699,068	-431,030	4,268,038	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,887,791	-750,210	7,137,581	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	4,345,717	-268,712	4,077,005	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	10,591,200	0	10,591,200	34.02
34.03	02400	NEURO INTENSIVE CARE	5,265,596	-193,691	5,071,905	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	14,190,318	-1,186,696	13,003,622	34.04
43.00	04300	NURSERY	5,127,123	-365,557	4,761,566	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	79,997,678	-10,427,916	69,569,762	50.00
51.00	05100	RECOVERY ROOM	5,265,152	0	5,265,152	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,246,363	-866,152	7,380,211	52.00
53.00	05300	ANESTHESIOLOGY	8,716,390	-4,382,589	4,333,801	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	46,067,086	-2,800,329	43,266,757	54.00
60.00	06000	LABORATORY	49,723,084	-907,072	48,816,012	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	6,111,849	0	6,111,849	62.00
65.00	06500	RESPIRATORY THERAPY	11,617,404	-1,406,302	10,211,102	65.00
66.00	06600	PHYSICAL THERAPY	2,903,913	0	2,903,913	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,298,685	0	1,298,685	67.00
68.00	06800	SPEECH PATHOLOGY	1,552,865	0	1,552,865	68.00
69.00	06900	ELECTROCARDIOLOGY	13,945,399	-1,785,499	12,159,900	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,629,012	0	4,629,012	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,493,529	0	6,493,529	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	63,508,006	-147,314	63,360,692	73.00
74.00	07400	RENAL DIALYSIS	5,247,000	0	5,247,000	74.00
76.00	03950	WAI VER PURCHASED PATIENT SERVICES	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	124,042,935	-7,582,575	116,460,360	90.00
91.00	09100	EMERGENCY	62,179,597	-10,822,117	51,357,480	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	704,053,072	-61,874,575	642,178,497	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
190.01	19001	DENTISTRY	5,388,491	-1,102,126	4,286,365	190.01
190.02	19002	ACHN SATELLITE CLINICS	0	0	0	190.02
190.03	19003	SPECIAL FUNDS	3,687,008	-174,594	3,512,414	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	190.04
194.00	07951	WAI VER ADMINISTRATIVE ONLY COSTS	335,368,344	0	335,368,344	194.00
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,048,496,915	-63,151,295	985,345,620	202.00

COST ALLOCATION STATISTICS

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet Non-CMS W
Date/Time Prepared:
5/13/2015 3:48 pm

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
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	WAI VER OVERHEAD COSTS	25	ASSI GNE D TIME	18.00
19.00	NONPHYSICIAN ANESTHETISTS	14	ASSI GNE D TIME	19.00
21.00	I&R SERVICES-SALARY & FRINGES APPRV	15	ASSI GNE D TIME	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	15	ASSI GNE D TIME	22.00
23.00	ALLIED HEALTH	23	ASSI GNE D TIME	23.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet B Part II Date/Time Prepared: 5/13/2015 3:48 pm
-------------------------------------	--	----------------------	---	--

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	477,124	40,754	517,878	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	10,968,838	8,808,869	2,067,169	21,844,876	5.00
7.00 00700	OPERATION OF PLANT	0	20,833,193	1,492,241	22,325,434	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	438,824	414	439,238	8.00
9.00 00900	HOUSEKEEPING	0	447,485	7,330	454,815	9.00
10.00 01000	DIETARY	0	25,208	58,450	83,658	10.00
11.00 01100	CAFETERIA	0	1,053,227	120	1,053,347	11.00
13.00 01300	NURSING ADMINISTRATION	8,556	274,184	276,652	559,392	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	1,481,988	527,402	2,009,390	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	733,359	3,387	736,746	16.00
17.00 01700	SOCIAL SERVICE	0	90,568	406	90,974	17.00
18.00 01851	WAIVER OVERHEAD COSTS	0	0	0	0	18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	26,009	5,029	31,038	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00 02300	ALLIED HEALTH	0	3,129	0	3,129	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	27,374	6,745,171	5,562,820	12,335,365	30.00
31.00 03100	INTENSIVE CARE UNIT	0	702,193	3,259	705,452	31.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	149,896	0	149,896	33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	236,184	0	236,184	34.00
34.01 02080	PEDIATRIC INTENSIVE CARE UNIT	0	166,393	3,085	169,478	34.01
34.02 02180	TRAUMA INTENSIVE CARE UNIT	0	567,843	416,022	983,865	34.02
34.03 02400	NEURO INTENSIVE CARE	0	118,655	0	118,655	34.03
34.04 02060	NEONATAL INTENSIVE CARE UNIT	0	302,571	51,779	354,350	34.04
43.00 04300	NURSERY	0	216,458	0	216,458	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	1,732,541	1,777,308	3,509,849	50.00
51.00 05100	RECOVERY ROOM	0	334,312	2,344	336,656	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	331,233	0	331,233	52.00
53.00 05300	ANESTHESIOLOGY	0	115,526	797,890	913,416	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	2,287,541	833,230	3,120,771	54.00
60.00 06000	LABORATORY	0	1,925,518	565,487	2,491,005	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	69,040	4,163	73,203	62.00
65.00 06500	RESPIRATORY THERAPY	375,833	137,880	560,011	1,073,724	65.00
66.00 06600	PHYSICAL THERAPY	0	114,425	7,014	121,439	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	110,995	0	110,995	67.00
68.00 06800	SPEECH PATHOLOGY	0	55,448	19,096	74,544	68.00
69.00 06900	ELECTROCARDIOLOGY	0	529,918	1,287,582	1,817,500	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	287,451	949,763	1,237,214	73.00
74.00 07400	RENAL DIALYSIS	0	58,226	40,721	98,947	74.00
76.00 03950	WAIVER PURCHASED PATIENT SERVICES	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	909,140	3,958,451	762,037	5,629,628	90.00
91.00 09100	EMERGENCY	0	1,744,656	362,291	2,106,947	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	12,289,741	57,691,692	18,485,256	88,466,689	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.01 19001	DENTISTRY	0	113,749	3,061	116,810	190.01
190.02 19002	ACHN SATELITE CLINICS	0	0	0	0	190.02
190.03 19003	SPECIAL FUNDS	0	525,938	0	525,938	190.03
190.04 19004	SENGSTACKE CLINIC	0	0	0	0	190.04
194.00 07951	WAIVER ADMINISTRATIVE ONLY COSTS	210,016	64,434	0	274,450	194.00
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers				0	201.00
202.00	TOTAL (sum lines 118-201)	12,499,757	58,395,813	18,488,317	89,383,887	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet B Part II Date/Time Prepared: 5/13/2015 3:48 pm		
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
		5.00	7.00	8.00	9.00	10.00
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	21,898,539			5.00
7.00	00700	OPERATION OF PLANT	1,468,196	23,813,657		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	70,397	369,563	879,494	8.00
9.00	00900	HOUSEKEEPING	323,919	376,857	0	1,165,627
10.00	01000	DIETARY	221,507	21,229	0	1,073
11.00	01100	CAFETERIA	49,128	886,994	0	44,821
13.00	01300	NURSING ADMINISTRATION	115,852	230,908	0	11,668
14.00	01400	CENTRAL SERVICES & SUPPLY	93,596	1,248,082	0	63,068
16.00	01600	MEDICAL RECORDS & LIBRARY	146,669	617,611	0	31,209
17.00	01700	SOCIAL SERVICE	21,097	76,274	0	3,854
18.00	01851	WAI VER OVERHEAD COSTS	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	767,515	21,904	0	1,107
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	531,524	0	0	0
23.00	02300	ALLIED HEALTH	8,129	2,635	0	133
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,723,698	5,680,565	232,307	287,048
31.00	03100	INTENSIVE CARE UNIT	281,082	591,364	35,514	29,883
33.00	03300	BURN INTENSIVE CARE UNIT	71,644	126,238	26,926	6,379
34.00	03400	SURGICAL INTENSIVE CARE UNIT	121,868	198,906	36,377	10,051
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	68,975	140,130	8,757	7,081
34.02	02180	TRAUMA INTENSIVE CARE UNIT	171,198	478,219	40,232	24,165
34.03	02400	NEURO INTENSIVE CARE	88,995	99,928	3,356	5,050
34.04	02060	NEONATAL INTENSIVE CARE UNIT	236,142	254,815	31,943	12,876
43.00	04300	NURSERY	81,217	182,294	11,215	9,212
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,201,113	1,459,089	122,381	73,730
51.00	05100	RECOVERY ROOM	79,717	281,547	38,958	14,227
52.00	05200	DELIVERY ROOM & LABOR ROOM	123,401	278,954	48,113	14,096
53.00	05300	ANESTHESIOLOGY	70,123	97,292	6,215	4,916
54.00	05400	RADIOLOGY-DIAGNOSTIC	708,717	1,926,493	89,871	97,349
60.00	06000	LABORATORY	864,300	1,621,609	0	81,943
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	121,043	58,143	0	2,938
65.00	06500	RESPIRATORY THERAPY	196,344	116,118	0	5,868
66.00	06600	PHYSICAL THERAPY	50,398	96,365	7,071	4,869
67.00	06700	OCCUPATIONAL THERAPY	19,465	93,477	0	4,724
68.00	06800	SPEECH PATHOLOGY	28,374	46,696	0	2,360
69.00	06900	ELECTROCARDIOLOGY	199,002	446,280	9,745	22,551
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	133,015	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,270,288	242,082	0	12,233
74.00	07400	RENAL DIALYSIS	101,742	49,036	0	2,478
76.00	03950	WAI VER PURCHASED PATIENT SERVICES	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,085,862	3,333,679	5,803	168,456
91.00	09100	EMERGENCY	880,580	1,469,293	124,710	74,246
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,795,832	23,220,669	879,494	1,135,662
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0
190.01	19001	DENTISTRY	80,783	95,796	0	4,841
190.02	19002	ACHN SATELLITE CLINICS	0	0	0	0
190.03	19003	SPECIAL FUNDS	39,234	442,928	0	22,382
190.04	19004	SENGSTACKE CLINIC	0	0	0	0
194.00	07951	WAI VER ADMINSTRATIVE ONLY COSTS	6,982,690	54,264	0	2,742
200.00		Cross Foot Adjustments				
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	21,898,539	23,813,657	879,494	1,165,627

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140124		Period: From 12/01/2013 To 11/30/2014		Worksheet B Part II Date/Time Prepared: 5/13/2015 3:48 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11.00	13.00	14.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	2,035,107					11.00
13.00	01300	21,976	943,536				13.00
14.00	01400	19,105	13,342	3,448,198			14.00
16.00	01600	44,354	0	0	1,581,008		16.00
17.00	01700	2,120	0	0	0	195,015	17.00
18.00	01851	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	260,671	0	0	0	0	21.00
22.00	02200	56,394	0	0	0	0	22.00
23.00	02300	2,253	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	363,335	203,047	4,824	240,864	59,011	30.00
31.00	03100	51,552	34,665	0	26,697	4,813	31.00
33.00	03300	13,193	7,598	83	5,019	2,396	33.00
34.00	03400	22,793	15,752	0	10,014	3,611	34.00
34.01	02080	15,304	9,256	0	3,501	2,396	34.01
34.02	02180	30,956	18,243	109	15,134	3,611	34.02
34.03	02400	19,889	13,123	2,451	9,732	3,611	34.03
34.04	02060	51,451	29,433	2,399	37,929	3,611	34.04
43.00	04300	17,721	12,341	0	2,237	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	163,926	96,703	1,320,953	242,470	0	50.00
51.00	05100	15,025	10,480	0	17,400	0	51.00
52.00	05200	23,261	16,198	0	4,768	0	52.00
53.00	05300	15,855	10,643	7,584	75,689	0	53.00
54.00	05400	92,562	0	120,146	206,033	0	54.00
60.00	06000	128,064	0	644	188,726	0	60.00
62.00	06200	9,563	0	0	12,851	0	62.00
65.00	06500	45,171	27,307	24,665	1,116	0	65.00
66.00	06600	9,976	0	20,158	3,327	0	66.00
67.00	06700	4,009	0	0	2,081	0	67.00
68.00	06800	4,445	0	406	1,599	0	68.00
69.00	06900	34,442	20,824	184,127	35,987	0	69.00
71.00	07100	0	0	1,689,201	19,784	0	71.00
72.00	07200	0	0	0	20,965	0	72.00
73.00	07300	143,487	0	6,979	139,714	0	73.00
74.00	07400	16,689	8,430	479	7,160	7,223	74.00
76.00	03950	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	28,730	209,635	49,009	149,876	68,618	90.00
91.00	09100	179,436	110,689	1,047	100,335	36,114	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		1,907,708	867,709	3,435,264	1,581,008	195,015	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	11,671	0	12,934	0	0	190.01
190.02	19002	0	0	0	0	0	190.02
190.03	19003	2,635	0	0	0	0	190.03
190.04	19004	0	0	0	0	0	190.04
194.00	07951	113,093	75,827	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		2,035,107	943,536	3,448,198	1,581,008	195,015	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet B
Part II
Date/Time Prepared:
5/13/2015 3:48 pm

Cost Center Description	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		ALLIED HEALTH	
	WAIVER OVERHEAD COSTS		SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
	18.00		19.00	21.00		
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
18.00 01851	WAIVER OVERHEAD COSTS	0				18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0			19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0		1,106,554		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0			609,253	22.00
23.00 02300	ALLIED HEALTH	0				16,550
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0				30.00
31.00 03100	INTENSIVE CARE UNIT	0				31.00
33.00 03300	BURN INTENSIVE CARE UNIT	0				33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0				34.00
34.01 02080	PEDIATRIC INTENSIVE CARE UNIT	0				34.01
34.02 02180	TRAUMA INTENSIVE CARE UNIT	0				34.02
34.03 02400	NEURO INTENSIVE CARE	0				34.03
34.04 02060	NEONATAL INTENSIVE CARE UNIT	0				34.04
43.00 04300	NURSERY	0				43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0				50.00
51.00 05100	RECOVERY ROOM	0				51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0				52.00
53.00 05300	ANESTHESIOLOGY	0				53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0				54.00
60.00 06000	LABORATORY	0				60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0				62.00
65.00 06500	RESPIRATORY THERAPY	0				65.00
66.00 06600	PHYSICAL THERAPY	0				66.00
67.00 06700	OCCUPATIONAL THERAPY	0				67.00
68.00 06800	SPEECH PATHOLOGY	0				68.00
69.00 06900	ELECTROCARDIOLOGY	0				69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0				71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0				72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0				73.00
74.00 07400	RENAL DIALYSIS	0				74.00
76.00 03950	WAIVER PURCHASED PATIENT SERVICES	0				76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0				90.00
91.00 09100	EMERGENCY	0				91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0				190.00
190.01 19001	DENTISTRY	0				190.01
190.02 19002	ACHN SATELLITE CLINICS	0				190.02
190.03 19003	SPECIAL FUNDS	0				190.03
190.04 19004	SENGSTACKE CLINIC	0				190.04
194.00 07951	WAIVER ADMINISTRATIVE ONLY COSTS	0				194.00
200.00	Cross Foot Adjustments		0	1,106,554	609,253	16,550
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118-201)	0	0	1,106,554	609,253	16,550

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet B
Part II
Date/Time Prepared:
5/13/2015 3:48 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
16.00	01600				16.00
17.00	01700				17.00
18.00	01851				18.00
19.00	01900				19.00
21.00	02100				21.00
22.00	02200				22.00
23.00	02300				23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	21,430,624	0	21,430,624	30.00
31.00	03100	1,786,723	0	1,786,723	31.00
33.00	03300	416,093	0	416,093	33.00
34.00	03400	664,041	0	664,041	34.00
34.01	02080	430,359	0	430,359	34.01
34.02	02180	1,775,917	0	1,775,917	34.02
34.03	02400	374,978	0	374,978	34.03
34.04	02060	1,026,826	0	1,026,826	34.04
43.00	04300	535,491	0	535,491	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	8,228,366	0	8,228,366	50.00
51.00	05100	796,646	0	796,646	51.00
52.00	05200	844,362	0	844,362	52.00
53.00	05300	1,204,310	0	1,204,310	53.00
54.00	05400	6,381,663	0	6,381,663	54.00
60.00	06000	5,395,392	0	5,395,392	60.00
62.00	06200	279,060	0	279,060	62.00
65.00	06500	1,498,232	0	1,498,232	65.00
66.00	06600	315,218	0	315,218	66.00
67.00	06700	235,367	0	235,367	67.00
68.00	06800	159,106	0	159,106	68.00
69.00	06900	2,776,615	0	2,776,615	69.00
71.00	07100	1,708,985	0	1,708,985	71.00
72.00	07200	153,980	0	153,980	72.00
73.00	07300	3,076,131	0	3,076,131	73.00
74.00	07400	296,064	0	296,064	74.00
76.00	03950	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	11,832,672	0	11,832,672	90.00
91.00	09100	5,151,582	0	5,151,582	91.00
92.00	09200		0		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		78,774,803	0	78,774,803	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	0	0	0	190.00
190.01	19001	325,630	0	325,630	190.01
190.02	19002	0	0	0	190.02
190.03	19003	1,034,071	0	1,034,071	190.03
190.04	19004	0	0	0	190.04
194.00	07951	7,517,026	0	7,517,026	194.00
200.00		1,732,357	0	1,732,357	200.00
201.00		0	0	0	201.00
202.00		89,383,887	0	89,383,887	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet B-1
Date/Time Prepared:
5/13/2015 3:48 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,332,778				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		6,789,927			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	19,060	14,967	421,717,859		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	351,894	759,178	43,699,667	-197,363,578	5.00
7.00 00700	OPERATION OF PLANT	832,238	548,033	16,309,031	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	17,530	152	241,277	0	8.00
9.00 00900	HOUSEKEEPING	17,876	2,692	8,172,401	0	9.00
10.00 01000	DIETARY	1,007	21,466	3,025,989	0	10.00
11.00 01100	CAFETERIA	42,074	44	665,538	0	11.00
13.00 01300	NURSING ADMINISTRATION	10,953	101,602	3,045,913	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	59,202	193,691	1,315,125	0	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	29,296	1,244	3,598,175	0	16.00
17.00 01700	SOCIAL SERVICE	3,618	149	566,737	0	17.00
18.00 01851	WAI VER OVERHEAD COSTS	0	0	0	0	18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	1,039	1,847	19,803,893	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	17,373,567	0	22.00
23.00 02300	ALLIED HEALTH	125	0	220,863	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	269,454	2,042,974	63,898,354	0	30.00
31.00 03100	INTENSIVE CARE UNIT	28,051	1,197	8,168,797	0	31.00
33.00 03300	BURN INTENSIVE CARE UNIT	5,988	0	2,869,085	0	33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	9,435	0	3,542,001	0	34.00
34.01 02080	PEDIATRIC INTENSIVE CARE UNIT	6,647	1,133	2,615,646	0	34.01
34.02 02180	TRAUMA INTENSIVE CARE UNIT	22,684	152,786	5,530,636	0	34.02
34.03 02400	NEURO INTENSIVE CARE	4,740	0	3,404,461	0	34.03
34.04 02060	NEONATAL INTENSIVE CARE UNIT	12,087	19,016	9,671,443	0	34.04
43.00 04300	NURSERY	8,647	0	2,276,763	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	69,211	652,725	31,068,727	0	50.00
51.00 05100	RECOVERY ROOM	13,355	861	2,146,925	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	13,232	0	3,532,516	0	52.00
53.00 05300	ANESTHESIOLOGY	4,615	293,029	2,098,640	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	91,382	306,008	16,059,174	0	54.00
60.00 06000	LABORATORY	76,920	207,678	15,554,347	0	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,758	1,529	1,074,186	0	62.00
65.00 06500	RESPIRATORY THERAPY	5,508	205,667	6,448,884	0	65.00
66.00 06600	PHYSICAL THERAPY	4,571	2,576	1,315,081	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	4,434	0	501,787	0	67.00
68.00 06800	SPEECH PATHOLOGY	2,215	7,013	555,572	0	68.00
69.00 06900	ELECTROCARDIOLOGY	21,169	472,871	5,013,452	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	11,483	348,805	19,653,110	0	73.00
74.00 07400	RENAL DIALYSIS	2,326	14,955	3,159,246	0	74.00
76.00 03950	WAI VER PURCHASED PATIENT SERVICES	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	158,131	279,862	50,716,147	0	90.00
91.00 09100	EMERGENCY	69,695	133,053	28,383,954	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,304,650	6,788,803	407,297,110	-197,363,578	575,064,377
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.01 19001	DENTISTRY	4,544	1,124	2,276,344	0	190.01
190.02 19002	ACHN SATELITTE CLINICS	0	0	0	0	190.02
190.03 19003	SPECIAL FUNDS	21,010	0	776,614	0	190.03
190.04 19004	SENGSTACKE CLINIC	0	0	0	0	190.04
194.00 07951	WAI VER ADMINISTRATIVE ONLY COSTS	2,574	0	11,367,791	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)	58,395,813	18,488,317	120,743,350		197,363,578
203.00	Unit cost multiplier (Wkst. B, Part I)	25.032735	2.722904	0.286313		0.231883
204.00	Cost to be allocated (per Wkst. B, Part II)			517,878		21,898,539

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet B-1
Date/Time Prepared:
5/13/2015 3:48 pm

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				
205.00 Unit cost multiplier (Wkst. B, Part II)			4.00 0.001228	5A	5.00 0.025729	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet B-1

Date/Time Prepared:
5/13/2015 3:48 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)		
		7.00	8.00	9.00	10.00	11.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT	1,129,586				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	17,530	2,232,635			8.00	
9.00	00900	HOUSEKEEPING	17,876	0	1,094,180		9.00	
10.00	01000	DIETARY	1,007	0	1,007	272,010	10.00	
11.00	01100	CAFETERIA	42,074	0	42,074	0	7,025,597	11.00
13.00	01300	NURSING ADMINISTRATION	10,953	0	10,953	0	75,867	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	59,202	0	59,202	0	65,953	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	29,296	0	29,296	0	153,119	16.00
17.00	01700	SOCIAL SERVICE	3,618	0	3,618	0	7,320	17.00
18.00	01851	WAI VER OVERHEAD COSTS	0	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,039	0	1,039	0	899,891	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	194,684	22.00
23.00	02300	ALLIED HEALTH	125	0	125	0	7,778	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	269,454	589,719	269,454	182,403	1,254,300	30.00
31.00	03100	INTENSIVE CARE UNIT	28,051	90,155	28,051	12,870	177,969	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	5,988	68,353	5,988	2,627	45,544	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	9,435	92,345	9,435	3,396	78,685	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	6,647	22,231	6,647	1,864	52,832	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	22,684	102,130	22,684	2,787	106,865	34.02
34.03	02400	NEURO INTENSIVE CARE	4,740	8,520	4,740	4,934	68,662	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	12,087	81,089	12,087	0	177,620	34.04
43.00	04300	NURSERY	8,647	28,470	8,647	0	61,177	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	69,211	310,669	69,211	0	565,907	50.00
51.00	05100	RECOVERY ROOM	13,355	98,897	13,355	0	51,871	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,232	122,136	13,232	0	80,302	52.00
53.00	05300	ANESTHESIOLOGY	4,615	15,778	4,615	0	54,734	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	91,382	228,143	91,382	0	319,544	54.00
60.00	06000	LABORATORY	76,920	0	76,920	0	442,103	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,758	0	2,758	0	33,014	62.00
65.00	06500	RESPIRATORY THERAPY	5,508	0	5,508	0	155,938	65.00
66.00	06600	PHYSICAL THERAPY	4,571	17,949	4,571	0	34,438	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,434	0	4,434	0	13,840	67.00
68.00	06800	SPEECH PATHOLOGY	2,215	0	2,215	0	15,344	68.00
69.00	06900	ELECTROCARDIOLOGY	21,169	24,737	21,169	0	118,901	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	11,483	0	11,483	0	495,347	73.00
74.00	07400	RENAL DIALYSIS	2,326	0	2,326	0	57,613	74.00
76.00	03950	WAI VER PURCHASED PATIENT SERVICES	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	158,131	14,731	158,131	33,754	99,182	90.00
91.00	09100	EMERGENCY	69,695	316,583	69,695	27,375	619,449	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,101,458	2,232,635	1,066,052	272,010	6,585,793	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	DENTISTRY	4,544	0	4,544	0	40,290	190.01
190.02	19002	ACHN SATELITTE CLINICS	0	0	0	0	0	190.02
190.03	19003	SPECIAL FUNDS	21,010	0	21,010	0	9,095	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07951	WAI VER ADMINISTRATIVE ONLY COSTS	2,574	0	2,574	0	390,419	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)	70,296,020	4,461,481	16,621,445	10,683,531	5,609,675	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	62.231667	1.998303	15.190778	39.276244	0.798462	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	23,813,657	879,494	1,165,627	331,183	2,035,107	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	21.081757	0.393926	1.065297	1.217540	0.289670	205.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 140124		Period: From 12/01/2013 To 11/30/2014		Worksheet B-1	
						Date/Time Prepared: 5/13/2015 3:48 pm	
Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE	WAI VER OVERHEAD COSTS	
	(DIRECT NRSNG HRS)				(ASSIGNED TIME)		
	13.00	14.00	16.00	17.00	18.00		
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500	ADMINISTRATIVE & GENERAL						5.00
7.00 00700	OPERATION OF PLANT						7.00
8.00 00800	LAUNDRY & LINEN SERVICE						8.00
9.00 00900	HOUSEKEEPING						9.00
10.00 01000	DIETARY						10.00
11.00 01100	CAFETERIA						11.00
13.00 01300	NURSING ADMINISTRATION	4,677,499					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	66,143	24,882,577				14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	1,168,152,685			16.00
17.00 01700	SOCIAL SERVICE	0	0	0	56,160		17.00
18.00 01851	WAI VER OVERHEAD COSTS	0	0	0	0	0	18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00 02300	ALLIED HEALTH	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	1,006,590	34,807	178,022,533	16,994	0	30.00
31.00 03100	INTENSIVE CARE UNIT	171,850	0	19,731,859	1,386	0	31.00
33.00 03300	BURN INTENSIVE CARE UNIT	37,668	601	3,709,861	690	0	33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	78,089	0	7,401,256	1,040	0	34.00
34.01 02080	PEDIATRIC INTENSIVE CARE UNIT	45,888	0	2,587,690	690	0	34.01
34.02 02180	TRAUMA INTENSIVE CARE UNIT	90,439	790	11,185,276	1,040	0	34.02
34.03 02400	NEURO INTENSIVE CARE	65,054	17,688	7,192,852	1,040	0	34.03
34.04 02060	NEONATAL INTENSIVE CARE UNIT	145,914	17,314	28,033,307	1,040	0	34.04
43.00 04300	NURSERY	61,177	0	1,653,662	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	479,399	9,532,130	178,840,763	0	0	50.00
51.00 05100	RECOVERY ROOM	51,952	0	12,860,429	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	80,302	0	3,523,774	0	0	52.00
53.00 05300	ANESTHESIOLOGY	52,762	54,729	55,941,272	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	866,984	152,278,395	0	0	54.00
60.00 06000	LABORATORY	0	4,650	139,486,928	0	0	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	9,498,219	0	0	62.00
65.00 06500	RESPIRATORY THERAPY	135,374	177,988	824,782	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	145,464	2,459,140	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	1,537,938	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	2,928	1,181,702	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	103,232	1,328,681	26,598,176	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	12,189,456	14,622,304	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	15,495,249	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	50,363	103,262,142	0	0	73.00
74.00 07400	RENAL DIALYSIS	41,791	3,460	5,292,072	2,080	0	74.00
76.00 03950	WAI VER PURCHASED PATIENT SERVICES	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	1,039,235	353,657	110,773,325	19,760	0	90.00
91.00 09100	EMERGENCY	548,733	7,552	74,157,779	10,400	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	4,301,592	24,789,242	1,168,152,685	56,160	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01 19001	DENTISTRY	0	93,335	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 ADMINISTRATIVE ONLY COSTS	375,907	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)	6,455,471	9,208,784	9,412,840	1,296,072	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1.380112	0.370090	0.008058	23.078205	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	943,536	3,448,198	1,581,008	195,015	0	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet B-1

Date/Time Prepared:
5/13/2015 3:48 pm

Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE WAIVER OVERHEAD COSTS (ASSIGNED TIME)	
	13.00	14.00	16.00	17.00	18.00	
205.00 Unit cost multiplier (Wkst. B, Part II)	0.201718	0.138579	0.001353	3.472489	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet B-1

Date/Time Prepared:
5/13/2015 3:48 pm

Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	INTERNS & RESIDENTS		ALLIED HEALTH (ASSIGNED TIME)	
		SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
		19.00	21.00		
GENERAL SERVICE COST CENTERS					
1.00 00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500 ADMINISTRATIVE & GENERAL					5.00
7.00 00700 OPERATION OF PLANT					7.00
8.00 00800 LAUNDRY & LINEN SERVICE					8.00
9.00 00900 HOUSEKEEPING					9.00
10.00 01000 DIETARY					10.00
11.00 01100 CAFETERIA					11.00
13.00 01300 NURSING ADMINISTRATION					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY					14.00
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	0				19.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV		46,298			21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV			46,298		22.00
23.00 02300 ALLIED HEALTH				10,000	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS		11,131	11,131	0	30.00
31.00 03100 INTENSIVE CARE UNIT		1,736	1,736	0	31.00
33.00 03300 BURN INTENSIVE CARE UNIT		316	316	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT		550	550	0	34.00
34.01 02080 PEDIATRIC INTENSIVE CARE UNIT		197	197	0	34.01
34.02 02180 TRAUMA INTENSIVE CARE UNIT		0	0	0	34.02
34.03 02400 NEURO INTENSIVE CARE		142	142	0	34.03
34.04 02060 NEONATAL INTENSIVE CARE UNIT		870	870	0	34.04
43.00 04300 NURSERY		268	268	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	7,645	7,645	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	635	635	0	52.00
53.00 05300 ANESTHESIOLOGY	0	3,213	3,213	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	2,053	2,053	0	54.00
60.00 06000 LABORATORY	0	665	665	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
65.00 06500 RESPIRATORY THERAPY	0	1,031	1,031	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	1,309	1,309	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	108	108	10,000	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
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0	5,559	5,559	0	90.00
91.00 09100 EMERGENCY	0	7,934	7,934	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE					113.00
118.00		45,362	45,362	10,000	118.00
NONREIMBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.01 19001 DENTISTRY	0	808	808	0	190.01
190.02 19002 ACHN SATELITTE CLINICS	0	0	0	0	190.02
190.03 19003 SPECIAL FUNDS	0	128	128	0	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					200.00
201.00					201.00
202.00	0	37,546,929	25,604,366	405,082	202.00
203.00	0.000000	810.983822	553.033954	40.508200	203.00
204.00	0	1,106,554	609,253	16,550	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet B-1

Date/Time Prepared:
5/13/2015 3:48 pm

Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	INTERNS & RESIDENTS		ALLIED HEALTH (ASSIGNED TIME)		
		SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)			
		19.00	21.00			
205.00 Unit cost multiplier (Wkst. B, Part II)	0.000000	23.900687	13.159381	1.655000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet C
Part I
Date/Time Prepared:
5/13/2015 3:48 pm

		Title XVIII		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	115,963,856		115,963,856	4,477,439	120,441,295	30.00
31.00	03100 INTENSIVE CARE UNIT	16,885,642		16,885,642	156,628	17,042,270	31.00
33.00	03300 BURN INTENSIVE CARE UNIT	4,268,038		4,268,038	172,359	4,440,397	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	7,137,581		7,137,581	0	7,137,581	34.00
34.01	02080 PEDIATRIC INTENSIVE CARE UNIT	4,077,005		4,077,005	56,481	4,133,486	34.01
34.02	02180 TRAUMA INTENSIVE CARE UNIT	10,591,200		10,591,200	214,155	10,805,355	34.02
34.03	02400 NEURO INTENSIVE CARE	5,071,905		5,071,905	37,889	5,109,794	34.03
34.04	02060 NEONATAL INTENSIVE CARE UNIT	13,003,622		13,003,622	329,534	13,333,156	34.04
43.00	04300 NURSERY	4,761,566		4,761,566	0	4,761,566	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	69,569,762		69,569,762	1,539,543	71,109,305	50.00
51.00	05100 RECOVERY ROOM	5,265,152		5,265,152	0	5,265,152	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7,380,211		7,380,211	0	7,380,211	52.00
53.00	05300 ANESTHESIOLOGY	4,333,801		4,333,801	1,108,333	5,442,134	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	43,266,757		43,266,757	627,220	43,893,977	54.00
60.00	06000 LABORATORY	48,816,012		48,816,012	190,237	49,006,249	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	6,111,849		6,111,849	0	6,111,849	62.00
65.00	06500 RESPIRATORY THERAPY	10,211,102	0	10,211,102	227,427	10,438,529	65.00
66.00	06600 PHYSICAL THERAPY	2,903,913	0	2,903,913	0	2,903,913	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,298,685	0	1,298,685	0	1,298,685	67.00
68.00	06800 SPEECH PATHOLOGY	1,552,865	0	1,552,865	0	1,552,865	68.00
69.00	06900 ELECTROCARDIOLOGY	12,159,900		12,159,900	289,041	12,448,941	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4,629,012		4,629,012	0	4,629,012	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	6,493,529		6,493,529	0	6,493,529	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	63,360,692		63,360,692	0	63,360,692	73.00
74.00	07400 RENAL DIALYSIS	5,247,000		5,247,000	0	5,247,000	74.00
76.00	03950 WAIVER PURCHASED PATIENT SERVICES	0		0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	116,460,360		116,460,360	976,164	117,436,524	90.00
91.00	09100 EMERGENCY	51,357,480		51,357,480	2,057,833	53,415,313	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	16,681,585		16,681,585		16,681,585	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	658,860,082	0	658,860,082	12,460,283	671,320,365	200.00
201.00	Less Observation Beds	16,681,585		16,681,585		16,681,585	201.00
202.00	Total (see instructions)	642,178,497	0	642,178,497	12,460,283	654,638,780	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet C
Part I
Date/Time Prepared:
5/13/2015 3:48 pm

			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	155,580,740		155,580,740				30.00
31.00	03100	INTENSIVE CARE UNIT	19,731,859		19,731,859				31.00
33.00	03300	BURN INTENSIVE CARE UNIT	3,709,861		3,709,861				33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,401,256		7,401,256				34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	2,587,690		2,587,690				34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	11,185,276		11,185,276				34.02
34.03	02400	NEURO INTENSIVE CARE	7,192,852		7,192,852				34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	28,033,307		28,033,307				34.04
43.00	04300	NURSERY	1,653,662		1,653,662				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	101,457,257	77,383,506	178,840,763	0.389004	0.000000		50.00
51.00	05100	RECOVERY ROOM	4,887,299	7,973,130	12,860,429	0.409407	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,491,111	32,663	3,523,774	2.094405	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	37,534,349	18,406,923	55,941,272	0.077471	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	39,796,304	112,482,091	152,278,395	0.284129	0.000000		54.00
60.00	06000	LABORATORY	41,872,911	97,614,017	139,486,928	0.349968	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	7,404,167	2,094,052	9,498,219	0.643473	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	18,754	806,028	824,782	12.380365	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	800,299	1,658,841	2,459,140	1.180865	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	428,252	1,109,686	1,537,938	0.844433	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	11,626	1,170,076	1,181,702	1.314092	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	12,823,740	13,774,436	26,598,176	0.457170	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,034,086	5,588,218	14,622,304	0.316572	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,255,076	5,240,173	15,495,249	0.419066	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,837,845	43,424,297	103,262,142	0.613591	0.000000		73.00
74.00	07400	RENAL DIALYSIS	49,825	5,242,247	5,292,072	0.991483	0.000000		74.00
76.00	03950	WAI VER PURCHASED PATIENT SERVICES	0	0	0	0.000000	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	1,076,952	109,696,373	110,773,325	1.051339	0.000000		90.00
91.00	09100	EMERGENCY	11,294,781	62,862,998	74,157,779	0.692543	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,885,307	15,556,486	22,441,793	0.743327	0.000000		92.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	586,036,444	582,116,241	1,168,152,685				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	586,036,444	582,116,241	1,168,152,685				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet C Part I Date/Time Prepared: 5/13/2015 3:48 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
33.00	03300 BURN INTENSIVE CARE UNIT			33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT			34.00
34.01	02080 PEDIATRIC INTENSIVE CARE UNIT			34.01
34.02	02180 TRAUMA INTENSIVE CARE UNIT			34.02
34.03	02400 NEURO INTENSIVE CARE			34.03
34.04	02060 NEONATAL INTENSIVE CARE UNIT			34.04
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.397612		50.00
51.00	05100 RECOVERY ROOM	0.409407		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2.094405		52.00
53.00	05300 ANESTHESIOLOGY	0.097283		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.288248		54.00
60.00	06000 LABORATORY	0.351332		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.643473		62.00
65.00	06500 RESPIRATORY THERAPY	12.656107		65.00
66.00	06600 PHYSICAL THERAPY	1.180865		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.844433		67.00
68.00	06800 SPEECH PATHOLOGY	1.314092		68.00
69.00	06900 ELECTROCARDIOLOGY	0.468037		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.316572		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.419066		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.613591		73.00
74.00	07400 RENAL DIALYSIS	0.991483		74.00
76.00	03950 WAIVER PURCHASED PATIENT SERVICES	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	1.060152		90.00
91.00	09100 EMERGENCY	0.720293		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.743327		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet C
Part I
Date/Time Prepared:
5/13/2015 3:48 pm

		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	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	115,963,856		115,963,856	4,477,439	120,441,295	30.00
31.00	03100 INTENSIVE CARE UNIT	16,885,642		16,885,642	156,628	17,042,270	31.00
33.00	03300 BURN INTENSIVE CARE UNIT	4,268,038		4,268,038	172,359	4,440,397	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	7,137,581		7,137,581	0	7,137,581	34.00
34.01	02080 PEDIATRIC INTENSIVE CARE UNIT	4,077,005		4,077,005	56,481	4,133,486	34.01
34.02	02180 TRAUMA INTENSIVE CARE UNIT	10,591,200		10,591,200	214,155	10,805,355	34.02
34.03	02400 NEURO INTENSIVE CARE	5,071,905		5,071,905	37,889	5,109,794	34.03
34.04	02060 NEONATAL INTENSIVE CARE UNIT	13,003,622		13,003,622	329,534	13,333,156	34.04
43.00	04300 NURSERY	4,761,566		4,761,566	0	4,761,566	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	69,569,762		69,569,762	1,539,543	71,109,305	50.00
51.00	05100 RECOVERY ROOM	5,265,152		5,265,152	0	5,265,152	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7,380,211		7,380,211	0	7,380,211	52.00
53.00	05300 ANESTHESIOLOGY	4,333,801		4,333,801	1,108,333	5,442,134	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	43,266,757		43,266,757	627,220	43,893,977	54.00
60.00	06000 LABORATORY	48,816,012		48,816,012	190,237	49,006,249	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	6,111,849		6,111,849	0	6,111,849	62.00
65.00	06500 RESPIRATORY THERAPY	10,211,102	0	10,211,102	227,427	10,438,529	65.00
66.00	06600 PHYSICAL THERAPY	2,903,913	0	2,903,913	0	2,903,913	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,298,685	0	1,298,685	0	1,298,685	67.00
68.00	06800 SPEECH PATHOLOGY	1,552,865	0	1,552,865	0	1,552,865	68.00
69.00	06900 ELECTROCARDIOLOGY	12,159,900		12,159,900	289,041	12,448,941	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4,629,012		4,629,012	0	4,629,012	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	6,493,529		6,493,529	0	6,493,529	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	63,360,692		63,360,692	0	63,360,692	73.00
74.00	07400 RENAL DIALYSIS	5,247,000		5,247,000	0	5,247,000	74.00
76.00	03950 WAIVER PURCHASED PATIENT SERVICES	0		0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	116,460,360		116,460,360	976,164	117,436,524	90.00
91.00	09100 EMERGENCY	51,357,480		51,357,480	2,057,833	53,415,313	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	16,681,585		16,681,585		16,681,585	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	658,860,082	0	658,860,082	12,460,283	671,320,365	200.00
201.00	Less Observation Beds	16,681,585		16,681,585		16,681,585	201.00
202.00	Total (see instructions)	642,178,497	0	642,178,497	12,460,283	654,638,780	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet C Part I Date/Time Prepared: 5/13/2015 3:48 pm
--	--	----------------------	---	---

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	155,580,740		155,580,740			30.00
31.00 03100 INTENSIVE CARE UNIT	19,731,859		19,731,859			31.00
33.00 03300 BURN INTENSIVE CARE UNIT	3,709,861		3,709,861			33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	7,401,256		7,401,256			34.00
34.01 02080 PEDIATRIC INTENSIVE CARE UNIT	2,587,690		2,587,690			34.01
34.02 02180 TRAUMA INTENSIVE CARE UNIT	11,185,276		11,185,276			34.02
34.03 02400 NEURO INTENSIVE CARE	7,192,852		7,192,852			34.03
34.04 02060 NEONATAL INTENSIVE CARE UNIT	28,033,307		28,033,307			34.04
43.00 04300 NURSERY	1,653,662		1,653,662			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	101,457,257	77,383,506	178,840,763	0.389004	0.000000	50.00
51.00 05100 RECOVERY ROOM	4,887,299	7,973,130	12,860,429	0.409407	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	3,491,111	32,663	3,523,774	2.094405	0.000000	52.00
53.00 05300 ANESTHESIOLOGY	37,534,349	18,406,923	55,941,272	0.077471	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	39,796,304	112,482,091	152,278,395	0.284129	0.000000	54.00
60.00 06000 LABORATORY	41,872,911	97,614,017	139,486,928	0.349968	0.000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	7,404,167	2,094,052	9,498,219	0.643473	0.000000	62.00
65.00 06500 RESPIRATORY THERAPY	18,754	806,028	824,782	12.380365	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	800,299	1,658,841	2,459,140	1.180865	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	428,252	1,109,686	1,537,938	0.844433	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	11,626	1,170,076	1,181,702	1.314092	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	12,823,740	13,774,436	26,598,176	0.457170	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	9,034,086	5,588,218	14,622,304	0.316572	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	10,255,076	5,240,173	15,495,249	0.419066	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	59,837,845	43,424,297	103,262,142	0.613591	0.000000	73.00
74.00 07400 RENAL DIALYSIS	49,825	5,242,247	5,292,072	0.991483	0.000000	74.00
76.00 03950 WAIVER PURCHASED PATIENT SERVICES	0	0	0	0.000000	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	1,076,952	109,696,373	110,773,325	1.051339	0.000000	90.00
91.00 09100 EMERGENCY	11,294,781	62,862,998	74,157,779	0.692543	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	6,885,307	15,556,486	22,441,793	0.743327	0.000000	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	586,036,444	582,116,241	1,168,152,685		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	586,036,444	582,116,241	1,168,152,685		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet C Part I Date/Time Prepared: 5/13/2015 3:48 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
33.00	03300 BURN INTENSIVE CARE UNIT			33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT			34.00
34.01	02080 PEDIATRIC INTENSIVE CARE UNIT			34.01
34.02	02180 TRAUMA INTENSIVE CARE UNIT			34.02
34.03	02400 NEURO INTENSIVE CARE			34.03
34.04	02060 NEONATAL INTENSIVE CARE UNIT			34.04
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
76.00	03950 WAIVER PURCHASED PATIENT SERVICES	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet D Part I Date/Time Prepared: 5/13/2015 3:48 pm
--	----------------------	---	---

Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	21,430,624	0	21,430,624	84,691	253.04	30.00
31.00	INTENSIVE CARE UNIT	1,786,723		1,786,723	6,919	258.23	31.00
33.00	BURN INTENSIVE CARE UNIT	416,093		416,093	1,201	346.46	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	664,041		664,041	2,574	257.98	34.00
34.01	PEDIATRIC INTENSIVE CARE UNIT	430,359		430,359	926	464.75	34.01
34.02	TRAUMA INTENSIVE CARE UNIT	1,775,917		1,775,917	2,720	652.91	34.02
34.03	NEURO INTENSIVE CARE	374,978		374,978	2,509	149.45	34.03
34.04	NEONATAL INTENSIVE CARE UNIT	1,026,826		1,026,826	9,482	108.29	34.04
43.00	NURSERY	535,491		535,491	2,070	258.69	43.00
200.00	Total (lines 30-199)	28,441,052		28,441,052	113,092		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	8,963	2,267,998	30.00
31.00	INTENSIVE CARE UNIT	1,111	286,894	31.00
33.00	BURN INTENSIVE CARE UNIT	133	46,079	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	411	106,030	34.00
34.01	PEDIATRIC INTENSIVE CARE UNIT	0	0	34.01
34.02	TRAUMA INTENSIVE CARE UNIT	431	281,404	34.02
34.03	NEURO INTENSIVE CARE	130	19,429	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)	11,179	3,007,834	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet D Part II Date/Time Prepared: 5/13/2015 3:48 pm
--	--	----------------------	---	--

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	8,228,366	178,840,763	0.046009	9,036,623	415,766	50.00
51.00	05100 RECOVERY ROOM	796,646	12,860,429	0.061946	338,781	20,986	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	844,362	3,523,774	0.239619	0	0	52.00
53.00	05300 ANESTHESIOLOGY	1,204,310	55,941,272	0.021528	2,913,432	62,720	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	6,381,663	152,278,395	0.041908	4,608,675	193,140	54.00
60.00	06000 LABORATORY	5,395,392	139,486,928	0.038680	5,226,484	202,160	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	279,060	9,498,219	0.029380	749,652	22,025	62.00
65.00	06500 RESPIRATORY THERAPY	1,498,232	824,782	1.816519	3,284	5,965	65.00
66.00	06600 PHYSICAL THERAPY	315,218	2,459,140	0.128182	127,624	16,359	66.00
67.00	06700 OCCUPATIONAL THERAPY	235,367	1,537,938	0.153041	60,102	9,198	67.00
68.00	06800 SPEECH PATHOLOGY	159,106	1,181,702	0.134641	511	69	68.00
69.00	06900 ELECTROCARDIOLOGY	2,776,615	26,598,176	0.104391	1,968,553	205,499	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,708,985	14,622,304	0.116875	805,841	94,183	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	153,980	15,495,249	0.009937	372,595	3,702	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,076,131	103,262,142	0.029790	7,353,836	219,071	73.00
74.00	07400 RENAL DIALYSIS	296,064	5,292,072	0.055945	5,352	299	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	11,832,672	110,773,325	0.106819	97,443	10,409	90.00
91.00	09100 EMERGENCY	5,151,582	74,157,779	0.069468	1,438,501	99,930	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2,968,221	22,441,793	0.132263	13,481	1,783	92.00
200.00	Total (lines 50-199)	53,301,972	931,076,182		35,120,770	1,583,264	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140124		Period: From 12/01/2013 To 11/30/2014		Worksheet D Part III Date/Time Prepared: 5/13/2015 3:48 pm	
Title XVIII			Hospital			PPS		
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	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	02400	NEURO INTENSIVE CARE	0	0	0	0	0	34.03
34.04	02060	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	84,691	0.00	8,963	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	6,919	0.00	1,111	0	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	1,201	0.00	133	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	2,574	0.00	411	0	0	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	926	0.00	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	2,720	0.00	431	0	0	34.02
34.03	02400	NEURO INTENSIVE CARE	2,509	0.00	130	0	0	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	9,482	0.00	0	0	0	34.04
43.00	04300	NURSERY	2,070	0.00	0	0	0	43.00
200.00		Total (lines 30-199)	113,092		11,179	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	02400	NEURO INTENSIVE CARE	0	0				34.03
34.04	02060	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 12/01/2013
To 11/30/2014

Worksheet D
Part IV
Date/Time Prepared:
5/13/2015 3:48 pm

Cost Center Description		Title XVIII				Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)			
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	405,082	0	405,082	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
76.00	03950	WAIVER PURCHASED PATIENT SERVICES	0	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	405,082	0	405,082	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet D
Part IV
Date/Time Prepared:
5/13/2015 3:48 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	178,840,763	0.000000	0.000000	9,036,623	50.00
51.00	05100	RECOVERY ROOM	0	12,860,429	0.000000	0.000000	338,781	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,523,774	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	55,941,272	0.000000	0.000000	2,913,432	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	152,278,395	0.000000	0.000000	4,608,675	54.00
60.00	06000	LABORATORY	0	139,486,928	0.000000	0.000000	5,226,484	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	9,498,219	0.000000	0.000000	749,652	62.00
65.00	06500	RESPIRATORY THERAPY	0	824,782	0.000000	0.000000	3,284	65.00
66.00	06600	PHYSICAL THERAPY	0	2,459,140	0.000000	0.000000	127,624	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,537,938	0.000000	0.000000	60,102	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,181,702	0.000000	0.000000	511	68.00
69.00	06900	ELECTROCARDIOLOGY	0	26,598,176	0.000000	0.000000	1,968,553	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	14,622,304	0.000000	0.000000	805,841	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,495,249	0.000000	0.000000	372,595	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	405,082	103,262,142	0.003923	0.003923	7,353,836	73.00
74.00	07400	RENAL DIALYSIS	0	5,292,072	0.000000	0.000000	5,352	74.00
76.00	03950	WAI VER PURCHASED PATIENT SERVICES	0	0	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	110,773,325	0.000000	0.000000	97,443	90.00
91.00	09100	EMERGENCY	0	74,157,779	0.000000	0.000000	1,438,501	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	22,441,793	0.000000	0.000000	13,481	92.00
200.00		Total (lines 50-199)	405,082	931,076,182			35,120,770	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet D
Part IV
Date/Time Prepared:
5/13/2015 3:48 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School		
		11.00	12.00	13.00	21.00	22.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,166,374	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	506,766	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	72	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	777,928	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,199,281	0	0	0	54.00
60.00	06000	LABORATORY	0	3,879,751	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	108,905	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	46,972	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	237	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	49,554	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,255,294	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	386,406	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	260,702	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,849	5,300,518	20,794	0	0	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
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	15,465,561	0	0	0	90.00
91.00	09100	EMERGENCY	0	2,608,920	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,539,578	0	0	0	92.00
200.00		Total (lines 50-199)	28,849	42,552,819	20,794	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet D
Part IV
Date/Time Prepared:
5/13/2015 3:48 pm

Cost Center Description		PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	Title XVIII	Hospital	PPS
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	WAI VER PURCHASED PATIENT SERVICES	0	0		76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Total (Lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet D Part V Date/Time Prepared: 5/13/2015 3:48 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.389004	2,166,374	0	0	842,728	50.00
51.00	05100	RECOVERY ROOM	0.409407	506,766	0	0	207,474	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.094405	72	0	0	151	52.00
53.00	05300	ANESTHESIOLOGY	0.077471	777,928	0	0	60,267	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.284129	8,199,281	0	0	2,329,654	54.00
60.00	06000	LABORATORY	0.349968	3,879,751	358	0	1,357,789	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.643473	108,905	376	0	70,077	62.00
65.00	06500	RESPIRATORY THERAPY	12.380365	46,972	0	0	581,531	65.00
66.00	06600	PHYSICAL THERAPY	1.180865	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.844433	237	0	0	200	67.00
68.00	06800	SPEECH PATHOLOGY	1.314092	49,554	0	0	65,119	68.00
69.00	06900	ELECTROCARDIOLOGY	0.457170	1,255,294	0	0	573,883	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.316572	386,406	0	0	122,325	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.419066	260,702	8,700	0	109,251	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.613591	5,300,518	35,715	208,686	3,252,350	73.00
74.00	07400	RENAL DIALYSIS	0.991483	0	0	0	0	74.00
76.00	03950	WAIVER PURCHASED PATIENT SERVICES	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1.051339	15,465,561	0	0	16,259,547	90.00
91.00	09100	EMERGENCY	0.692543	2,608,920	0	0	1,806,789	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.743327	1,539,578	0	0	1,144,410	92.00
200.00		Subtotal (see instructions)		42,552,819	45,149	208,686	28,783,545	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		42,552,819	45,149	208,686	28,783,545	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet D Part V Date/Time Prepared: 5/13/2015 3:48 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00 06000 LABORATORY	125	0		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	242	0		62.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	3,646	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	21,914	128,048		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03950 WAIVER PURCHASED PATIENT SERVICES	0	0		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00 Subtotal (see instructions)	25,927	128,048		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	25,927	128,048		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet D Part V Date/Time Prepared: 5/13/2015 3:48 pm
	Title XIX	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.389004	0	0	10,824,668	0
51.00 05100 RECOVERY ROOM	0.409407	0	0	1,219,090	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	2.094405	0	0	10,103	0
53.00 05300 ANESTHESIOLOGY	0.077471	0	0	3,105,366	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.284129	0	0	18,047,743	0
60.00 06000 LABORATORY	0.349968	0	0	14,374,337	0
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.643473	0	0	608,212	0
65.00 06500 RESPIRATORY THERAPY	12.380365	0	0	182,546	0
66.00 06600 PHYSICAL THERAPY	1.180865	0	0	283,384	0
67.00 06700 OCCUPATIONAL THERAPY	0.844433	0	0	216,922	0
68.00 06800 SPEECH PATHOLOGY	1.314092	0	0	210,507	0
69.00 06900 ELECTROCARDIOLOGY	0.457170	0	0	1,810,993	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.316572	0	0	739,565	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.419066	0	0	803,785	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.613591	0	0	9,037,492	0
74.00 07400 RENAL DIALYSIS	0.991483	0	0	1,248,159	0
76.00 03950 WAIVER PURCHASED PATIENT SERVICES	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	1.051339	0	0	18,219,511	0
91.00 09100 EMERGENCY	0.692543	0	0	10,182,861	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.743327	0	0	3,860,989	0
200.00 Subtotal (see instructions)		0	0	94,986,233	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	0	94,986,233	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet D Part V Date/Time Prepared: 5/13/2015 3:48 pm
	Title XIX	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	4,210,839		50.00
51.00 05100 RECOVERY ROOM	0	499,104		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	21,160		52.00
53.00 05300 ANESTHESIOLOGY	0	240,576		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	5,127,887		54.00
60.00 06000 LABORATORY	0	5,030,558		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	391,368		62.00
65.00 06500 RESPIRATORY THERAPY	0	2,259,986		65.00
66.00 06600 PHYSICAL THERAPY	0	334,638		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	183,176		67.00
68.00 06800 SPEECH PATHOLOGY	0	276,626		68.00
69.00 06900 ELECTROCARDIOLOGY	0	827,932		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	234,126		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	336,839		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	5,545,324		73.00
74.00 07400 RENAL DIALYSIS	0	1,237,528		74.00
76.00 03950 WAIVER PURCHASED PATIENT SERVICES	0	0		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	19,154,882		90.00
91.00 09100 EMERGENCY	0	7,052,069		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2,869,977		92.00
200.00 Subtotal (see instructions)	0	55,834,595		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	55,834,595		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet D-1 Date/Time Prepared: 5/13/2015 3:48 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		84,691	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		84,691	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)		72,961	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)		8,963	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		120,441,295	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)		120,441,295	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		120,441,295	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,422.13	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		12,746,551	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)		12,746,551	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet D-1 Date/Time Prepared: 5/13/2015 3:48 pm	
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	17,042,270	6,919	2,463.11	1,111	2,736,515	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT	4,440,397	1,201	3,697.25	133	491,734	45.00
46.00 SURGICAL INTENSIVE CARE UNIT	7,137,581	2,574	2,772.95	411	1,139,682	46.00
46.01 PEDIATRIC INTENSIVE CARE UNIT	4,133,486	926	4,463.81	0	0	46.01
46.02 TRAUMA INTENSIVE CARE UNIT	10,805,355	2,720	3,972.56	431	1,712,173	46.02
46.03 NEURO INTENSIVE CARE	5,109,794	2,509	2,036.59	130	264,757	46.03
46.04 NEONATAL INTENSIVE CARE UNIT	13,333,156	9,482	1,406.15	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)					14,905,569	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					33,996,981	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)					3,007,834	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,612,113	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					4,619,947	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					29,377,034	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)					11,730	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,422.13	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					16,681,585	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140124		Period: From 12/01/2013 To 11/30/2014		Worksheet D-1 Date/Time Prepared: 5/13/2015 3:48 pm	
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	21,430,624	120,441,295	0.177934	16,681,585	2,968,221	90.00
91.00	Nursing School cost	0	120,441,295	0.000000	16,681,585	0	91.00
92.00	Allied health cost	0	120,441,295	0.000000	16,681,585	0	92.00
93.00	All other Medical Education	0	120,441,295	0.000000	16,681,585	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet D-1
		Title XIX		Date/Time Prepared: 5/13/2015 3:48 pm
		Hospital		Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		84,691	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		84,691	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)		72,961	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)		24,361	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)		2,070	15.00
16.00	Nursery days (title V or XIX only)		1,808	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		115,963,856	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)		115,963,856	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		115,963,856	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,369.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		33,356,543	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)		33,356,543	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet D-1 Date/Time Prepared: 5/13/2015 3:48 pm			
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)	
Title XIX			1.00	2.00	3.00	4.00	5.00	
Hospital			4,761,566	2,070	2,300.27	1,808	4,158,888	
Cost								
42.00	NURSERY (title V & XIX only)		4,761,566	2,070	2,300.27	1,808	4,158,888	42.00
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT		16,885,642	6,919	2,440.47	3,270	7,980,337	43.00
44.00	CORONARY CARE UNIT							44.00
45.00	BURN INTENSIVE CARE UNIT		4,268,038	1,201	3,553.74	387	1,375,297	45.00
46.00	SURGICAL INTENSIVE CARE UNIT		7,137,581	2,574	2,772.95	711	1,971,567	46.00
46.01	PEDIATRIC INTENSIVE CARE UNIT		4,077,005	926	4,402.81	495	2,179,391	46.01
46.02	TRAUMA INTENSIVE CARE UNIT		10,591,200	2,720	3,893.82	1,666	6,487,104	46.02
46.03	NEURO INTENSIVE CARE		5,071,905	2,509	2,021.48	126	254,706	46.03
46.04	NEONATAL INTENSIVE CARE UNIT		13,003,622	9,482	1,371.40	8,328	11,421,019	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)						51,131,191	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						120,316,043	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
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)							0
52.00	Total Program excludable cost (sum of lines 50 and 51)							0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)							0
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges							0
55.00	Target amount per discharge						0.00	54.00
56.00	Target amount (line 54 x line 55)							0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							0
58.00	Bonus payment (see instructions)							0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	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
62.00	Relief payment (see instructions)							0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)							0
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)							0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)							0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)							0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)						11,730	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,369.26	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						16,061,420	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140124		Period: From 12/01/2013 To 11/30/2014		Worksheet D-1 Date/Time Prepared: 5/13/2015 3:48 pm	
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	21,430,624	115,963,856	0.184804	16,061,420	2,968,215	90.00
91.00	Nursing School cost	0	115,963,856	0.000000	16,061,420	0	91.00
92.00	Allied health cost	0	115,963,856	0.000000	16,061,420	0	92.00
93.00	All other Medical Education	0	115,963,856	0.000000	16,061,420	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet D-3 Date/Time Prepared: 5/13/2015 3:48 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		19,130,672	30.00
31.00	03100	INTENSIVE CARE UNIT		3,221,900	31.00
33.00	03300	BURN INTENSIVE CARE UNIT		412,300	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		1,191,900	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT		0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT		1,336,100	34.02
34.03	02400	NEURO INTENSIVE CARE		377,000	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT		0	34.04
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.397612	9,036,623	50.00
51.00	05100	RECOVERY ROOM	0.409407	338,781	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.094405	0	52.00
53.00	05300	ANESTHESIOLOGY	0.097283	2,913,432	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.288248	4,608,675	54.00
60.00	06000	LABORATORY	0.351332	5,226,484	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.643473	749,652	62.00
65.00	06500	RESPIRATORY THERAPY	12.656107	3,284	65.00
66.00	06600	PHYSICAL THERAPY	1.180865	127,624	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.844433	60,102	67.00
68.00	06800	SPEECH PATHOLOGY	1.314092	511	68.00
69.00	06900	ELECTROCARDIOLOGY	0.468037	1,968,553	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.316572	805,841	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.419066	372,595	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.613591	7,353,836	73.00
74.00	07400	RENAL DIALYSIS	0.991483	5,352	74.00
76.00	03950	WAIWER PURCHASED PATIENT SERVICES	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1.060152	97,443	90.00
91.00	09100	EMERGENCY	0.720293	1,438,501	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.743327	13,481	92.00
200.00		Total (sum of lines 50-94 and 96-98)		35,120,770	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)		35,120,770	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet D-3 Date/Time Prepared: 5/13/2015 3:48 pm	
Cost Center Description		Title XIX	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		53,850,644	30.00
31.00	03100	INTENSIVE CARE UNIT		8,267,519	31.00
33.00	03300	BURN INTENSIVE CARE UNIT		1,288,385	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		2,747,389	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT		1,583,223	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT		4,263,924	34.02
34.03	02400	NEURO INTENSIVE CARE		2,792,945	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT		20,764,599	34.04
43.00	04300	NURSERY		1,144,800	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.389004	30,579,750	11,895,645 50.00
51.00	05100	RECOVERY ROOM	0.409407	1,469,290	601,538 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.094405	2,229,697	4,669,889 52.00
53.00	05300	ANESTHESIOLOGY	0.077471	11,903,864	922,204 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.284129	12,856,583	3,652,928 54.00
60.00	06000	LABORATORY	0.349968	14,895,984	5,213,118 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.643473	2,755,918	1,773,359 62.00
65.00	06500	RESPIRATORY THERAPY	12.380365	4,515	55,897 65.00
66.00	06600	PHYSICAL THERAPY	1.180865	268,188	316,694 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.844433	147,168	124,274 67.00
68.00	06800	SPEECH PATHOLOGY	1.314092	4,447	5,844 68.00
69.00	06900	ELECTROCARDIOLOGY	0.457170	3,639,424	1,663,835 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.316572	2,381,179	753,815 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.419066	2,564,900	1,074,862 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.613591	23,694,004	14,538,428 73.00
74.00	07400	RENAL DIALYSIS	0.991483	12,264	12,160 74.00
76.00	03950	WAIVER PURCHASED PATIENT SERVICES	0.000000	0	0 76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1.051339	132,330	139,124 90.00
91.00	09100	EMERGENCY	0.692543	3,483,300	2,412,335 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.743327	1,755,946	1,305,242 92.00
200.00		Total (sum of lines 50-94 and 96-98)		114,778,751	51,131,191 200.00
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)		114,778,751	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet E Part A Date/Time Prepared: 5/13/2015 3:48 pm	
		Title XVIII	Hospital	PPS	
		0	before 1/1	on/after 1/1	2.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments		0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		13,983,478		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		2,561,555		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0		1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0		1.04
2.00	Outlier payments for discharges. (see instructions)		7,248,249		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		1,936,534		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		424.86		4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		522.08		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		36.60		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 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		448.47		10.00
11.00	FTE count for residents in dental and podiatric programs.		14.21		11.00
12.00	Current year allowable FTE (see instructions)		414.69		12.00
13.00	Total allowable FTE count for the prior year.		413.08		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		411.98		14.00
15.00	Sum of lines 12 through 14 divided by 3.		413.25		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		413.25		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.972673		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.907370		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.907370		21.00
22.00	IME payment adjustment (see instructions)		7,457,608		22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0		22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		47.99		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)		0		28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0		28.01
29.00	Total IME payment (sum of lines 22 and 28)		7,457,608		29.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet E Part A Date/Time Prepared: 5/13/2015 3:48 pm	
		Title XVIII	Hospital		PPS
		0	before 1/1	on/after 1/1	2.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		1.00	1.01	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		12.64		30.00
31.00	Percentage of Medicaid patient days (see instructions)		61.04		31.00
32.00	Sum of lines 30 and 31		73.68		32.00
33.00	Allowable disproportionate share percentage (see instructions)		50.00		33.00
34.00	Disproportionate share adjustment (see instructions)		2,068,130		34.00
			Prior to October 1	On/After October 1	
		0	1.00	1.01	2.00
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0		35.00
35.01	Factor 3 (see instructions)		0.00000000		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)		10,988,110		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		12,879,651		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		46,198,671		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
49.00	Total payment for inpatient operating costs (see instructions)		46,198,671		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		3,334,961		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		2,346,670		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 (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		28,849		58.00
59.00	Total (sum of amounts on lines 49 through 58)		51,909,151		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		51,909,151		61.00
62.00	Deductibles billed to program beneficiaries		1,959,136		62.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet E Part A Date/Time Prepared: 5/13/2015 3:48 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	1.01	On/After October 1 2.00
63.00	Coinsurance billed to program beneficiaries		102,088		63.00
64.00	Allowable bad debts (see instructions)		476,784		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		309,910		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		8,644		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		50,157,837		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		-67,419		70.93
70.94	HRR adjustment amount (see instructions)		-67,405		70.94
70.95	Recovery of accelerated depreciation		0		70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		66,750		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		49,956,263		71.00
71.01	Sequestration adjustment (see instructions)		999,125		71.01
72.00	Interim payments		49,257,314		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)		-300,176		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		564,486		75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet E Part A Date/Time Prepared: 5/13/2015 3:48 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1		On/After 10/1
	HSP Bonus Payment Amount	1.00	1.01	2.00
100.00	HSP bonus amount (see instructions)	0		0
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.998332		0
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0		0
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.9960		0.0000
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0		0

CALCULATION OF DSH PAYMENT PERCENTAGE			Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet DSH Date/Time Prepared: 5/13/2015 3:48 pm		
			Title XVIII	Hospital	PPS		
			Original .mcrx 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)	12.64	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	61.04	0.00			61.04	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	73.68	0.00			61.04	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)	424.86	0.00			424.86	5.00
6.00	Disproportionate Share Payment Percentage (transfer to Worksheet E, Part A, line 33)	50.00	0.00			39.57	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)	12.64	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)	41,152	0			41,152	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	9,000	0			9,000	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)	12,292	0			12,292	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)	62,444	0			62,444	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	101,362	0			101,362	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	930	0			930	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)	102,292	0			102,292	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	61.04	0.00			61.04	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140124		Period: From 12/01/2013 To 11/30/2014		Worksheet DSH Date/Time Prepared: 5/13/2015 3:48 pm	
		Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	50.00		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		50.00		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.		50.00		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE							
32.00	Does the hospital qualify under the Pickle amendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet DSH Date/Time Prepared: 5/13/2015 3:48 pm
		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	39.57	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	39.57	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.	39.57	31.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/13/2015 3:48 pm
		Title XVIII	Hospital	PPS

	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col. 2 and 3)	
	0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00				1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	13,983,478	13,983,478		13,983,478
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,561,555		2,561,555	2,561,555
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00	7,248,249	6,974,973	273,276	7,248,249
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0
3.00	Operating outlier reconciliation	2.01	0	0	0	0
4.00	Managed care simulated payments	3.00	1,936,534	1,390,914	545,620	1,936,534
Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.907370	0.907370	0.907370	
6.00	IME payment adjustment (see instructions)	22.00	7,457,608	6,203,813	1,253,795	7,457,608
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	7,457,608	6,203,813	1,253,795	7,457,608
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0
Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.5000	0.5000	0.5000	
11.00	Disproportionate share adjustment (see instructions)	34.00	2,068,130	1,747,935	320,195	2,068,130
11.01	Uncompensated care payments	36.00	12,879,651	10,988,110	1,891,541	12,879,651
Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0
13.00	Subtotal (see instructions)	47.00	46,198,671	39,898,309	6,300,362	46,198,671
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	46,198,671	39,898,309	6,300,362	46,198,671
16.00	Payment for inpatient program capital	50.00	3,334,961	2,951,465	383,496	3,334,961
17.00	Special add-on payments for new technologies	54.00	0	0	0	0
17.01	Net organ acquisition cost	55.00	0	0	0	0
17.02	Capital received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0
19.00	SUBTOTAL			42,849,774	6,683,858	49,533,632

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/13/2015 3:48 pm
		Title XVIII	Hospital	PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,322,251	1,117,455	204,796	1,322,251	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	1,103,134	1,065,313	37,821	1,103,134	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.5270	0.5270	0.5270		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	696,826	588,899	107,927	696,826	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1609	0.1609	0.1609		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	212,750	179,798	32,952	212,750	25.00
26.00	Total prospective capital payments (see instructions)	12.00	3,334,961	2,951,465	383,496	3,334,961	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-67,419	-65,130	-2,289	-67,419	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-67,405	-60,878	-6,527	-67,405	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	66,750	66,750	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet E Part B Date/Time Prepared: 5/13/2015 3:48 pm
		Title XVII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		153,975	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		28,762,751	2.00
3.00	PPS payments		14,496,217	3.00
4.00	Outlier payment (see instructions)		2,185,005	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		20,794	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		153,975	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		253,835	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		253,835	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		253,835	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		99,860	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)		153,975	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		16,702,016	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		1,818	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		3,883,402	26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		12,970,771	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		1,997,431	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		14,968,202	30.00
31.00	Primary payer payments		128	31.00
32.00	Subtotal (line 30 minus line 31)		14,968,074	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		1,227,955	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		798,171	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		578,267	36.00
37.00	Subtotal (see instructions)		15,766,245	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		15,766,245	40.00
40.01	Sequestration adjustment (see instructions)		315,325	40.01
41.00	Interim payments		14,944,531	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		506,389	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00
			Overrides	
			1.00	
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0.112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet E-1
Part I
Date/Time Prepared:
5/13/2015 3:48 pm

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		48,894,782		14,924,661	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	07/18/2014	255,440		0	3.01
3.02		11/12/2014	107,092	11/12/2014	58,384	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	07/18/2014	38,514	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)		362,532		19,870	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)		49,257,314		14,944,531	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		506,389	6.01
6.02	SETTLEMENT TO PROGRAM		300,176		0	6.02
7.00	Total Medicare program liability (see instructions)		48,957,138		15,450,920	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 12/01/2013 To 11/30/2014	Worksheet E-1 Part II Date/Time Prepared: 5/13/2015 3:48 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			20,608 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			11,179 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			1,300 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			99,292 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			1,168,152,685 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			228,967,889 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			920,888 8.00
9.00	Sequestration adjustment amount (see instructions)			18,418 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			902,470 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			469,770 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)			432,700 32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			0 108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet E-3 Part VII Date/Time Prepared: 5/13/2015 3:48 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		120,316,043		1.00
2.00	Medical and other services			55,834,595	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		120,316,043	55,834,595	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)		120,316,043	55,834,595	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		96,703,428		8.00
9.00	Ancillary service charges		114,778,751	94,986,233	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)		211,482,179	94,986,233	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		211,482,179	94,986,233	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		91,166,136	39,151,638	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		120,316,043	55,834,595	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0	0	24.00
25.00	Capital exception payments (see instructions)		0	0	25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		120,316,043	55,834,595	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		120,316,043	55,834,595	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	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		120,316,043	55,834,595	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		120,316,043	55,834,595	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		120,316,043	55,834,595	40.00
41.00	Interim payments		120,316,043	55,834,595	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00
OVERRIDES					
109.00	Override Ancillary service charges (line 9)		0	0	109.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet E-4 Date/Time Prepared: 5/13/2015 3:48 pm	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			526.48	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			65.83	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 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)			452.16	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.	196.65	212.92	409.57	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.	174.25	188.66	362.91	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		13.71		10.00
11.00	Total weighted FTE count	174.25	202.37		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	173.73	199.12		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	179.27	193.90		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	175.75	198.46		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
17.00	Adjusted rolling average FTE count	175.75	198.46		17.00
18.00	Per resident amount	95,052.72	94,247.94		18.00
19.00	Approved amount for resident costs	16,705,516	18,704,446	35,409,962	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)			51.51	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)			35,409,962	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	11,179	1,300		26.00
27.00	Total Inpatient Days (see instructions)	100,222	100,222		27.00
28.00	Ratio of inpatient days to total inpatient days	0.111542	0.012971		28.00
29.00	Program direct GME amount	3,949,698	459,303		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		64,900		30.00
31.00	Net Program direct GME amount			4,344,101	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 140124	Period: From 12/01/2013 To 11/30/2014	Worksheet E-4 Date/Time Prepared: 5/13/2015 3:48 pm
		Title XVIII	Hospital	PPS
				1.00
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		5,292,072	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
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		33,996,981	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		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)		33,996,981	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		28,937,520	42.00
43.00	Primary payer payments (see instructions)		128	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		28,937,392	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		62,934,373	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.540197	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.459803	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		4,344,101	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		2,346,670	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		1,997,431	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 12/01/2013
To 11/30/2014

Worksheet G

Date/Time Prepared:
5/13/2015 3:48 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	3,556,343	0	0	0	1.00
2.00	Temporary investments	1,184,015,017	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	57,787,595	0	0	0	4.00
5.00	Other receivable	23,309,801	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,691,453	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	121,878,855	0	0	0	9.00
10.00	Due from other funds	-67,532	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	1,393,171,532	0	0	0	11.00
FIXED ASSETS						
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	-1,742,288	0	0	0	14.00
15.00	Buildings	523,013,795	0	0	0	15.00
16.00	Accumulated depreciation	-248,807,726	0	0	0	16.00
17.00	Leasehold improvements	93,874,543	0	0	0	17.00
18.00	Accumulated depreciation	-27,157,466	0	0	0	18.00
19.00	Fixed equipment	167,172,324	0	0	0	19.00
20.00	Accumulated depreciation	-146,195,923	0	0	0	20.00
21.00	Automobiles and trucks	934,396	0	0	0	21.00
22.00	Accumulated depreciation	-813,337	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	10,632,409	0	0	0	27.00
28.00	Accumulated depreciation	-6,820,867	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)	366,807,372	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	1,759,978,904	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	25,242,183	0	0	0	37.00
38.00	Salaries, wages, and fees payable	25,282,984	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	479,500,285	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)	530,025,452	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	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)	530,025,452	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	1,229,953,452	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	1,229,953,452	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	1,759,978,904	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet G-1

Date/Time Prepared:
5/13/2015 3:48 pm

		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		995,293,928		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		212,048,655			2.00
3.00	Total (sum of line 1 and line 2)		1,207,342,583		0	3.00
4.00	INVESTMENTS IN CAPITAL ASSESTS	22,610,870		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)		22,610,870		0	10.00
11.00	Subtotal (line 3 plus line 10)		1,229,953,453		0	11.00
12.00	ROUNDING	1		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)		1		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		1,229,953,452		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 ASSESTS		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	ROUNDING		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/13/2015 3:48 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	157,234,402		157,234,402	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)	157,234,402		157,234,402	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	19,731,859		19,731,859	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT	3,709,861		3,709,861	13.00
14.00	SURGICAL INTENSIVE CARE UNIT	7,401,256		7,401,256	14.00
14.01	PEDIATRIC INTENSIVE CARE UNIT	2,587,690		2,587,690	14.01
14.02	TRAUMA INTENSIVE CARE UNIT	11,185,276		11,185,276	14.02
14.03	NEURO INTENSIVE CARE	7,192,852		7,192,852	14.03
14.04	NEONATAL INTENSIVE CARE UNIT	28,033,307		28,033,307	14.04
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	79,842,101		79,842,101	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	237,076,503		237,076,503	17.00
18.00	Ancillary services	329,702,901		723,703,285	18.00
19.00	Outpatient services	19,257,040	188,115,857	207,372,897	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	20,811,436	20,811,436	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	586,036,444	602,927,677	1,188,964,121	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		1,152,456,442		29.00
30.00	POST CLOSING JOURNAL ENTRIES	1,466,740			30.00
31.00	INTERCOMPANY ACCOUNTS NOT ON W/S A	221,345,195			31.00
32.00	POST CLOSING ENTRY RESERVE 4 CLAIMS	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)		222,811,935		36.00
37.00	ROUNDING	2			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)		2		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		1,375,268,375		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140124

Period:
From 12/01/2013
To 11/30/2014

Worksheet G-3

Date/Time Prepared:
5/13/2015 3:48 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,188,964,121	1.00
2.00	Less contractual allowances and discounts on patients' accounts	408,888,800	2.00
3.00	Net patient revenues (line 1 minus line 2)	780,075,321	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	1,375,268,375	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-595,193,054	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	42,997	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	3,129,696	12.00
13.00	Revenue from laundry and linen service	5,050	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	168,631	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	140,384,887	23.00
24.00		0	24.00
24.01	MI SCCELLANEOUS INCOME	3,137,130	24.01
24.02	WAI VER REVENUE	656,028,981	24.02
24.03	EHR INCENTIVE REVENUE	4,344,337	24.03
25.00	Total other income (sum of lines 6-24)	807,241,709	25.00
26.00	Total (line 5 plus line 25)	212,048,655	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)	212,048,655	29.00

ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

Provider CCN: 140124

Period:

Worksheet I-1

Component CCN: 142313

From 12/01/2013
To 11/30/2014

Date/Time Prepared:
5/13/2015 3:48 pm

Renal Dialysis

		Total Costs	Basis	Statistics	FTEs per 2080 Hours	
		1.00	2.00	3.00	4.00	
1.00	REGISTERED NURSES	869,046	Hours of Service	23,589.00	11.34	1.00
2.00	LICENSED PRACTICAL NURSES	147,146	Hours of Service	5,027.00	2.42	2.00
3.00	NURSES AIDES	37,185	Hours of Service	2,131.00	1.02	3.00
4.00	TECHNICIANS	155,407	Hours of Service	4,160.00	2.00	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	1,291,167	Accumulated Cost			7.00
8.00	NON-PATIENT CARE SALARY	443,469	Accumulated Cost			8.00
9.00	SUBTOTAL (SUM OF LINES 1-8)	2,943,420				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	3,460	Requisitions			14.00
15.00	DRUGS	0	Requisitions			15.00
16.00	OTHER	4,000	Accumulated Cost			16.00
17.00	SUBTOTAL (SUM OF LINES 9-16)*	2,950,880				17.00
18.00	CAPITAL RELATED COSTS-BLDGS. & FIXTURES	58,226	Square Feet			18.00
19.00	CAPITAL RELATED COSTS-MOV. EQUIP.	40,721	Percentage of Time			19.00
20.00	EMPLOYEE BENEFITS DEPARTMENT	904,533	Salary			20.00
21.00	ADMINISTRATIVE & GENERAL	916,949	Accumulated Cost			21.00
22.00	MAINT./REPAIRS-OPER-HOUSEKEEPING	180,085	Square Feet			22.00
23.00	MEDICAL EDUCATION PROGRAM COSTS	0				23.00
24.00	CENTRAL SERVICE & SUPPLIES	1,281	Requisitions			24.00
25.00	PHARMACY	0	Requisitions			25.00
26.00	OTHER ALLOCATED COSTS	194,325	Accumulated Cost			26.00
27.00	SUBTOTAL (SUM OF LINES 17-26)*	5,247,000				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	WAIVER PURCHASED PATIENT SERVICES	0	Charges	0		30.00
31.00	TOTAL COSTS (SUM OF LINES 27-30)	5,247,000				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 12/01/2013 To 11/30/2014	Worksheet 1-2
		Component CCN: 142313		Date/Time Prepared: 5/13/2015 3:48 pm
		Renal Dialysis		

		Capital Related Costs		Direct Patient Care Salary		Employee Benefits Department	Drugs	
		Building	Equipment	RNs	Other			
		1.00	2.00	3.00	4.00			
1.00	Total Renal Department Costs	238,311	40,721	869,046	339,738	904,533	0	1.00
MAINTENANCE								
2.00	Hemodialysis	195,564	33,417	713,160	278,797	742,281	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	CCPD	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	CCPD	0	0	0	0	0	0	11.00
OTHER BILLABLE SERVICES								
12.00	Inpatient Dialysis	42,747	7,304	155,886	60,941	162,252	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 through 16)	238,311	40,721	869,046	339,738	904,533	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	4,741	0	2,397,090	2,849,910	5,247,000		1.00
MAINTENANCE								
2.00	Hemodialysis	3,891	0	1,967,110	2,338,705	4,305,815		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	CCPD	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	CCPD	0	0	0	0	0		11.00
OTHER BILLABLE SERVICES								
12.00	Inpatient Dialysis	850	0	429,980	511,205	941,185		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 through 16)	4,741	0	2,397,090	2,849,910	5,247,000		17.00
18.00	Medical Educational Program Costs					0		18.00
19.00	Total Renal Costs (line 17 + line 18)					5,247,000		19.00

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140124

Period: From 12/01/2013

Worksheet 1-3

Component CCN: 142313

To 11/30/2014

Date/Time Prepared: 5/13/2015 3:48 pm

		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	238,311	40,721	869,046	339,738	904,533	1.00
MAINTENANCE							
2.00	Hemodialysis	9,287	9,287.00	9,287.00	9,287.00	9,287	2.00
3.00	Intermittent Peritoneal	0	0.00	0.00	0.00	0	3.00
TRAINING							
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	CCPD	0	0.00	0.00	0.00	0	7.00
HOME							
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	CCPD	0	0.00	0.00	0.00	0	11.00
OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis Treatments	2,030	2,030.00	2,030.00	2,030.00	2,030	12.00
13.00	Method II Home Patient	0	0.00	0.00	0.00	0	13.00
14.00	EPO	0	0.00	0.00	0.00	0	14.00
15.00	ARANESP	0	0.00	0.00	0.00	0	15.00
16.00	Other	0	0.00	0.00	0.00	0	16.00
17.00	Total Statistical Basis	11,317	11,317.00	11,317.00	11,317.00	11,317	17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)	21.057789	3.598215	76.791199	30.020147	79.926924	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	4,741	0	2,397,090	2,849,910	1.00
MAINTENANCE							
2.00	Hemodialysis	0	9,287	0			2.00
3.00	Intermittent Peritoneal	0	0	0			3.00
TRAINING							
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	CCPD	0	0	0			7.00
HOME							
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	CCPD	0	0	0			11.00
OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis Treatments	0	2,030	0			12.00
13.00	Method II Home Patient	0	0	0			13.00
14.00	EPO	0	0	0			14.00
15.00	ARANESP	0	0	0			15.00
16.00	Other	0	0	0			16.00
17.00	Total Statistical Basis	0	11,317	0		2,397,090	17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)	0.000000	0.418927	0.000000		1.188904	18.00

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

Provider CCN: 140124

Period: From 12/01/2013

Worksheet 1-4

Component CCN: 142313

To 11/30/2014

Date/Time Prepared: 5/13/2015 3:48 pm

		Rate 0			Renal Dialysis		
		Number of Total Treatments	Total Cost (from Wkst. 1-2, col. 11)	Average Cost of Treatments (col. 2 ÷ col. 1)	Number of Program Treatments (prior to Jan. 1)	Number of Program Treatments (on/after Jan. 1)	
		1.00	2.00	3.00	4.01	4.02	
1.00	Maintenance - Hemodialysis	11,317	4,305,815	380.47	21	238	1.00
2.00	Maintenance - Peritoneal Dialysis	0	0	0.00	0	0	2.00
3.00	Training - Hemodialysis	0	0	0.00	0	0	3.00
4.00	Training - Peritoneal Dialysis	0	0	0.00	0	0	4.00
5.00	Training - Continuous Ambulatory Peritoneal Dialysis	0	0	0.00	0	0	5.00
6.00	Training - Continuous Cycling Peritoneal Dialysis	0	0	0.00	0	0	6.00
7.00	Home Program - Hemodialysis	0	0	0.00	0	0	7.00
8.00	Home Program - Peritoneal Dialysis	0	0	0.00	0	0	8.00
		Patient Weeks			Patient Weeks (prior to Jan. 1)	Patient Weeks (on/after Jan. 1)	
		1.00	2.00	3.00	4.01	4.02	
9.00	Home Program - Continuous Ambulatory Peritoneal Dialysis	0	0	0.00	0	0	9.00
10.00	Home Program - Continuous Cycling Peritoneal Dialysis	0	0	0.00	0	0	10.00
11.00	Totals (sum of lines 1-8, columns 1 and 4) (sum of lines 1-10, columns 2, 5, and 6)	11,317	4,305,815		21	238	11.00
12.00	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3))	11,317					12.00
		Total Program Expenses (see instructions)	Total Program Payment (prior to Jan. 1)	Total Program Payment (on/after Jan. 1)	Average Payment Rate (col. 6.01 ÷ col. 4.01)	Average Payment Rate (col. 6.02 ÷ col. 4.02)	
		5.00	6.01	6.02	7.01	7.02	
1.00	Maintenance - Hemodialysis	98,542	5,885	64,088	280.24	269.28	1.00
2.00	Maintenance - Peritoneal Dialysis	0	0	0	0.00	0.00	2.00
3.00	Training - Hemodialysis	0	0	0	0.00	0.00	3.00
4.00	Training - Peritoneal Dialysis	0	0	0	0.00	0.00	4.00
5.00	Training - Continuous Ambulatory Peritoneal Dialysis	0	0	0	0.00	0.00	5.00
6.00	Training - Continuous Cycling Peritoneal Dialysis	0	0	0	0.00	0.00	6.00
7.00	Home Program - Hemodialysis	0	0	0	0.00	0.00	7.00
8.00	Home Program - Peritoneal Dialysis	0	0	0	0.00	0.00	8.00
			(prior to Jan. 1)	(on/after Jan. 1)			
		5.00	6.01	6.02	7.01	7.02	
9.00	Home Program - Continuous Ambulatory Peritoneal Dialysis	0	0	0	0.00	0.00	9.00
10.00	Home Program - Continuous Cycling Peritoneal Dialysis	0	0	0	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)	98,542	5,885	64,088			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 12/01/2013 To 11/30/2014	Worksheet I-5 Date/Time Prepared: 5/13/2015 3:48 pm
--	--	----------------------	---	---

		1.00	2.00	
PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B				
1.00	Total expenses related to care of program beneficiaries (see instructions)	98,542		1.00
2.00	Total payment due (from Wkst. 1-4, col. 6, line 11) (see instructions)			2.00
2.01	Total payment due (from Wkst. 1-4, col. 6.01, line 11) (see instructions)	5,885	5,885	2.01
2.02	Total payment due (from Wkst. 1-4, col. 6.02, line 11) (see instructions)	64,088	64,088	2.02
2.03	Total payment due (see instructions)	69,973	69,973	2.03
2.04	Outlier payments	0		2.04
3.00	Deductibles billed to Medicare (Part B) patients (see instructions)			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			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)	0	0	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)	0	0	8.00
9.00	Program payment (see instructions)	0	55,978	9.00
10.00	Unrecovered from Medicare (Part B) patients (see instructions)			10.00
11.00	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)	0		11.00
PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE				
12.00	Total allowable expenses (see instructions)	4,305,815		12.00
13.00	Total composite costs (from Wkst. 1-4, col. 2, line 11)	4,305,815		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 12/01/2013 To 11/30/2014	Worksheet L Parts I-III Date/Time Prepared: 5/13/2015 3:48 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,322,251	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		1,103,134	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)		274.58	3.00
4.00	Number of interns & residents (see instructions)		413.25	4.00
5.00	Indirect medical education percentage (see instructions)		52.70	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)		696,826	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		12.64	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		61.04	8.00
9.00	Sum of lines 7 and 8		73.68	9.00
10.00	Allowable disproportionate share percentage (see instructions)		16.09	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		212,750	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		3,334,961	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00