Health Financia	al Systems	METHODIST HOSPITAL O	F CHI CAGO	In Lieu	ıof Form CMS-2552-	-10	
This report is	required by law (42 USC 1395	g; 42 CFR 413.20(b)). Falur	e to report can resu	ult in all interim	FORM APPROVED		
payments made	since the beginning of the co	st reporting period being d	eemed overpayments	(42 USC 1395g).	OMB NO. 0938-0050		
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX C SUMMARY	OST REPORT CERTIFICATION	Provi der CCN: 14019	From 10/01/2011	Worksheet S Parts I-III Date/Time Prepared 2/27/2013 1:04 pm		
PART I - COST	REPORT STATUS						
Provi der	1. [X] Electronically filed	cost report		Date: 2/27/20	13 Time: 1:04	pm	
use only	2. [] Manually submitted co	st report					
	3. [O]If this is an amended report enter the number of times the provider resubmitted this cost report 4. [F] Medicare Utilization. Enter "F" for full or "L" for low.						
Contractor use only	5. [1]Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended		this Provider CCN 12			<u> </u>	

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 METHODIST HOSPITAL OF CHICAGO (140197) for the cost reporting period beginning 10/01/2011 and ending 09/30/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)	Officer or Administrator of Provider(s)
Title	,
Date	

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	1, 445	-131, 684	0	0	1. 00
2.00	Subprovider - IPF	0	0	0		0	2. 00
3.00	Subprovider - IRF	0	0	0		0	3. 00
4.00	SUBPROVI DER I	0	0	0		0	4. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
7.00	SKILLED NURSING FACILITY	0	53, 475	-284		0	7. 00
8.00	NURSING FACILITY	0				0	8. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
12.00	CMHC I	0		0		0	12. 00
200.00	Total	0	54, 920	-131, 968	0	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.

	paid days	eligible	Medicaid	Medi cai d		days		
		unpai d	paid days	el i gi bl e				
		days		unpai d				
	1.00	2. 00	3. 00	4. 00	5. 00	6. 00		
24.00 If this provider is an IPPS hospital, enter the	9, 308	1, 420	0	0	741	0	24. 00	
in-state Medicaid paid days in col. 1, in-state								
Medicaid eligible unpaid days in col. 2,								
out-of-state Medicaid paid days in col. 3,								
out-of-state Medicaid eligible unpaid days in col.								
4, Medicaid HMO paid and eligible but unpaid days in								
column 5, and other Medicaid days in column 6.								
25.00 If this provider is an IRF, enter the in-state	0	0	0	0	0	0	25. 00	
Medicaid paid days in col. 1, the in-state Medicaid								
eligible unpaid days in col. 2, out-of-state								
Medicaid days in col. 3, out-of-state Medicaid								
eligible unpaid days in col. 4, Medicaid HMO paid								
and eligible but unpaid days in col. 5, and other								
Medicaid days in col. 6.				1				
Urban/Rural S Date of Geogr								
					00	2. 00		
26.00 Enter your standard geographic classification (not w		at the beg	ginning of t	he	1		26. 00	
cost reporting period. Enter "1" for urban or "2" fo								
27.00 Enter your standard geographic classification (not w				st	1		27. 00	
reporting period. Enter in column 1, "1" for urban o			ргі сарге,					
enter the effective date of the geographic reclassif			III ototuo ir				35. 00	
35.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number of	perrous so	л Status II	1	۷		35.00	
errect in the cost reporting perrod.				l l	I		l	

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi	der CCN: 140197	Peri od:	/2011	Workshe	eet S-2	2552-1
		From 10/01 To 09/30)/2011	Part I Date/Ti 2/27/20		
		Begi nn		Endi	ng:	ļ
.00 Enter applicable beginning and ending dates of SCH status. Subscript I	ino 24 for numb	1.0	0	2.0	00	36. C
of periods in excess of one and enter subsequent dates.	THE 30 TOT HUMB	31				30.0
.00 If this is a Medicare dependent hospital (MDH), enter the number of pe	eriods MDH statu	5	0)		37.0
in effect in the cost reporting period. .00 Enter applicable beginning and ending dates of MDH status. Subscript I	ine 38 for numbe	er				38.0
of periods in excess of one and enter subsequent dates.						
		1. 0		Y/ 2.0		1
.00 Does the facility potentially qualify for the inpatient hospital adjusticular volume hospitals as deemed by CMS according to the Federal Register? "Y" for yes or "N" for no. Additionally, does the facility meet the mirequirements in accordance with 42 CFR 412.101(b)(2)? Enter in column "N" for no.	Enter in column leage	1 N	<u> </u>			39.0
			V 1. 00	XVIII 0 2.00	XI X 3. 00	
Prospective Payment System (PPS)-Capital						
.00 Does this facility qualify and receive Capital payment for disproporti with 42 CFR Section §412.320? (see instructions)	onate share in a	accordance	N	Y	N	45. 0
.00 Is this facility eligible for additional payment exception for extraor pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III			N	N	N	46. 0
	or yes or "N" fo	r no.	N	N	N	47. C
.00 Is the facility electing full federal capital payment? Enter "Y" for Teaching Hospitals			N	N	N	48. 0
.00 Is this a hospital involved in training residents in approved GME progor "N" for no.	rams? Enter "Y	' for yes	N			56. (
.00 If line 56 is yes, is this the first cost reporting period during which GME programs trained at this facility? Enter "Y" for yes or "N" for ris "Y" did residents start training in the first month of this cost refor yes or "N" for no in column 2. If column 2 is "Y", complete Works	o in column 1. porting period?	f column 1 Enter "Y"				57. (
"N", complete Worksheet D, Part III & IV and D-2, Part II, if applicated the solution of the s	sicians' services	s as				58. 0
defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Worksh			N			59. (
.00 Are you claiming nursing school and/or allied health costs for a progr	am that meets t	ne	N			60. (
provider-operated criteria under §413.85? Enter "Y" for yes or "N" for	or no. (see insti	ructions) IME Ave	rane	Di rect	t GME	
	.,,,,	7.00	go	Aver	age	
.00 Did your facility receive additional FTE slots under ACA section 5503?	1. 00 N	2.0	0. 00	3.0		61. (
Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in colum 2 and direct GME in column 3, from the hospital's three most recent coreports ending and submitted before March 23, 2010. (see instructions	umn ost		0.00		0.00	01.1
ACA Provisions Affecting the Health Resources and Services Administration. OU Enter the number of FTE residents that your hospital trained in this		00				62. (
cost reporting period for which your hospital received HRSA PCRE fundi (see instructions)						
.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)		00				62. (
Teaching Hospitals that Claim Residents in Non-Provider Settings	nie N					63. (
.00 Has your facility trained residents in non-provider settings during the cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)						03.
	Unwei ghte			Ratio (d		
	FTEs Nonprovide Site	r Hospi		(col . 1 2)		
Continue CEON of the ACA D. M. STE D. M.	1.00	2.0		3. (
Section 5504 of the ACA Base Year FTE Residents in Nonprovider setting period that begins on or after July 1, 2009 and before June 30, 2010.	jsinis base ye	ar is your	cost r	eportino)	
.00 Enter in column 1, if line 63 is yes, or your facility trained resider in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care		00	0. 00	0.	000000	64.

Health Financial Systems		HOSPITAL OF CHICAGO		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION DA	TA Provi der		eriod: rom 10/01/2011 o 09/30/2012	Worksheet S-2 Part I Date/Time Pre 2/27/2013 1:0	pared:
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	, p
	1.00	2. 00	3. 00	4. 00	5. 00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0. 000000	65. 00
			Unwei ghted FTEs Nonprovi der Si te	FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
C+i FF04 C !! 404 0	V FTF D ' ' ' '	Name and the	1.00	2.00	3.00	
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider setting	sEffective fo	or cost reporti	ng periods	
66.00 Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unweighted Unweighted Ratio (col.						
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))	
	1.00	2. 00	3. 00	4. 00	5. 00	
67.00 If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0. 000000	67.00

for yes or "N" for no for each therapy.				
	1.00	2.00	3.00	
Miscellaneous Cost Reporting Information				
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes,	N		0	115. 00
enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3				
either "93" percent for short term hospital or "98" percent for long term care (includes				
psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS				
15-1, §2208. 1.				
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	Y			117. 00
no.				
118.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is	2			118. 00
claim-made. Enter 2 if the policy is occurrence.				

147.00 Was there a change in the statistical basis? Enter "Y" for y	N		147. 00					
148.00 Was there a change in the order of allocation? Enter "Y" for	N		148. 00					
149.00 Was there a change to the simplified cost finding method? En	N		149. 00					
no.								
	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 Hospi tal	N	N	N	N	155. 00			
156.00 Subprovider - IPF	N	N	N	N	156. 00			
157. 00 Subprovi der - IRF	N	N	N	N	157. 00			
158. 00 SUBPROVI DER					158. 00			
159. 00 SNF	N	N	N	N	159. 00			
160.00 HOME HEALTH AGENCY	N	N	N	N	160. 00			
161. 00 CMHC		N	N	N	161. 00			
161. 10 CORF		N	N	N	161. 10			

1 00

Ν

2 00

146, 00

services only? Enter "Y" for yes or "N" for no.

enter the approval date (mm/dd/yyyy) in column 2.

146.00 Has the cost allocation methodology changed from the previously filed cost report?

Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes,

Health Financial Systems	METHODIST HO	SPITAL OF	CHI CAGO			In Lie	u of Form CMS-	2552-10
From 10/01/2011 To 09/30/2012 I							pared:	
		1.00	-					
Multicampus							1. 00	
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	N	165. 00						
	Name	Cou	ınty	State	Zip Code	CBSA	FTE/Campus	
	0	1.	00	2. 00	3. 00	4. 00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5							0. 00	166. 00
							1. 00	_
Health Information Technology (HI	(incentive in the Ame	eri can Re	covery and	Rei nves	tment Act		1.00	
167.00 Is this provider a meaningful user	•						N	167. 00
168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H			user (line	167 is '	Y"), enter	the	(168. 00
169.00 If this provider is a meaningful utransition factor. (see instruction		and is no	ot a CAH (li	ine 105	is "N"), e	nter the	0.00	169. 00

Ν

19.00

20.00

instructions.

the other adjustments:

made to PS&R Report data for corrections of other PS&R Report information? If yes, see

If line 16 or 17 is yes, were adjustments

made to PS&R Report data for Other? Describe

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 140197 Peri od: Worksheet S-2 From 10/01/2011 Part II 09/30/2012 Date/Time Prepared: 2/27/2013 1:01 pm Part A Description Y/N Date 0 1.00 2.00 21 00 21.00 Was the cost report prepared only using the Ν provider's records? If yes, see . instructions 1.00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 22.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost 23.00 23.00 reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? 24.00 If ves. see instructions Have there been new capitalized leases entered into during the cost reporting period? If yes, see 25.00 25.00 instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see 26,00 instructions. 27 00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit 27.00 сору. Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting 28.00 period? If yes, see instructions. Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) 29.00 treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see 30.00 instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see 31.00 instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual 32.00 arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If 33.00 33.00 no, see instructions. Provi der-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? 34.00 If yes, see instructions. Iffine 34 is yes, were there new agreements or amended existing agreements with the provider-based 35.00 physicians during the cost reporting period? If yes, see instructions. Y/N Date 1.00 2.00 Home Office Costs 36, 00 Were home office costs claimed on the cost report? 36, 00 N 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? N 37.00 If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of N 38.00 the provider? If yes, enter in column 2 the fiscal year end of the home office. If line 36 is yes, did the provider render services to other chain components? If yes, 39.00 39.00 N see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see Ν 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position SCOTT MARTIN 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. Enter the employer/company name of the cost report CROWE HORWATH LLP 42.00 42.00 preparer. 43.00 Enter the telephone number and email address of the cost (574) 232-3992 SCOTT. MARTI N@CROWEHORWATH. CO 43.00 report preparer in columns 1 and 2, respectively.

Provi der CCN: 140197

						2/27/2013 1:0	
		Par	t B				
		Y/N	Date				
		3. 00	4.00				
	PS&R Data						
16. 00	Was the cost report prepared using the PS&R	Υ	02/12/2013				16. 00
	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						
17. 00	instructions) Was the cost report prepared using the PS&R	N					17. 00
17.00	Report for totals and the provider's records	IV					17.00
	for allocation? If either column 1 or 3 is						
	yes, enter the paid-through date in columns						
	2 and 4. (see instructions)						
18.00		N					18. 00
	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.						
19. 00	If line 16 or 17 is yes, were adjustments	N					19. 00
	made to PS&R Report data for corrections of						
	other PS&R Report information? If yes, see						
20.00	instructions.	N					20.00
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe	N					20. 00
	the other adjustments:						
21. 00	Was the cost report prepared only using the	N					21. 00
21.00	provider's records? If yes, see						21.00
	instructions.						
	To a second seco		3.	00			
	Cost Report Preparer Contact Information		D. DEOTOD				
41.00	Enter the first name, last name and the title		DI RECTOR				41. 00
	held by the cost report preparer in columns 1	i, 2, and 3,					
42.00	respectively. Enter the employer/company name of the cost r	cenort					42. 00
72.00	preparer.	срог с					72.00
43. 00		of the cost					43. 00
	report preparer in columns 1 and 2, respective						
	1 the property of the property	- 3	1		1		1

Cost Center Description					10	09/30/2012	2/27/2013 1:01 pm
1.00 2.00 3.00 4.00		Cost Center Description	Worksheet A	No. of Beds	Bed Days	CAH Hours	
1.00							
8 exclude Swing Bed, Observation Bed and Hospice days) 2.00 HM0 3.00 HM0 IPF Subprovider 4.00 HM0 IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 10.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 14.00 Total (see instructions) 8 exclude Swing Bed and Hospical Adults 9.200 9.00 9.00 9.00 9.00 9.00 9.00 9.0							
Hospi ce days Hospi ca day	1.00		30. 00	162	59, 292	0. 00	1. 00
2.00 3.00 HMO IPF Subprovider 4.00 HMO IRF Subprovider 4.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 14.00 Total (see instructions) 2.00 3.00 4.00 5.00 5.00 6.00 7.00 5.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 7							
3.00 4.00 HM0 I PF Subprovi der 4.00 HM0 I RF Subprovi der 5.00 Hospi tal Adul ts & Peds. Swi ng Bed SNF 6.00 Hospi tal Adul ts & Peds. Swi ng Bed NF 7.00 Total Adul ts and Peds. (exclude observation beds) (see instructions) 8.00 I NTENSI VE CARE UNI T 9.00 CORONARY CARE UNI T 10.00 BURN I NTENSI VE CARE UNI T 11.00 SURGI CAL I NTENSI VE CARE UNI T 12.00 OTHER SPECI AL CARE (SPECI FY) 13.00 14.00 Total (see instructions) 3.00 4.00 5.00 5.00 5.00 6.00 7.00 7.00 7.00 7.00 7.00 7.00 7							
4.00 HM0 I RF Subprovi der 5.00 Hospi tal Adul ts & Peds. Swing Bed SNF 6.00 Hospi tal Adul ts & Peds. Swing Bed NF 7.00 Total Adul ts and Peds. (exclude observation beds) (see instructions) 8.00 I NTENSI VE CARE UNI T 31.00 SURGI CAL I NTENSI VE CARE UNI T 32.00 10.00 SURGI CAL I NTENSI VE CARE UNI T 33.00 0 THER SPECI AL CARE (SPECI FY) 13.00 NURSERY 43.00 14.00 Total (see instructions) 4.00 5.00 5.00 5.00 6.00 7.00 6.00 6		1					
5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 43.00 14.00 Total (see instructions) 5.00 6.00 7.00 6.00 7.00 8.00 9.00 0.00 0.00 10.00 11.00 12.00 13.00 14.00 15.00 162,220 0.00 162,220 0.00 17.00 18.00 18.00 19.0							
6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 43.00 162 59, 292 0.00 7.00 8.00 9.00 0.00 9.00 10.00 11.00 12.00 13.00 14.00 150 162 59, 292 0.00 162 0.00 18.00 18.00 19.00 10.00 11.00 11.00 12.00 13.00 14.00 14.00							
7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 43.00 162 59, 292 0.00 7.00 8.00 9.00 9.00 10.00 10.00 11.00 12.00 13.00 14.00 150 62, 220 10.00 10.00 11.00 14.00							
beds) (see instructions)				4.0	F0 000	0.00	
8.00 INTENSIVE CARE UNIT 31.00 8 2,928 0.00 8.00 9.00 CORONARY CARE UNIT 32.00 0 0 0 0.00 9.00 9.00 10.00 BURN INTENSIVE CARE UNIT 33.00 0 0 0 0 0.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 34.00 0 0 0 0 0.00 11.00	7.00			162	59, 292	0.00	7.00
9.00 CORONARY CARE UNIT 32.00 0 0.00 9.00 10.00 11.00 SURGI CAL INTENSIVE CARE UNIT 34.00 0 0 0.00 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 14.00 Total (see instructions) 170 62,220 0.00 14.00 14.00 14.00 15.00 1	0.00		21 00		2 020	0.00	0.00
10.00 BURN INTENSIVE CARE UNIT 33.00 0 0 0.00 10.00 11.00 11.00 SURGICAL INTENSIVE CARE UNIT 34.00 0 0 0 0.00 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 43.00 170 62,220 0.00 14.00		1			2, 928		
11.00 SURGICAL INTENSIVE CARE UNIT 34.00 0 0.00 11.00 12.00 13.00 NURSERY 43.00 14.00 162,220 0.00 14.00 14.00 15.00 1		· ·					
12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 43.00 14.00 Total (see instructions) 12.00 13.00 14.00		1			_		
13.00 NURSERY 43.00 14.00 Total (see instructions) 170 62,220 0.00 14.00		1	34.00		١	0.00	
14.00 Total (see instructions) 170 62,220 0.00 14.00			43.00		•		
		4	43.00		62 220	0.00	
10.00 0/11 113113		` ′		170	02, 220	0.00	
16. 00 SUBPROVI DER - I PF 40. 00 0 16. 00		4	40.00	0			
17. 00 SUBPROVI DER - I RF 41. 00 0 17. 00		4			_		
18.00 SUBPROVI DER 42.00 0 0 18.00		4			_		
19.00 SKILLED NURSING FACILITY 44.00 23 7, 981 19.00		4			_		
20. 00 NURSING FACILITY 45. 00 0 0 20. 00							
21.00 OTHER LONG TERM CARE 46.00 0 0 21.00	21. 00	OTHER LONG TERM CARE		0	o		21. 00
22. 00 HOME HEALTH AGENCY 101. 00 22. 00	22. 00	HOME HEALTH AGENCY	101. 00				22. 00
23. 00 AMBULATORY SURGI CAL CENTER (D. P.) 115. 00 23. 00	23.00	AMBULATORY SURGICAL CENTER (D. P.)	115. 00				23. 00
24. 00 HOSPI CE 116. 00 0 24. 00	24.00	HOSPI CE	116. 00	0	0		24. 00
25. 00 CMHC - CMHC 99. 00 25. 00	25.00	CMHC - CMHC	99. 00				25. 00
25. 10 CMHC - CORF 99. 10 25. 10	25. 10	CMHC - CORF	99. 10				25. 10
26. 00 RURAL HEALTH CLINIC 88. 00 26. 00	26.00	RURAL HEALTH CLINIC	88. 00				26. 00
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89. 00 26. 25	26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				26. 25
27.00 Total (sum of lines 14-26) 193 27.00	27. 00	Total (sum of lines 14-26)		193			27. 00
28.00 Observation Bed Days 28.00	28. 00	Observation Bed Days					
29. 00 Ambul ance Tri ps 29. 00	29. 00						
30.00 Employee discount days (see instruction) 30.00	30.00						
31.00 Employee discount days - IRF	31. 00	1 ' 3					
32.00 Labor & delivery days (see instructions) 32.00	32.00						
33.00 LTCH non-covered days	33. 00	LTCH non-covered days					33.00

| Peri od: | Worksheet S-3 | From 10/01/2011 | Part | To 09/30/2012 | Date/Time Prepared: Health Financial Systems METHODIST HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 140197

				10	09/30/2012	2/27/2013 1:0	
			/P Days / O/P	Visits / Trips		272772013 1.0	ı piii
	Cost Center Description	Title V	Title XVIII	Title XIX	Total All		
					Pati ents		
		5. 00	6. 00	7. 00	8. 00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	0	12, 300	11, 205	24, 089		1. 00
	8 exclude Swing Bed, Observation Bed and						
0.00	Hospi ce days)		0.0				0.00
2.00	HMO		20	0			2.00
3.00	HMO IPF Subprovider		0	0			3.00
4.00	HMO I RF Subprovi der		0	0			4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5. 00
6.00	Hospital Adults & Peds. Swing Bed NF	0	40.000	14 005	0 4 000		6.00
7. 00	Total Adults and Peds. (exclude observation	0	12, 300	11, 205	24, 089		7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT	0	470	264	751		8. 00
9. 00	CORONARY CARE UNIT	0	470	204	751		9.00
10.00	BURN INTENSIVE CARE UNIT	0	0	0	0		10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	0	0	0	0		11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)	O	O	o l	ď		12.00
13. 00	NURSERY	0		0	٥		13. 00
14. 00	Total (see instructions)	0	12, 770	11, 469	24, 840		14. 00
15. 00	CAH visits	0	12,770	0	21,010		15. 00
16. 00	SUBPROVI DER - I PF	0	0	0	0		16.00
17. 00	SUBPROVI DER - I RF	0	0	0	0		17. 00
18. 00	SUBPROVI DER	0	0	0	o		18. 00
19. 00	SKILLED NURSING FACILITY	0	950	Ö	957		19. 00
20. 00	NURSING FACILITY	0		O	o		20.00
21. 00	OTHER LONG TERM CARE				o		21. 00
22. 00	HOME HEALTH AGENCY	0	o	0	o		22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE		O	0	o		24. 00
25.00	CMHC - CMHC	0	0	0	o		25. 00
25. 10	CMHC - CORF	0	0	0	0		25. 10
26.00	RURAL HEALTH CLINIC	0	0	0	0		26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		26. 25
27. 00	Total (sum of lines 14-26)						27. 00
28. 00	Observation Bed Days	0		0	0		28. 00
29. 00	Ambul ance Tri ps		0				29. 00
30.00	Employee discount days (see instruction)				0		30. 00
31. 00	Employee discount days - IRF				0		31. 00
32. 00	Labor & delivery days (see instructions)			0	0		32.00
33. 00	LTCH non-covered days		0		l		33. 00

Health Financial Systems METHODIST HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 140197

| Peri od: | Worksheet S-3 | From 10/01/2011 | Part | To 09/30/2012 | Date/Time Prepared:

				1	0 09/30/2012	2/27/2013 1:0	
		Full	Time Equivale	ents	Di scharges	2,2,,,2010 110	
	Cost Center Description	Total Interns & Residents	Employees On Payroll	Nonpai d Workers	Title V	Title XVIII	
		9. 00	10.00	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)				0	2, 015	1. 00
2.00	HMO					6	2. 00
3. 00	HMO IPF Subprovider					O	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						7. 00
7.00	beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0. 00	406. 24	0.00	0	2, 015	
15. 00	CAH visits						15.00
16.00	SUBPROVI DER - I PF	0. 00			- 1	0	16.00
17.00	SUBPROVI DER - I RF	0. 00				0	17.00
18. 00	SUBPROVI DER	0. 00				0	18.00
19. 00	SKILLED NURSING FACILITY	0. 00					19. 00
20. 00	NURSING FACILITY	0. 00					20.00
21. 00	OTHER LONG TERM CARE	0. 00					21.00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0. 00					23.00
24. 00	HOSPI CE	0. 00					24. 00
25. 00	CMHC - CMHC	0. 00					25. 00
25. 10	CMHC - CORF	0. 00					25. 10
26. 00	RURAL HEALTH CLINIC	0. 00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00	412. 23	0.00			27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31. 00 32. 00
32.00	Labor & delivery days (see instructions)						32. 00 33. 00
33. 00	LTCH non-covered days	l	I	I	l l		33.00

 Heal th Financial
 Systems
 METHODIST

 HOSPITAL
 AND
 HOSPITAL
 HEALTH CARE COMPLEX
 STATISTICAL
 DATA
 Provider CCN: 140197

				2/27/2013 1:0	1 pm
		Di scha	arges		
	Cost Center Description	Title XIX	Total All		
	·		Pati ents		
		14.00	15.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 938	4, 080		1.00
	8 exclude Swing Bed, Observation Bed and				
	Hospi ce days)				
2.00	HMO				2. 00
3.00	HMO IPF Subprovider				3. 00
4.00	HMO IRF Subprovider				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF				5. 00
6.00	Hospital Adults & Peds. Swing Bed NF				6. 00
7. 00	Total Adults and Peds. (exclude observation				7. 00
	beds) (see instructions)				
8. 00	I NTENSI VE CARE UNI T				8. 00
9.00	CORONARY CARE UNIT				9. 00
10.00	BURN INTENSIVE CARE UNIT				10.00
11. 00	SURGI CAL INTENSI VE CARE UNI T				11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)				12. 00
13. 00	NURSERY				13. 00
14.00	Total (see instructions)	1, 938	4, 080		14.00
15.00	CAH visits				15.00
16.00	SUBPROVIDER - I PF	0	0		16.00
17. 00	SUBPROVIDER - IRF	0	0		17. 00
18.00	SUBPROVI DER	O	0		18.00
19. 00	SKILLED NURSING FACILITY				19.00
20.00	NURSING FACILITY				20.00
21.00	OTHER LONG TERM CARE		0		21.00
22. 00	HOME HEALTH AGENCY				22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)				23. 00
24. 00	HOSPI CE				24. 00
25. 00	CMHC - CMHC				25. 00 25. 10
25. 10 26. 00	CMHC - CORF RURAL HEALTH CLINIC				26. 00
26. 00	· I				26. 00
	FEDERALLY QUALIFIED HEALTH CENTER				27. 00
27. 00	Total (sum of lines 14-26)				28.00
28. 00 29. 00	Observation Bed Days Ambulance Trips				28.00
30.00	Employee discount days (see instruction)				30.00
31.00	Employee discount days (see instruction)				31.00
31.00	Labor & delivery days (see instructions)				31.00
	LTCH non-covered days		-		32.00
SS. 00	LIGHT HOH-COVELED DAYS	ļ		I	J 33. 00

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 140197 Peri od: Worksheet S-3 From 10/01/2011 Part II 09/30/2012 Date/Time Prepared: 2/27/2013 1:01 pm Adj usted Worksheet A Amount Recl assi fi cati Paid Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (from (col.2 ± col Salaries in col. 5) Worksheet A-6) 3) col. 4 2.00 5.00 6. 00 1.00 3.00 4.00 PART II - WAGE DATA SALARI ES 1.00 Total salaries (see 200. 00 20, 052, 056 20, 052, 056 860, 735. 00 1.00 23.30 instructions) 2.00 Non-physician anesthetist Part 0 0 0.00 0.00 2.00 3.00 Non-physician anesthetist Part 0 0.00 0.00 3.00 4.00 Physician-Part A -0 0.00 0.00 4.00 Admi ni strati ve 4.01 Physicians - Part A - Teaching 0 0.00 0.00 4.01 5.00 Physician-Part B 0.00 0.00 5.00 6.00 Non-physician-Part B 0 0.00 0.00 6.00 Interns & residents (in an 21 00 7.00 0 0.00 0.00 7.00 approved program) 7.01 Contracted interns and C 0.00 0.00 7.01 residents (in an approved programs) 8.00 Home office personnel 0.00 0.00 8.00 44 00 263, 612 9 00 SNF 263 612 11, 748, 00 22 44 9 00 10.00 Excluded area salaries (see 498, 794 -266, 468 232, 326 6,813.00 34. 10 10.00 instructions) OTHER WAGES & RELATED COSTS 122, 916 122, 916 6, 461. 00 19. 02 11.00 Contract Labor (see 11.00 instructions) 12.00 Contract management and 0 C 0 0.00 0.00 12.00 admi ni strati vė servi ces 0.00 13.00 Contract Labor: Physician-Part 0 0.00 13.00 A - Administrative Home office salaries & 14.00 546, 794 0 546, 794 6,760.00 80.89 14.00 wage-related costs 15.00 Home office: Physician Part A 0 0 0.00 0.00 15.00 - Administrative 16.00 Home office and Contract 0 0.00 0.00 16.00 Physicians Part A - Teaching WAGE-RELATED COSTS 17.00 Wage-related costs (core) Wkst 3, 782, 445 3, 782, 445 17.00 S-3, Part IV line 24 Wage-related costs (other)Wkst 18.00 18.00 S-3, Part IV line 25 19.00 Excluded areas 175, 124 175, 124 19.00 Non-physician anesthetist Part 20.00 Ω 20.00 21.00 Non-physician anesthetist Part 0 0 21.00 Physician Part A -22.00 22.00 0 Admi ni strati ve 22.01 Physician Part A - Teaching C 22.01 23.00 Physician Part B 0 0 23.00 0 24.00 Wage-related costs (RHC/FQHC) 0 24.00 Interns & residents (in an 25.00 25.00 0 approved program) OVERHEAD COSTS - DIRECT SALARIES 7, 187. 00 Employee Benefits 4. 00 231, 506 231, 506 32. 21 26.00 26.00 27.00 Administrative & General 5.00 1, 960, 000 -232, 326 1, 727, 674 75, 345. 00 22. 93 27.00 Administrative & General under 0.00 28.00 28.00 0.00 contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 0.00 29.00 Operation of Plant 17. 20 30.00 7.00 1, 287, 695 1, 287, 695 74, 851. 00 30.00 Laundry & Linen Service 31.00 0.00 31.00 8.00 0.00 32.00 Housekeepi ng 9.00 390, 706 390, 706 38, 715. 00 10.09 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 34.00 10.00 782, 763 -53, 868 728, 895 57, 872.00 12. 59 34.00 Di etary 35.00 Dietary under contract (see 0.00 35.00 0.00 instructions) Cafeteri a 71, 493 53,868 6, 394. 00 19. 61 36.00 11.00 125, 361 36.00 37.00 Maintenance of Personnel 12.00 0.00 0.00 37.00 Nursing Administration 13.00 18, 999, 00 38.00 38.00 717.847 C 717, 847 37. 78 39.00 Central Services and Supply 14.00 109, 435 C 109, 435 8, 890.00 12. 31 39.00 15.00 451, 149 451, 149 0.00 40.00 40.00 Pharmacy 0.00 Medical Records & Medical 16.00 583, 445 41.00 41.00 583.445 26, 487, 00 22. 03

Records Library

Health Financial Systems	ME	ETHODIST HOSPI	TAL OF CHICAGO		In Li€	eu of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der	CCN: 140197	Peri od:	Worksheet S-3	
					From 10/01/2011		
				'	Γο 09/30/2012	Date/Time Pre	
						2/27/2013 1:0	1 pm
	Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			(from	(col.2 ± col.	Salaries in	col. 5)	
			Worksheet A-6)	3)	col. 4		
	1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
42.00 Social Service	17. 00	271, 945	0	271, 94	5 13, 721. 00	19. 82	42.00
43.00 Other General Service	18. 00	0	0		0.00	0.00	43.00

6.00

7.00

28 07

20.17

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provider CCN: 140197 Peri od: From 10/01/2011 To 09/30/2012 2/27/2013 1:01 pm Average Hourly Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col . 2 ± col . col. 5) (from Salaries in Works<u>heet A-6)</u> 3) col. 4 1. 00 4.00 5.00 6.00 2.00 3.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 20, 052, 056 20, 052, 056 860, 735. 00 23. 30 1.00 instructions) 2.00 Excluded area salaries (see 762, 406 -266, 468 495, 938 18, 561. 00 26. 72 2.00 instructions) 3.00 Subtotal salaries (line 1 19, 289, 650 266, 468 19, 556, 118 842, 174. 00 23. 22 3.00 minus line 2) 4.00 Subtotal other wages & related 669, 710 669, 710 13, 221. 00 50.66 4.00 costs (see inst.) Subtotal wage-related costs 5.00 3, 782, 445 C 3, 782, 445 0.00 19.34 5.00

23, 741, 805

6, 857, 984

24, 008, 273

6, 625, 658

855, 395. 00

328, 461. 00

266, 468

-232, 326

(see inst.)

instructions)

6.00

7.00

Total (sum of lines 3 thru 5)

Total overhead cost (see

Health Financial Systems	METHODIST HOSPITAL OF CHICAGO	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 140197	
		From 10/01/2011 Part IV
		To 00/20/2012 Data/Time Dropared

PART IV - WAGE RELATED COSTS 1.00		To 09/30/2012	Date/Time Prep 2/27/2013 1:0	
PART IV - WAGE RELATED COSTS 1.00				ı piii
PART I V - WAGE RELATED COSTS Part A - Core List				
Part A - Core List RETIREMENT COST				
RETIREMENT COST		PART IV - WAGE RELATED COSTS		
1. 00		Part A - Core List		
2. 00		RETI REMENT COST		
3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 0.00 0.0	1.00	401K Employer Contributions	0	1.00
3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 0.00 0.0	2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
PLAM ADMINISTRATIVE COSTS (Paid to External Organization) 401K/TSA Plan Administration fees 0 0 0 0 0 0 0 0 0	3.00		683, 843	3. 00
PLAM ADMINISTRATIVE COSTS (Paid to External Organization) 401K/TSA Plan Administration fees 0 0 0 0 0 0 0 0 0	4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
5.00 401K/TSA PI an Administration fees 0 5.00 6.00 Legal Accounting/Management Fees-Pension PI an 0 6.00 7.00 Employee Managed Care Program Administration Fees 0 7.00 8.00 Heal th Insurance (Purchased or Self Funded) 1, 225, 072 8.00 9.00 Prescription Drug Plan 0 9.00 10.00 Dental, Hearing and Vision Plan 0 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 16, 12 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 14.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 364, 767 15.00 16.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 17.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 18.00 Medicare Taxes - Employers Portion Only 1, 427, 695				
Employee Managed Care Program Administration Fees 1, 200 HEALTH AND INSURANCE COST 1, 225, 072 8.00 9.00 Prescription Drug Plan 2, 200 0.0	5.00		0	5. 00
HEALTH AND INSURANCE COST	6.00	Legal/Accounting/Management Fees-Pension Plan	0	6. 00
Real th Insurance (Purchased or Self Funded) 1,225,072 8.00 9.00 10.	7.00	Employee Managed Care Program Administration Fees	0	7. 00
9.00 Prescription Drug Plan 0 9.00 10.00 Dental, Hearing and Vision Plan 0 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 16.124 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 13.00 15.00 'Workers' Compensation Insurance 364,767 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion) 1,427,695 17.00 18.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 48,336 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 0THER Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00		HEALTH AND INSURANCE COST		
9.00 Prescription Drug Plan 0 9.00 10.00 Dental, Hearing and Vision Plan 0 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 16.124 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 13.00 15.00 'Workers' Compensation Insurance 364,767 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion) 1,427,695 17.00 18.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 48,336 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 0THER Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00	8.00	Health Insurance (Purchased or Self Funded)	1, 225, 072	8. 00
10.00 Dental, Hearing and Vision Plan 0 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 16,124 12.00 Accident Insurance (If employee is owner or beneficiary) 0 13.00 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 364,767 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 17.00 Non cumulative portion 1,427,695 17.00 FI CA-Employers Portion Only 1,427,695 18.00 Wedicare Taxes - Employers Portion Only 1,427,695 19.00 Unemployment Insurance 48,336 20.00 OTHER 2.00 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions) 2.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuit ion Reimbursement 16,608 23.00 Part B - Other than Core Related Cost 2.00 Part B - Other than Core Related Cost 2.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00	9.00			
11.00	10.00		0	10.00
13.00 Disability Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 'Workers' Compensation Insurance 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FICA-Employers Portion Only 18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 17.00 Instructions) 22.00 Day Care Cost and Allowances 23.00 Tuition Reimbursement 16.608 23.00 Part B - Other than Core Related Cost	11. 00		16, 124	11. 00
14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 'Workers' Compensation Insurance Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 Medicare Taxes - Employers Portion Only 18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance State or Federal Unemployment Taxes 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 16,608 23.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	12.00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
15. 00 Workers' Compensation Insurance 364, 767 15. 00	13.00	Disability Insurance (If employee is owner or beneficiary)	0	13. 00
Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FICA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 00 State or Federal Unemployment Taxes O THER 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 16. 00 16. 00 17. 00 18. 00 18. 00 20. 00 21. 00 22. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 29. 00 20. 00 2	14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
Non cumulative portion TAXES 17.00 FICA-Employers Portion Only 1,427,695 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.	15.00	'Workers' Compensation Insurance	364, 767	15. 00
TAXES FI CA-Employers Portion Only 1, 427, 695 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 48, 336 19.00 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 0 21.00 instructions)) 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 16, 608 23.00 24.00 Total Wage Related Cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost 3, 782, 445 24.00 Part B - Other than Core Related Cost 24.00 25.00	16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
17. 00 FI CA-Employers Portion Only 1, 427, 695 17. 00 18. 00 Medicare Taxes - Employers Portion Only 0 18. 00 19. 00 Unemployment Insurance 48, 336 19. 00 20. 00 OTHER 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 0 22. 00 23. 00 Tuition Reimbursement 16, 608 23. 00 24. 00 Total Wage Related cost (Sum of Lines 1 -23) 24. 00 Part B - Other than Core Related Cost 24. 00 Part B - Other than Core Related Cost 25. 00 26. 00 26. 00 26. 00 27		Non cumulative portion)		
18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 48,336 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 16,608 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 3,782,445 24.00 Part B - Other than Core Related Cost		TAXES		
19.00 Unemployment Insurance 48,336 19.00	17. 00		1, 427, 695	17. 00
20.00 State or Federal Unemployment Taxes 0 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 0 23.00 Tuition Reimbursement 16,608 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 3,782,445 24.00 Part B - Other than Core Related Cost			0	18. 00
OTHER 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances Tuition Reimbursement 24. 00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost 21. 00 22. 00 3, 782, 445 24. 00			48, 336	19. 00
21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see of cost of cost instructions) 10 22.00 22.00 16,608 23.00 24.00 Part B - Other than Core Related Cost	20.00		0	20. 00
instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 1 instructions) 2 2.00 2 3.00 2 3.00 3,782,445 2 4.00				
22. 00 Day Care Cost and Allowances 0 22. 00 23. 00 Tuition Reimbursement 16, 608 23. 00 24. 00 Total Wage Related cost (Sum of lines 1 -23) 3, 782, 445 24. 00 Part B - Other than Core Related Cost 20. 00 22. 00 24. 00	21. 00		0	21. 00
23. 00 Tui ti on Reimbursement 24. 00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 24. 00				
24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 3,782,445				
Part B - Other than Core Related Cost				
	24. 00		3, 782, 445	24. 00
25. 00 OTHER WAGE RELATED COSTS (SPECIFY) 0 25. 00				
	25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Health Financial Systems	METHODIST HOSPITAL OF CHICAGO	In Lie	eu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 140	From 10/01/2011	Worksheet S-3 Part V Date/Time Prepared:

		Т	o 09/30/2012	Date/Time Prep 2/27/2013 1:0	
	Cost Center Description		Contract Labor		ı pili
			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		122, 916	3, 757, 899	1. 00
2.00	Hospi tal		122, 916	3, 709, 134	2. 00
3.00	Subprovi der - I PF		0	0	3. 00
4.00	Subprovi der - IRF		0	0	4. 00
5.00	Subprovider - (Other)		0	0	5. 00
6.00	Swing Beds - SNF		0	ol	6. 00
7.00	Swing Beds - NF		0	0	7. 00
8.00	Hospi tal -Based SNF		0	48, 765	8. 00
9.00	Hospi tal -Based NF		0	ol	9. 00
10.00	Hospi tal -Based OLTC				10.00
11. 00	Hospi tal -Based HHA		0	0	11. 00
12.00	Separately Certified ASC		0	0	12.00
13.00	Hospi tal -Based Hospi ce		0	0	13.00
14.00	Hospital-Based Health Clinic RHC		0	0	14.00
15. 00	Hospital-Based Health Clinic FQHC		0	0	15. 00
	Hospi tal -Based-CMHC		0	0	16. 00
16. 10	Hospi tal -Based-CMHC 10		0	0	16. 10
17. 00	Renal Dialysis		0	0	17. 00
18. 00	Other		0	0	18. 00

Health Financial Systems METHODIST HOSPI	TAL OF CHICAGO		In lie	u of Form CMS-2	2552-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		CCN: 140197	Peri od:	Worksheet S-7	
	1		From 10/01/2011		
			To 09/30/2012	Date/Time Pre	
		CNE D	C ' D I CNE	2/27/2013 1:0	1 pm
	Group	SNF Days	Swing Bed SNF	Total (sum of	
	1 00	2.00	<u>Days</u> 3. 00	col. 2 + 3) 4.00	
69.00	1. 00 PE2	2.00	0 0	4.00	69. 00
70.00	PE2 PE1		0 0	0	
71. 00	PD2		0 0	0	
72.00	PD2 PD1		1 0	1	
73. 00	PC2		0 0	0	
74. 00	PC2 PC1		0 0	0	
75. 00	PB2		0 0	0	
76. 00	PB2 PB1		0	0	
76. 00 77. 00	PA2		0 0	0	
78.00	PA2 PA1		0 0	0	
199, 00	AAA		0 0	0	199. 00
200. 00 TOTAL	AAA		50 0	_	200.00
200. 00 TOTAL] 9	CBSA at	CBSA on/after	200.00
			Beginning of	October 1 of	
			Cost Reporting	the Cost	
			Peri od	Reporting	
			101100	Period (if	
				appl i cabl e)	
			1. 00	2. 00	
SNF SERVICES					
201.00 Enter in column 1 the SNF CBSA code or 5 character non-CBSA	A code if a rur	al facility,	16974	16974	201. 00
in effect at the beginning of the cost reporting period. Er	nter in column	2, the code			
in effect on or after October 1 of the cost reporting period	od (if applicab	l e).			
		Expenses	Percentage	Associ ated	
				with Direct	
				Patient Care	
				and Related	
		1 00	0.00	Expenses?	
		1.00	2. 00	3. 00	
A notice published in the Federal Register Volume 68, No. 1					
payments beginning 10/01/2003. Congress expected this incre					
expenses. For lines 202 through 207: Enter in column 1 the column 2 the percentage of total expenses for each category					
line 7, column 3. In column 3, enter "Y" for yes or "N" for					
with direct patient care and related expenses for each cate			is filereases assi	crateu	
202. 00 Staffing	gury. (See 1118	263, 6	12 55. 79	Υ	202. 00
203. 00 Recrui tment		15, 8			203. 00
204. 00 Retention of employees		34, 1			204. 00
205. 00 Trai ni ng		1	44 0.05		205. 00
206. 00 OTHER (SPECIFY)			0.00		206. 00
207. 00 Total SNF revenue (Worksheet G-2, Part I, line 7, column 3))	472, 5			207. 00
	•	270	(ı	

Heal th	Financial Systems METHODIST HOSPITAL OF (CHI CAGO		In Lie	u of Form CMS-2	2552-10
		rovi der	CCN: 140197	Peri od:	Worksheet S-1	
				From 10/01/2011 To 09/30/2012		
		Date/Time Pre 2/27/2013 1:0				
					2/2//2013 1.0	ı pili
					1. 00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divide	ed by lin	ne 202 column	8)	0. 601488	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				17, 258, 048	
3.00	Did you receive DSH or supplemental payments from Medicaid?				Υ	3. 00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental pa		from Medicaid	?	Υ	4. 00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Me	edi cai d			0	
6.00	Medi cai d charges				26, 875, 336	1
7. 00 8. 00	Medicaid cost (line 1 times line 6)	. 7 min	uo oum of Lim	as 2 and E. i.f.	16, 165, 192 0	1
8.00	Difference between net revenue and costs for Medicaid program (lin < zero then enter zero)			es 2 and 5; 11	0	8.00
0.00	State Children's Health Insurance Program (SCHIP) (see instruction	is for ea	ach line)			0.00
9.00	Net revenue from stand-alone SCHIP Stand-alone SCHIP charges				0	
10. 00 11. 00	Stand-alone SCHIP cost (line 1 times line 10)				0	
12. 00		no 11 mi	inus lina O	if / zero then	0	
12.00	enter zero)	ne ii iii	illus Illie 7,	II \ Zero then		12.00
	Other state or local government indigent care program (see instruc	tions fo	or each line)			
13.00	Net revenue from state or local indigent care program (Not include)	0	13. 00
14.00	Charges for patients covered under state or local indigent care pr	ogram (I	Not included	in lines 6 or	0	14. 00
	10)					
15.00						
16. 00	Difference between net revenue and costs for state or local indige	ent care	program (lin	e 15 minus line	0	16. 00
	13; if < zero then enter zero) Uncompensated care (see instructions for each line)					
17. 00		ng chari	ity care		0	17. 00
18. 00					0	
19. 00				s (sum of lines	0	
	8, 12 and 16)	g	p9	- (
			Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
		6.11	1.00	2.00	3. 00	
20. 00	Total initial obligation of patients approved for charity care (at		257, 57	754, 414	1, 011, 993	20. 00
21. 00	charges excluding non-reimbursable cost centers) for the entire fa Cost of initial obligation of patients approved for charity care (154, 93	453, 771	608, 702	21 00
21.00	times line 20)	, i i iie i	134, 73	455, 771	000, 702	21.00
22. 00	Partial payment by patients approved for charity care			0	0	22. 00
23. 00	Cost of charity care (line 21 minus line 22)		154, 93	1 453, 771	608, 702	23. 00
		•				
					1. 00	
24. 00	Does the amount in line 20 column 2 include charges for patient da		nd a Length c	f stay limit	N	24. 00
25. 00	imposed on patients covered by Medicaid or other indigent care pro If line 24 is "yes," charges for patient days beyond an indigent		oaram's Lonat	h of stay limit	0	25. 00
26. 00			ogram s rengt	n or stay IIIIII t	_	
27. 00						
28. 00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus)		643, 912	
29. 00	Cost of non-Medicare bad debt expense (line 1 times line 28)	TITIC ZI,	,		387, 305	
30. 00	, ,	ne 29)			996, 007	
	Total unreimbursed and uncompensated care cost (line 19 plus line	,			996, 007	
· · · ·	1	.,				

RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der	CCN: 140197 F	Period: From 10/01/2011	u of Form CMS-2 Worksheet A	
					o 09/30/2012	Date/Time Pre 2/27/2013 1:0	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	·
	OFNEDAL CEDIU OF COCT CENTEDS	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		1, 523, 478	1, 523, 478	-568, 048	955, 430	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0	C	805, 678	805, 678	2.00
3. 00 4. 00	00300 OTHER CAP REL COSTS 00400 EMPLOYEE BENEFITS	231, 506	0 1, 496, 122	1, 727, 628	0 3 795, 923	0 2, 523, 551	3. 00 4. 00
5. 01	00510 NONPATI ENT TELEPHONES	118, 315	271, 204	389, 519	-35, 535	353, 984	5. 01
5. 02 5. 03	00520 DATA PROCESSING 00530 PURCHASING RECEIVING AND STORES	270, 823 240, 099	232, 720 -58, 532			503, 543 181, 567	5. 02 5. 03
5. 04	00540 ADMITTING	228, 539	52, 524			281, 063	5. 04
5.05	00550 CASHI ERI NG/ACCOUNTS RECEI VABLE	373, 267	183, 985			557, 252 5 130, 014	5. 05
5. 06 6. 00	00560 OTHER ADMINISTRATIVE AND GENERAL 00600 MAINTENANCE & REPAIRS	728, 957 0	5, 503, 296 0	6, 232, 253 C	-1, 093, 439 0	5, 138, 814 0	5. 06 6. 00
7. 00	00700 OPERATION OF PLANT	1, 287, 695	1, 457, 264			2, 744, 959	7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	390, 706	251, 584 209, 764	251, 584 600, 470		251, 584 600, 470	8. 00 9. 00
10. 00	01000 DI ETARY	782, 763	237, 362	1, 020, 125	-169, 528	850, 597	10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	71, 493 717, 847	13, 634 97, 386			254, 655 814, 842	
14. 00	01400 CENTRAL SERVICES & SUPPLY	109, 435	-235, 181	-125, 746		135, 726	
15.00	01500 PHARMACY	451, 149	2, 146, 493			493, 963	
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	583, 445 271, 945	191, 878 74, 770			775, 323 346, 715	
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	C	0	0	•
19. 00 20. 00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0	0		0	0	
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	0	0	Č	o o	0	
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	C	0	0	22.00
23. 00	02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0) 0	0	23. 00
30. 00	03000 ADULTS & PEDIATRICS	7, 218, 268	1, 310, 145			7, 487, 713	30.00
31. 00 32. 00	03100 NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	0	18, 109 0			644, 923 0	31. 00 32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	Ö	Ö	C	o o	0	•
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	0	C	0	0	34. 00 40. 00
41. 00	04100 SUBPROVIDER - I RF	0	0		0	0	41.00
42. 00	04200 SUBPROVI DER	0	0	C	0	0	42.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	263, 612	55, 809	319, 421	-15, 800	0 303, 621	43. 00 44. 00
45. 00	04500 NURSING FACILITY	0	0	C	0	0	45. 00
46. 00	O4600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	0	<u> </u>	0	0	46. 00
50. 00	05000 OPERATING ROOM	1, 070, 255	802, 675	1, 872, 930	-310, 729	1, 562, 201	50. 00
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	1
53. 00	05300 ANESTHESI OLOGY	75, 951	198, 328	274, 279	-15, 810	258, 469	
54. 00	05400 RADI OLOGY - DI AGNOSTI C	509, 540	494, 946	1, 004, 486	-2, 267	1, 002, 219	1
55. 00 56. 00	O5500 RADI OLOGY-THERAPEUTI C O5600 RADI OI SOTOPE	0	0) C	0	0	1
57. 00	05700 CT SCAN	O	0	C	0	0	57.00
58. 00 59. 00	05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	
60.00	06000 LABORATORY	795, 237	1, 161, 752	1, 956, 989	-765	1, 956, 224	60.00
60. 01	06001 BLOOD LABORATORY	0	0	C	0	0	60. 01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	61. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	[c	0	0	63.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0 566, 701	0 124, 655	691, 356	0 -12, 573	0 678, 783	
66. 00	06600 PHYSI CAL THERAPY	215, 122	24, 323			239, 319	1
67.00	06700 OCCUPATI ONAL THERAPY	0	0	C	0	0	1
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	164, 245	178, 316	342, 561	-672	0 341, 889	
70. 00	07000 ELECTROENCEPHALOGRAPHY	o	0		0	0	70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 MPL. DEV. CHARGED TO PATIENTS	0	0		318, 381 240, 927	318, 381 240, 927	
73. 00	07300 DRUGS CHARGED TO PATIENTS		0		2, 103, 500	2, 103, 500	
74.00	07400 RENAL DIALYSIS	0	22, 798	22, 798	0	22, 798	
75. 00	07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	ı U	0	<u> </u>	, U	0	75. 00
88. 00	08800 RURAL HEALTH CLINIC	0	0			0	88. 00
39. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	[C	0	0	89.00

Heal th Financial	Systems	METHODIST HOSPITAL OF	F CHI CAGO	In Lie	u of Form CMS-2552-10

Health Financial Systems	METHODIST HOSPITAL	OF CHI CAGO		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C)F EXPENSES	Provi der		eri od:	Worksheet A	
				rom 10/01/2011	D 1 /T' D	
			1	o 09/30/2012	Date/Time Pre 2/27/2013 1:0	
Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	Reclassi fi ed	l piii
	00.0	01	+ col . 2)	ons (See A-6)	Trial Balance	
			,	, ,	(col. 3 +-	
					col . 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
90. 00 09000 CLI NI C	0	0	0	۱	0	90. 00
90. 01 09001 PARTI AL HOSPI TALI ZATI ON	600, 085	247, 163			847, 079	90. 01
91. 00 09100 EMERGENCY	1, 216, 262	216, 593	1, 432, 855	765, 341	2, 198, 196	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00 98. 00
98.00 05950 OTHER REIMBURSABLE COST CENTERS		0	0	0	0	98.00
99. 10 09900 CMHC 99. 10 09910 CORF		0	0	0	0	99. 00
100.00 10000 1&R SERVICES-NOT APPRVD PRGM	498, 794	313, 960	812, 754	-812, 754	-	100.00
101. 00 10100 HOME HEALTH AGENCY	470, 774	313, 3 00	012, 754	-612, 754		101.00
SPECIAL PURPOSE COST CENTERS	J O	<u> </u>	0	<u> </u>	0	1101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0	O	0	105. 00
106. 00 10600 HEART ACQUISITION	0	0	0	o		106. 00
107. 00 10700 LIVER ACQUISITION	o	Ō	0	o		107. 00
108.00 10800 LUNG ACQUISITION	O	O	0	o	0	108. 00
109.00 10900 PANCREAS ACQUISITION	O	0	0	o	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	o	0	110. 00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE		191, 247	191, 247	-191, 247	0	113. 00
114.00 11400 UTILIZATION REVIEW-SNF	0	0	0	0		114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0		115. 00
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	20, 052, 056	19, 010, 570	39, 062, 626	-286, 668	38, 775, 958	118. 00
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
193. 00 19300 NONPALD WORKERS	0	0	0	286, 668	286, 668	
193. 01 19301 MARKETI NG 200. 00 TOTAL (SUM OF LINES 118-199)	20, 052, 056	10 010 F70	20 042 424	0		193. 01
200.00 TOTAL (SUM OF LINES 118-199)	20, 052, 056	19, 010, 570	39, 062, 626	ı U	39, 062, 626	J200. 00

Provi der CCN: 140197

| Period: | Worksheet A | From 10/01/2011 | To 09/30/2012 | Date/Time Prepared: 2/27/2013 1:01 pm

Part					2/27/2013 1:0	
STATEMENT SERVINET COST CRITETIES 1.00 0.000 1		Cost Center Description				
MIRRIAL STRVIET DOST CENTRES 1.00 00000 (APRIE COST) SERVICE & FIXIT 279, 80 195, 430 19. 10.					1	
1.00 001000 CAP REL COSTS-BLUE & FIXT		CENEDAL SERVICE COST CENTERS	6.00	7.00		
2.00 00000 CAP REL COSTS - MONE E EQUIP - 277-800	1 00		0	955 430		1 00
3.00 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.00000000						
DOSTO DOST				l		1
DOZIO DOZIO BIATA PROCESSING DOZIONA D	4.00	00400 EMPLOYEE BENEFITS	31, 729	2, 555, 280		4. 00
0.0390 DIRCHASTING RECEIVING AND STORES 0 181, 567 5.03 5.04 0.0510 AUST TINC 5.04 0.0510 AUST TINC 5.05 5			-52, 213	301, 771		
5. 04 100-40 CASH ENRIGACOUNTS RECEIVABLE 5. 04 5. 775 5. 05 6. 05050 (2014 ENRIGACOUNTS RECEIVABLE 6.54,716 5. 793,500 5. 06 6. 06 6. 070 6			0	l		
5.05 00500 CASSIL PENINGACCOUNTS RECT LYMSIF 0 557, 759 5.05 5.05 6.00 5.05 6.00 5.05 6.00 5.05 6.00 5.05 6.00 5.05 6.00 6				l		
6.00 0.0600 MAINTENINGE & REPAIRS 0 0 0 0 0 0 0 0 0			_	1	I I	
2.00 00700 (DEPARTION OF PLANT 1.44 2.744, B15 7.00 00700 (JURIST & LINES SERVICE 0.251, S84 9.00 00700 (JURIST & LINES SERVICE 0.251, LINES SERVICE 0.251, S84 9.00 00700 (JURIST & LINES SERVICE 0.251, LINES S			054, / 10	5, 793, 530		
8 00 0 00800 (AMNORY & LINEN SERVICE 0 251, 884 9 0 0 0 0090 (DISTARPT PIRE 0 0 600, 470 9 0 0 0090 (DISTARPT PIRE 0 0 600, 470 9 0 0 0 0090 (DISTARPT PIRE 0 0 600, 470 9 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			_144	2 744 815		
9.00 0.9000 BUSERCEPING 0 0.00,470 9.00 11.00 0.1000 DEFAINY 1.20,807 729,790 10.00 11.00 0.1000 DEFAINY 1.50,907 2.48,723 11.00 13.00 13.00 13.00 MIRSTING ADMINISTRATION 0 13.00 13.00 13.00 MIRSTING ADMINISTRATION 1 13.00 13.00 13.00 MIRSTING ADMINISTRATION 1 13.00 15.00 0.1000 MIRSTING ADMINISTRATION 1 13.00 15.00 0.1000 MIRSTING ADMINISTRATION 1 13.00 17.00 0.1000 MIRSTING ADMINISTRATION 1 13.00 17.00 0.1000 MIRSTING ADMINISTRATION 1 15.00 17.00 0.1000 MIRSTING ADMINISTRATION 1 1 1 1 17.00 0.1000 MIRSTING ADMINISTRATION 1 1 1 1 1 17.00 0.1000 MIRSTING ADMINISTRATION 1 1 1 1 1 1 17.00 0.1000 MIRSTING ADMINISTRATION 1 1 1 1 1 1 1 1 17.00 0.1000 MIRSTING ADMINISTRATION 1 1 1 1 1 1 1 1 1			1	1	l I	1
10.00 1000 DIETARY -120, 807 729, 790 10.00 13.0				l		
13.00 1300 MURSING ADMINISTRATION 0 814,842 13.00 15.00	10.00	01000 DI ETARY	-120, 807	l		10. 00
14. 0.0 1400 (CENTRAL SERVICES & SUPPLY 0 439, 363 15.0 0 1500 (1400) (PRIMARY 7.7.20 7.8.6) 0.33 15.0 0 1500 (PRIMARY 1.7.20 7.8.6) 0.33 15.0 0 1500 (PRIMARY 1.7.20 7.8.6) 0.33 15.0 0 1500 (PRIMARY 1.7.20 7.8.6) 0.34 17.5 17.0 0 18.0 0 18.	11.00	01100 CAFETERI A	-5, 932	248, 723	3	11. 00
15.00 01500 PHARMARCY 0 493, 963 11.0 00 01700			1	l		
10.00 01.000 MEDICAL RECORDS & LIBRARY -7, 290 7.68, 033 11.0 0.0 0346, 715 17.0 01.700 01.700 01.000 01.000 01.850 01.1 0.0 01.000						
17.00 0 1700 SOCIAL SERVICE (SPECIFY) 0 0 18.00 0 19.00 10 19.00			-	l		1
18. DO 01800 OTHER CEMERAL SERVICE (SPECIFY) DO DO 19.			1	l		1
19. 00 01900 NON-PHYSIC ICAN AMESTHERT ISTS 0 0 0 22. 00 22			1	1	l I	
20.00 02000 MURSING SCHOOL 0 0 0 0 22.00 0 22.00 02200 18R SERVICES-SALARY & FRINGES APPRVD 0 0 0 0 22.00 02200 18R SERVICES-OTHER PROM COSTS APPRVD 0 0 0 23.00 02200 18R SERVICES-OTHER PROM COSTS APPRVD 0 0 0 23.00 02200 18R SERVICES-OTHER PROM COSTS APPRVD 0 0 0 0 0 0 0 0 0			1			
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30.00	23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		23. 00
31.00 03100 INTERSIVE CARE UNIT			,			
32.00 03200 03200 03200 03200 03200 03200 03200 0330						
33.00 03300 BURN INTENSIVE CARE UNIT					l I	1
34. 00 03400 SURRICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0						1
40.00 0.4000 0.			0	0		1
11.00			0			
42 00 04200 SUBPROVIDER			0	0		
43. 00 04300 NURSERY			0	Ö		
45. 00 46			0	o		1
46. 00	44.00	04400 SKILLED NURSING FACILITY	0	303, 621		44. 00
ANCILLARY SERVICE COST CENTERS	45. 00	04500 NURSING FACILITY		1		45. 00
50.00	46. 00		0	0		46. 00
51.00 05100 RECOVERY ROOM 51.00 52.0	FO 00		15.000	1 547 201		F0 00
52.00 05200 DELI IVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0			1	1	l I	
53.00 05300 ANESTHESI OLOGY -119, 583 138, 886 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 1,002, 219 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 0 0			0	0		
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 1,002,219 55. 00 55. 0			-119 583	138 886		1
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 55. 00 56. 00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 57. 00 05700 CT SCAN 0 0 0 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 60. 00 06000 LABORATORY -181, 333 1,774,891 60. 00 60. 01 06001 BLOOD LABORATORY 0 0 0 61. 00 06200 BLOOD LABORATORY 0 0 0 0 61. 00 06200 BLOOD LABORATORY 0 0 0 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 64. 00 06400 NIPARENOUS THERAPY 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 67. 00 0700 CULPATI IONAL THERAPY 0 0 0 0 68. 00 06900 ELECTROCARDI OLOGY 0 </td <td></td> <td>l l</td> <td>1</td> <td></td> <td></td> <td>1</td>		l l	1			1
56. 00 05600 RADI OI SOTOPE 0 0 55. 00 57. 00 57. 00 57. 00 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 59. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 59. 00 0 0 59. 00 60. 00 61. 00 60. 00 61. 00 62. 00 62. 00 62. 00 62. 00 62. 00 62. 00 63. 00 63. 00 64. 00 64. 00 64. 00 65. 00 66. 00 65. 00 66. 00 65. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 <td></td> <td></td> <td>1</td> <td></td> <td>l I</td> <td></td>			1		l I	
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 59.00 59.00 59.00 59.00 59.00 60.00 59.00 60			0	0		56. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 59. 00 60. 00 06000 LABORATORY -181, 333 1, 774, 891 60. 00 60. 01 06001 BLOOD LABORATORY 0 0 60. 01 61. 00 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY 0 0 61. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 63. 00 06300 BLOOD STORI NG, PROCESSING & TRANS. 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 678, 783 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 239, 319 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 68. 00 69. 00 0ELECTROCARDI OLOGY -52, 900 288, 989 69. 00 70. 00 0TOOD ELECTROCARDI PALLOGRAPHY 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 240, 927 72. 00 <td>57. 00</td> <td>05700 CT SCAN</td> <td>0</td> <td>0</td> <td></td> <td>57. 00</td>	57. 00	05700 CT SCAN	0	0		57. 00
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60. 01 06001 BLOOD LABORATORY 0 0 0 0 61.00 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 0 0 0 62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 63.00 06300 BLOOD STORING, PROCESSI NG & TRANS. 0 0 0 0 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 65.00 06500 RESPI RATORY THERAPY 0 0 678, 783 65.00 06500 RESPI RATORY THERAPY 0 0 239, 319 66.00 06700 OCCUPATI ONAL THERAPY 0 0 239, 319 66.00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0		
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69. 00 06900 ELECTROCARDI OLOGY -52, 900 288, 989 69. 00 70. 00 70. 00 71. 00 70. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 72. 00			0	0)	1
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0			0	0		
71. 00			-52, 900	288, 989		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 240, 927 72. 00 73. 00 7300 DRUGS CHARGED TO PATIENTS 0 2, 103, 500 73. 00 74. 00 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0			0	0 210 221		
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 2, 103, 500 73. 00 74. 00 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0				l		1
74. 00			1	l		1
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0						1
SERVICE COST CENTERS			1	l	l I	1
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 90. 00 09000 CLINIC 0 0 0 90. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00				•	1
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 90. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0	88. 00		0	0		88. 00
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	90. 01	09001 PARTIAL HOSPITALIZATION	0	847, 079)	90.01

Heal th FinancialSystemsMETHODIST HORECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140197

Period: Worksheet A From 10/01/2011 To 09/30/2012 Date/Time Prepared:

Adj ustments See A-8 For Al location See A-8				То	09/30/2012	Date/Time Prepar 2/27/2013 1:01 p	
See A - B) For All Ocation 6.00 7.00	Cost Center Description	Adiustments	Net Expenses			272772013 1.01 p	JIII
91.00 09100 EMERGENCY -827, 217 1, 370, 979 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) -827, 217 1, 370, 979 92.00 94.00 09400 HOME PROGRAM DIA LYSIS 0 0 0 94.00 95.00 09500 AMBULANCE SERVI CES 0 0 0 0 95.00 97.00 09700 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 97.00 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 98.00 99.00 099700 CHMC 0 0 0 99.00 99.00 099900 CHMC 0 0 0 0 99.00 99.00 099910 CORF 0 0 0 0 0 99.00 099910 CORF 0 0 0 0 0 99.10 099910 CORF 0 0 0 0 0 99.10 099910 CORF 0 0 0 0 0 100.00 10000 IAR SERVI CES-NOT APPRVD PRGM 0 0 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 105.00 105600 KIDNEY ACQUISITION 0 0 0 105.00 105600 KIDNEY ACQUISITION 0 0 0 106.00 105600 KIDNEY ACQUISITION 0 0 0 107.00 10700 LIVER ACQUISITION 0 0 0 108.00 10800 LUNG ACQUISITION 0 0 0 109.00 10900 PANCREAS ACQUISITION 0 0 0 101.00 11100 INTESTINAL ACQUISITION 0 0 0 101.00 11000 INTESTINAL ACQUISITION 0 0		,					
92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0 0THER REI MBURSABLE COST CENTERS 94. 00 0 0 0 0 0 0 0 0 0			7.00				
OTHER REI MBURSABLE COST CENTERS	91. 00 09100 EMERGENCY	-827, 217	1, 370, 979			91	1. 00
94. 00 95. 00 950 00 950 00 950 00 950 00 950 00 960 00 960 00 960 00 97	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					92	2.00
95. 00 09500 MBBULANCE SERVI CES 0 0 0 96. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 98. 00 09500 DTHER REI MBURSABLE COST CENTERS 0 0 0 99. 00 09900 CMHC 0 0 0 99. 10 09910 CMF 0 0 0 99. 10 09910 CORF 0 0 0 101. 00 10100 I AR SERVI CES-NOT APPRVD PRGM 0 0 0 101. 00 10100 I AR SERVI CES-NOT APPRVD PRGM 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 107. 00 10500 KI DNEY ACQUISI TI ON 0 0 0 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 110. 00 11000 I TRESTI NAL ACQUI SI TI ON 0 0 0 111. 00 11100 I TRESTI NAL ACQUI SI TI ON 0 0 0 113. 00 11300 I TRESTI NAL ACQUI SI TI ON 0 0 0 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 0 0 0 115. 00 10500 MBULATORY SURGI CAL CENTER (D. P.) 0 0 116. 00 11600 HOSPI CE 0 0 0 118. 00 SUBTOTALS (SUM OF LI NES 1-117) -1, 106, 177 37, 669, 781 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 191. 00 19100 RESERBACH 0 0 0 192. 00 19200 PHYSI CI ANS* PRI NATE OFFI CES 0 0 193. 00 19300 NONPAID WORKERS -286, 668 -286, 668 -286, 668 193. 01	OTHER REIMBURSABLE COST CENTERS						
96. 00 99.00 09000 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 97. 00 97. 00 97. 00 99. 00 09900 OURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 99. 00 99. 00 09900 CMHC 0 0 0 0 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 100. 00	94.00 09400 HOME PROGRAM DIALYSIS	0	0			94	4.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 98. 00 09950 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 99. 00 99. 00 09900 CMHC 0 0 0 0 0 0 99. 00 99. 00 09910 CORF 0 0 0 0 0 0 99. 10 100. 00 10000 18R SERVI CES-NOT APPRVD PRGM 0 0 0 0 101. 00 10100 HORE HEALTH AGENCY 0 0 0 0 101. 00 10100 HORE HEALTH AGENCY 0 0 0 0 101. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 107. 00 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 107. 00 10800 LUNG ACQUI SI TI ON 0 0 0 109. 00 109. 00 10900 PAUREAS ACQUI SI TI ON 0 0 0 0 109. 00 109. 00 101. 00 INTESTI NAL ACQUI SI TI ON 0 0 0 0 101. 00 111. 00 INTESTI NAL ACQUI SI TI ON 0 0 0 0 111. 00 113. 00 11300 INTEREST EXPENSE 0 0 0 0 114. 00 114. 00 114. 00 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 115. 00 115. 00 10900 PAURESABLE COST CENTERS 0 0 0 0 115. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 11900 GEFSARCH 0 0 0 0 119. 00 19100 GEFSARCH 0 0 0 1910 0 19100 GEFSARCH 0 0 0 1910 0 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 286, 668 193. 01	95. 00 09500 AMBULANCE SERVICES	0	0			95	5.00
98. 00 05950 OTHER REIMBURSABLE COST CENTERS 0 0 0 99. 00 99. 00 09900 CMHC 0 0 0 0 99. 00 99. 10 09910 CORF 0 0 0 0 100. 00 100.00 L&R SERVI CES-NOT APPRVD PRGM 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 0 0 107. 00 10700 LIVER ACQUISITION 0 0 0 108. 00 10800 LING ACQUISITION 0 0 0 109. 00 10900 PANCREAS ACQUISITION 0 0 0 109. 00 10900 PANCREAS ACQUISITION 0 0 0 110. 00 11000 INTESTI NAL ACQUISITION 0 0 0 111. 00 11300 INTESTI NAL ACQUISITION 0 0 0 111. 00 11100 ISLET ACQUISITION 0 0 0 111. 00 11100 INTESTI NAL ACQUISITION 0 0 0 111. 00 11400 UTILIZATION REVIEW-SNF 0 0 0 115. 00 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 0 0 116. 00 11600 HOSPI CE 0 0 0 117. 00 19100 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 119. 00 19100 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 193. 00 19300 NONPAID WORKERS 0 0 286, 668 193. 01	96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0			96	6.00
99. 00 09900 CMHC 0 0 0 0 99. 00 99. 10 09910 CORF 0 0 0 0 0 0 100. 00 100. 00 101. 00 105. 00 107. 00 100. 00 107. 00	97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0			97	7.00
99. 10	98.00 05950 OTHER REIMBURSABLE COST CENTERS	0	0			98	8.00
100. 00 10000 1&R SERVICES-NOT APPRVD PRGM 0 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 101.00 HOME HEALTH AGENCY 0 0 0 101.00 101.00 105.00 105.00 105.00 105.00 105.00 105.00 105.00 105.00 105.00 105.00 105.00 105.00 105.00 105.00 105.00 105.00 105.00 106.00 106.00 107.00 1	99. 00 09900 CMHC	0	0			99	9. 00
101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 0 0 0	99. 10 09910 CORF	0	0			99	9. 10
SPECI AL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 105. 00 106. 00 106.00 106.00 106.00 106.00 106.00 106.00 107.00 10700 LI VER ACQUI SI TI ON 0 0 0 107.00 107.00 107.00 LI VER ACQUI SI TI ON 0 0 0 107.00 108.00 LING ACQUI SI TI ON 0 0 0 108.00 108.00 109.0	100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0			100	0.00
105. 00 105.00 105.00 106. 00 10600 HEART ACQUI SITION 0 0 0 0 107.00 10700 LI VER ACQUI SITION 0 0 0 0 108. 00 10800 LUNG ACQUI SITION 0 0 0 0 109. 00 109. 00 109. 00 109. 00 110. 00 110. 00 110. 00 111. 00 111. 00 111. 00 111. 00 113. 00 113. 00 113. 00 113. 00 114. 00 114. 00 114. 00 115. 00 115. 00 115. 00 115. 00 115. 00 116. 00 117. 00 117. 00 118. 00 119. 00 119. 00 119. 00 110. 0	101.00 10100 HOME HEALTH AGENCY	0	0			101	1.00
106. 00 10600 HEART ACQUI SI TI ON 0 0 0 107. 00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 108.00 10800 LUNG ACQUI SI TI ON 0 0 0 108.00 10800 LUNG ACQUI SI TI ON 0 109.00 109.00 PANCREAS ACQUI SI TI ON 0 0 0 109.00 110.00 11000 INTESTI NAL ACQUI SI TI ON 0 0 0 111. 00 11100 I SLET ACQUI SI TI ON 0 0 0 111. 00 11100 I SLET ACQUI SI TI ON 0 0 0 111. 00 11100 I SLET ACQUI SI TI ON 0 0 0 111. 00 113.00 113.00 INTEREST EXPENSE 0 0 0 0 113.00 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 0 0 0 115.00 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 116.00 HOSPI CE 0 0 0 116.00 HOSPI CE 0 0 0 116.00 HOSPI CE 0 0 0 116.00 SUBTOTALS (SUM OF LI NES 1-117) -1, 106, 177 37, 669, 781 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 191.00 19100 RESEARCH 0 0 0 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 193.00 19300 NONPAI D WORKERS 0 286, 668 193.01 193.01 19301 MARKETI NG -286, 668 -286, 668 193.01							
107. 00 10700 10700 LI VER ACQUI SI TI ON 0 0 0 107. 00 108. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 0 109. 00 109. 00 109. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 111. 00 110. 01 110. 0	105.00 10500 KIDNEY ACQUISITION	0	0			105	5.00
108. 00 10800 LUNG ACQUISITION 0 0 0 109. 00 10900 PANCREAS ACQUISITION 0 0 0 109. 00 110. 00 110. 00 110. 00 110. 00 111. 00 11	106.00 10600 HEART ACQUISITION	0	0			106	6.00
109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 111. 00	107.00 10700 LIVER ACQUISITION	0	0				
110. 00 111. 0	108.00 10800 LUNG ACQUISITION	0	0			108	8.00
111. 00 113. 00 113. 00 113. 00 113. 00 114. 00 114. 00 114. 00 114. 00 115. 00 115. 00 115. 00 115. 00 115. 00 116. 00 116. 00 116. 00 116. 00 117. 00 118. 00 118. 00 NONREI MBURSABLE COST CENTERS 100 100 100 100 100 100 100 100 100 1	109.00 10900 PANCREAS ACQUISITION	0	0			109	9. 00
113. 00	110.00 11000 INTESTINAL ACQUISITION	0	0			110	0. 00
114. 00 115. 00 115. 00 115. 00 115. 00 115. 00 116. 00 116. 00 116. 00 116. 00 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 191. 00 192. 00 192. 00 193. 00 193. 00 19300 NONPAI D WORKERS 193. 01 193. 01 193. 01 193. 01 193. 01 193. 01 193. 01 194. 00 0 0 0 0 0 114. 00 0 0 0 115. 00 0 0 116. 00 0 116. 00 0 118. 00 0 0 0 119. 00 190. 00 190. 00 190. 00 191. 00 192. 00 193. 00 193. 01 193. 01 193. 01	111.00 11100 ISLET ACQUISITION	0	0			111	1.00
115. 00	113.00 11300 INTEREST EXPENSE	0	0			113	3.00
116. 00 118. 00 118. 00 118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 191. 00 191. 00 191. 00 191. 00 192. 00 192. 00 192. 00 193. 00 193. 00 193. 01 193. 01 193. 01 193. 01 193. 01 193. 01		0	0			l l	
118. 00 SUBTOTALS (SUM OF LINES 1-117) -1, 106, 177 37, 669, 781 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 19100 RESEARCH 0 0 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 192. 00 19300 NONPAI D WORKERS 0 286, 668 193. 01 19301 MARKETI NG -286, 668 -286, 668 193. 01		0	0				
NONRE MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0				
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 191. 00 19100 RESEARCH 0 0 0 192. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 193. 00 19300 NONPAI D WORKERS 0 286, 668 193. 00 193. 01 19301 MARKETI NG -286, 668 193. 01		-1, 106, 177	37, 669, 781			118	8. 00
191. 00 19100 RESEARCH							
192. 00 19200 19200 19200 1930		0	0				
193. 00 19300 NONPAI D WORKERS 0 286, 668 193. 01 19301 MARKETI NG -286, 668 193. 01		0	0				
193. 01 19301 MARKETI NG -286, 668 -286, 668 193. 01		0	0				
		0					
200. 00 TOTAL (SUM OF LINES 118-199) -1, 392, 845 37, 669, 781 200. 00							
	200.00 TOTAL (SUM OF LINES 118-199)	-1, 392, 845	37, 669, 781			200	0. 00

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 10/01/2011 To 09/30/2012 Date/Time Prepared: 2/27/2013 1:01 pm Provider CCN: 140197

					/27/2013 1:01 pm
		Increases			
	Cost Center	Li ne #	Salary	0ther	
	2. 00	3. 00	4. 00	5. 00	
1. 00	A - DRUGS CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	73. 00	0	2, 103, 500	1.00
1.00	TOTALS			2, 103, 500 2, 103, 500	1.00
	B - EMPLOYEE MEALS EXPENSE		<u> </u>	2, 103, 300	
1.00	CAFETERI A	11.00	53, 868	0	1. 00
2.00	CAFETERI A	11.00	0	115, 660	2. 00
	TOTALS		53, 868	115, 660	
	C - INTEREST EXPENSE				
1.00	CAP REL COSTS-MVBLE EQUIP		0	19 <u>1, 2</u> 47	1. 00
	TOTALS		0	191, 247	
	D - ER PHYSICIANS - PRO. AND		400 704		4.00
1.00	EMERGENCY	91.00	498, 794	0	1.00
2.00	TOTALS	91.00		31 <u>3, 960</u> 313, 960	2. 00
	E - PROPERTY INSURANCE EXPENS	E .	490, 794	313, 900	
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	46, 383	1.00
1.00	TOTALS	— — ° -	 	46, 383	1.00
	F - IMPLANTABLE DEVICES EXPEN	SE	-1		
1.00	IMPL. DEV. CHARGED TO	72.00	0	240, 927	1. 00
	PATI ENTS				
	TOTALS		0	240, 927	
	G - DEPRECIATION EXPENSE		. 1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
1. 00	CAP REL COSTS-MVBLE EQUIP		0	614, 431	1.00
	TOTALS H - CHARGEABLE MEDICAL SUPPLI	EC ENDENCE	U	614, 431	
1. 00	MEDICAL SUPPLIES CHARGED TO	71.00	0	391	1.00
1.00	PATIENTS	, 1. 00	٩	371	1.00
2.00	MEDICAL SUPPLIES CHARGED TO	71.00	o	74, 998	2.00
	PATI ENTS			,	
3.00	MEDICAL SUPPLIES CHARGED TO	71.00	O	179	3. 00
	PATI ENTS				
4.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	149, 523	4. 00
г оо	PATIENTS	71 00		2.4	F 00
5. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00	0	36	5. 00
6.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	13, 459	6. 00
0.00	PATI ENTS	71.00		13, 437	0.00
7.00	MEDICAL SUPPLIES CHARGED TO	71. 00	О	15, 810	7. 00
	PATI ENTS				
8.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	2, 267	8. 00
	PATI ENTS	74 00		7.5	
9. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00	0	765	9. 00
10. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	12, 573	10.00
10.00	PATIENTS	71.00	٩	12, 373	10.00
11. 00	MEDICAL SUPPLIES CHARGED TO	71.00	o	126	11. 00
	PATI ENTS				
12.00	MEDICAL SUPPLIES CHARGED TO	71.00	O	672	12.00
	PATI ENTS				
13.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	169	13. 00
14.00	PATIENTS	74 00	م ا	47 412	14 00
14. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00	٩	47, 413	14. 00
	TOTALS — — —	+		318, 381	
	I - CORPORATE EMPLOYEE BENEFI	TS EXPENSE	٥	5.5, 551	
1.00	EMPLOYEE BENEFITS	4.00	0	53, 163	1. 00
2.00	EMPLOYEE BENEFITS	4.00	0	<u>742, 7</u> 60	2. 00
	TOTALS		0	795, 923	
_	J - TELEMETRY/ICU SHARED STAF			-	
1.00	INTENSIVE CARE UNIT	31.00	590, 548	0	1.00
2. 00	INTENSIVE CARE UNIT	31.00	0	3 <u>6, 3</u> 02	2. 00
	TOTALS K - VOLUNTEER MARKETING/PR EX	DENCE	590, 548	36, 302	
1.00	NONPALD WORKERS	193. 00	0	35, 535	1.00
2.00	NONPALD WORKERS	193.00	232, 326	35, 535	2.00
3.00	NONPALD WORKERS	193.00	202, 320	18, 807	3. 00
	TOTALS		232, 326	5 <u>4, 342</u>	5.00
	L - MEDICAL SUPPLIES EXPENSE			· ,	
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	79, 996	1. 00
2.00	CENTRAL SERVICES & SUPPLY	14. 00	0	21, 899	2. 00
3.00	CENTRAL SERVICES & SUPPLY	14. 00	0	162, 432	3. 00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	2, 341	4. 00
5.00	CENTRAL SERVICES & SUPPLY		•	6 <u>9, 802</u>	5. 00
E00 00	TOTALS		1 275 524	336, 470	F00 00
500.00	Grand Total: Increases		1, 375, 536	5, 167, 526	500. 00

Provider CCN: 140197

Peri od: Worksheet A-6 From 10/01/2011 To 09/30/2012 Date/Time Prepared: 2/27/2013 1:01 pm

						2/27/2013	
		Decreases		·			
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8.00	9. 00	10. 00		
	A - DRUGS CHARGED TO PATIENTS	S EXPENSE					
1.00	PHARMACY	15. 00	0	2, 103, 500	o		1.00
	TOTALS		0	2, 103, 500			
	B - EMPLOYEE MEALS EXPENSE						
1.00	DI ETARY	10.00	53, 868	0	0		1. 00
2.00	DI ETARY	10.00	0	11 <u>5, 6</u> 60	0		2. 00
	TOTALS		53, 868	115, 660			
	C - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	191, <u>2</u> 47			1. 00
	TOTALS		0	191, 247			
	D - ER PHYSICIANS - PRO. AND	HOUSE STAFF					
1.00	I&R SERVICES-NOT APPRVD PRGM	100.00	498, 794	0	0		1. 00
2.00	I&R SERVICES-NOT APPRVD PRGM	100.00	0	313, 960	0		2. 00
	TOTALS		498, 794	313, 960			
	E - PROPERTY INSURANCE EXPENS	SE					
1.00	OTHER ADMINISTRATIVE AND	5. 06	0	46, 383	12		1. 00
	GENERAL						
	TOTALS		0	46, 383			
	F - IMPLANTABLE DEVICES EXPEN	VSE					
1.00	OPERATING ROOM	50.00	0	240, 927	0		1.00
	TOTALS		0	240, 927			
	G - DEPRECIATION EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	614, 431	9		1. 00
	TOTALS — — — — —			614, 431			
	H - CHARGEABLE MEDICAL SUPPLI	ES EXPENSE			,		
1.00	NURSING ADMINISTRATION	13.00	0	391	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	o	74, 998	0		2.00
3.00	PHARMACY	15. 00	O	179	o		3.00
4.00	ADULTS & PEDIATRICS	30.00	O	149, 523	o		4.00
5.00	INTENSIVE CARE UNIT	31.00	o	36			5. 00
6.00	SKILLED NURSING FACILITY	44.00	o	13, 459	o		6. 00
7.00	ANESTHESI OLOGY	53.00	o	15, 810			7. 00
8.00	RADI OLOGY-DI AGNOSTI C	54.00	o	2, 267			8. 00
9.00	LABORATORY	60.00	o	765			9. 00
10.00	RESPIRATORY THERAPY	65.00	o	12, 573			10.00
11.00	PHYSI CAL THERAPY	66.00	o	126			11. 00
12.00	ELECTROCARDI OLOGY	69.00	0	672	0		12. 00
13. 00	PARTIAL HOSPITALIZATION	90. 01	o	169	o		13.00
14. 00	EMERGENCY	91.00	Ö	47, 413			14. 00
	TOTALS			318, 381			
	I - CORPORATE EMPLOYEE BENEFI	TS EXPENSE					
1.00	OTHER ADMINISTRATIVE AND	5. 06	0	53, 163	0		1.00
	GENERAL						
2.00	OTHER ADMINISTRATIVE AND	5. 06	O	742, 760	o		2.00
	GENERAL						
	TOTALS		0	795, 923			
	J - TELEMETRY/ICU SHARED STAF	FF EXPENSE					
1.00	ADULTS & PEDIATRICS	30.00	590, 548	0	0		1. 00
2.00	ADULTS & PEDIATRICS	30.00	o	36, 302	o		2.00
	TOTALS		590, 548	36, 302			
	K - VOLUNTEER MARKETING/PR EX	XPENSE					
1.00	NONPATIENT TELEPHONES	5. 01	0	35, 535	0		1. 00
2.00	OTHER ADMINISTRATIVE AND	5. 06	232, 326	0			2.00
	GENERAL						
3.00	OTHER ADMINISTRATIVE AND	5.06	o	18, 807	o		3.00
	GENERAL						
	TOTALS		232, 326	54, 342			
	L - MEDICAL SUPPLIES EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	0	79, 996	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	21, 899	0		2. 00
3.00	ADULTS & PEDIATRICS	30.00	0	162, 432	0		3.00
4.00	SKILLED NURSING FACILITY	44. 00	0	2, 341	0		4.00
	OPERATING ROOM	50.00	O	69, 802	o		5. 00
5.00	or Elitrical Room						1
5.00	TOTALS		0 1, 375, 536	336, 470			

Heal th	Financial Systems	METHODIST HOSPIT	TAL OF CHICAGO		In Lie	eu of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der	F	Period: From 10/01/2011 To 09/30/2012		pared:
				Acqui si ti ons			
		Begi nni ng Bal ances	Purchases	Donati on	Total	Disposals and Retirements	
		1, 00	2.00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		2.00	0.00		0.00	
1.00	Land	1, 253, 638	O		0	231	1.00
2.00	Land Improvements	1, 278, 191	40, 082		40, 082		2.00
3.00	Buildings and Fixtures	24, 667, 524			51, 353		3. 00
4. 00	Building Improvements	21,007,021	01,000		01,000	0	4. 00
5. 00	Fi xed Equipment	10, 380, 843	28, 943		28, 943	71, 854	5. 00
6. 00	Movable Equipment	13, 282, 023	1, 487, 439		1, 487, 439		6.00
7. 00	HIT designated Assets	0	1, 107, 107		1, 107, 107	2,007,070	7. 00
8. 00	Subtotal (sum of lines 1-7)	50, 862, 219	1, 607, 817		1, 607, 817	_	8.00
9. 00	Reconciling Items	0	.,00,,01,		0 ., 55., 5.,	2,707,770	9. 00
10.00	Total (line 8 minus line 9)	50, 862, 219	1, 607, 817		1, 607, 817		
10.00	Tretar (Trile & miliae Trile 7)	00/002/21/		F CAPITAL	1,007,017	2/10//1/0	10.00
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
	·				instructions)	instructions)	
		9. 00	10.00	11. 00	12.00	13. 00	
-	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	ind 2			
1.00	CAP REL COSTS-BLDG & FIXT	1, 523, 478	0)	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0) (0	0	2.00
3.00	Total (sum of lines 1-2)	1, 523, 478	0) (0	0	3. 00
		COMF	PUTATION OF RAT	TI 0S	ALLOCATION OF		
					OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 - col.			
				2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS	_			_	
1.00	CAP REL COSTS-BLDG & FIXT	0	0		1.000000		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0.000000		2.00
3.00	Total (sum of lines 1-2)	0	0) (1. 000000	0	3. 00

Health Financial Systems	METHODIST HOSPITAL OF CHICAGO	In Lieu of Form CMS-2552	-10
RECONCILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 140197	Period: Worksheet A-7 From 10/01/2011 Parts I-III To 09/30/2012 Date/Time Prepare	ed:

					rom 10/01/2011 o 09/30/2012	Parts I-III Date/Time F 2/27/2013	Prepar	
		Endi ng Bal ance	Fully			2/2//2013	1.01	DIII
		Linaring Dar arroo	Depreciated					
			Assets					
		6. 00	7. 00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES						
1.00	Land	1, 253, 407	0					1.00
2.00	Land Improvements	1, 318, 273	0					2.00
3.00	Buildings and Fixtures	24, 718, 877	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	10, 337, 932	0)				5.00
6.00	Movable Equipment	12, 131, 772	0					6.00
7.00	HIT designated Assets	0	0)				7.00
8.00	Subtotal (sum of lines 1-7)	49, 760, 261	0)				8.00
9.00	Reconciling Items	0	0)				9.00
10.00	Total (line 8 minus line 9)	49, 760, 261	0)			1	0.00
		SUMMARY O	F CAPITAL					
	Cost Center Description		Total (1) (sum	ו				
		Capi tal -Relate						
		d Costs (see	through 14)					
		instructions)	45.00	_				
	DART LL DECONCLULATION OF AMOUNTS FROM WORK	14.00	15. 00					
1 00	PART II - RECONCILIATION OF AMOUNTS FROM WORL	KSHEET A, COLUM						1 00
1. 00 2. 00	CAP REL COSTS-BLDG & FLXT CAP REL COSTS-MVBLE EQUIP	0	1, 523, 478 0					1. 00 2. 00
3. 00		0		1				
3.00	Total (sum of lines 1-2)	ALLOCAT	1, 523, 478 FLON OF OTHER (SUMMARY OF			3. 00
		ALLUCAT	IION OF OTHER (CAPITAL	CAPITAL			
	Cost Center Description	Taxes	Other	Total (sum of		Lease		
	oost center bescription		Capi tal -Relate		Depreciation	LCd3C		
			d Costs	through 7)				
		6, 00	7. 00	8.00	9. 00	10.00		
	PART III - RECONCILIATION OF CAPITAL COSTS C					_		
1.00	CAP REL COSTS-BLDG & FLXT	0	0) C	909, 047		0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0) c	614, 431		0	2.00
3.00	Total (sum of lines 1-2)	0	0) c	1, 523, 478		0	3.00
	•			•	. '		•	

Health Financial Systems	METHODIST HOSPI	TAL OF CHICAGO		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Peri od:	Worksheet A-7	
				From 10/01/2011 Fo 09/30/2012		nared.
				10 07/30/2012	2/27/2013 1:0	1 pm
		SL	JMMARY OF CAPI	TAL		
		_				
Cost Center Description		Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
				d Costs (see	through 14)	
				instructions)		
	11.00	12. 00	13. 00	14.00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00 CAP REL COSTS-BLDG & FLXT	0	46, 383	(0	955, 430	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	-88, 556	0	(0	525, 875	2.00
3.00 Total (sum of lines 1-2)	-88, 556	46, 383		o o	1, 481, 305	3. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES Peri od: Worksheet A-8 From 10/01/2011 Date/Time Prepared: 2/27/2013 1:01 pm Provider CCN: 140197

				10 04/30/2012	2/27/2013 1:0	
			<u>'</u>	Expense Classification on		
				To/From Which the Amount is	to be Adjusted	
					,	
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	
		1.00	2. 00	3. 00	4. 00	
1.00	Investment income - CAP REL COSTS-BLDG &		0	CAP REL COSTS-BLDG & FLXT	1.00	1. 00
	FIXT (chapter 2)					
2.00	Investment income - CAP REL COSTS-MVBLE	В	-279, 803	CAP REL COSTS-MVBLE EQUIP	2. 00	2. 00
	EQUIP (chapter 2)		_			
3.00	Investment income - other (chapter 2)		0)	0.00	3. 00
4.00	Trade, quantity, and time discounts (chapter	В	-1, 349	DI ETARY	10.00	4. 00
	8)		=	071150 4011111 070471115 4110		
5. 00	Refunds and rebates of expenses (chapter 8)	В	-/44	OTHER ADMINISTRATIVE AND	5. 06	5. 00
4 00	Dental of provider energy by symplicars		0	GENERAL	0.00	/ 00
6. 00	Rental of provider space by suppliers		U		0.00	6. 00
7. 00	(chapter 8) Tel ephone services (pay stations excluded)	A	E2 212	NONPATIENT TELEPHONES	5. 01	7. 00
7.00	(chapter 21)	A	-52, 213	TELEFTIONES	3.01	7.00
8. 00	Television and radio service (chapter 21)		0		0.00	8. 00
9. 00	Parking lot (chapter 21)		0		0.00	
10. 00	Provi der-based physician adjustment	A-8-2	-1, 326, 433		0.00	10. 00
11. 00	Sale of scrap, waste, etc. (chapter 23)	A-0-2	-1, 320, 433		0.00	11. 00
12. 00	Related organization transactions (chapter	A-8-1	0		0.00	12. 00
12.00	10)	A-0-1	0	1		12.00
13. 00	Laundry and linen service		0		0.00	13. 00
14. 00	Cafeteria-employees and guests	В	-112, 684	DI ETARV	1	14. 00
15. 00	Rental of quarters to employee and others		-112,004	DILIANI	0.00	
16. 00	Sale of medical and surgical supplies to		0		1	16. 00
10.00	other than patients		U	1	0.00	10.00
17. 00	Sale of drugs to other than patients		0		0.00	17. 00
18. 00	Sale of medical records and abstracts	В	-7 290	MEDICAL RECORDS & LIBRARY	1	18. 00
19. 00	Nursing school (tuition, fees, books, etc.)		-7, 290	MEDICAL RECORDS & EIBRARI	0.00	
20. 00	Vending machines	В	E 022	CAFETERI A	11. 00	
21. 00	Income from imposition of interest, finance	D	-0, 932	CAFETERIA	0.00	
21.00	or penal ty charges (chapter 21)		U		0.00	21.00
22. 00	Interest expense on Medicare overpayments		0		0.00	22. 00
22.00	and borrowings to repay Medicare		0		0.00	22.00
	overpayments					
23. 00	Adjustment for respiratory therapy costs in	A-8-3	0	RESPIRATORY THERAPY	65.00	23. 00
	excess of limitation (chapter 14)					
24.00	Adjustment for physical therapy costs in	A-8-3	0	PHYSI CAL THERAPY	66.00	24.00
	excess of limitation (chapter 14)					
25.00	Utilization review - physicians'		0	UTILIZATION REVIEW-SNF	114.00	25.00
	compensation (chapter 21)					
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19. 00	28.00
29.00	Physicians' assistant		0		0.00	
30.00	Adjustment for occupational therapy costs in	A-8-3	0	OCCUPATI ONAL THERAPY	67.00	30.00
	excess of limitation (chapter 14)					
31.00	Adjustment for speech pathology costs in	A-8-3	0	SPEECH PATHOLOGY	68.00	31.00
	excess of limitation (chapter 14)					
32.00	CAH HIT Adjustment for Depreciation and		0		0.00	32.00
	Interest					
33.00	CORPORATE FINANCE BENEFITS	A		EMPLOYEE BENEFITS	4.00	33.00
33. 01	CORPORATE FINANCE EXPENSE	A	656, 500	OTHER ADMINISTRATIVE AND	5. 06	33. 01
				GENERAL		
33. 02	MARKETING WAGES AND OTHER EXPENSES	A		MARKETI NG	193. 01	
33. 03	PASTORAL CARE	A	-1, 040	OTHER ADMINISTRATIVE AND	5. 06	33. 03
00.01	MEAL C. OFFCET. (HOME)		, == -	GENERAL		00.01
33. 04	MEALS OFFSET (HOME)	В		DIETARY	10.00	
33. 05	MAINTENANCE MISC REVENUE	A		OPERATION OF PLANT	7.00	
50. 00	TOTAL (sum of lines 1 thru 49) (Transfer to		-1, 392, 845			50. 00
	Worksheet A, column 6, line 200.)	1		I		

Health Financial Systems	METHODIST HOSPITAL OF CHICAGO	In Lieu of Form CMS-2552-10
ADJUSTMENTS TO EXPENSES	Provider CCN: 140197	Period: Worksheet A-8 From 10/01/2011
		To 09/30/2012 Date/Time Prepared:

			2/27/2013 1: 0	
	Cost Center Description	Wkst. A-7 Ref.		
		5. 00		
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	0		1. 00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	11		2. 00
3.00	Investment income - other (chapter 2)	0		3. 00
4.00	Trade, quantity, and time discounts (chapter 8)	0		4. 00
5.00	Refunds and rebates of expenses (chapter 8)	0		5. 00
6.00	Rental of provider space by suppliers (chapter 8)	O		6. 00
7. 00	Telephone services (pay stations excluded) (chapter 21)	O		7. 00
8. 00	Television and radio service (chapter 21)	0		8. 00
9.00	Parking Lot (chapter 21)	0		9. 00
10.00	Provider-based physician adjustment	0		10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0		11. 00
12. 00	Related organization transactions (chapter 10)	0		12. 00
13.00	Laundry and linen service	0		13. 00
14.00	Cafeteria-employees and guests	0		14. 00
15.00	Rental of quarters to employee and others	0		15. 00
16. 00	Sale of medical and surgical supplies to other than patients	0		16. 00
17.00	Sale of drugs to other than patients	0		17. 00
18. 00	Sale of medical records and abstracts	0		18. 00
19. 00	Nursing school (tuition, fees, books, etc.)	0		19. 00
20.00	Vending machines	0		20. 00
21. 00	Income from imposition of interest, finance or penalty charges (chapter 21)	0		21. 00
22. 00	Interest expense on Medicare overpayments and borrowings to repay Medicare	0		22. 00
23. 00	overpayments Adjustment for respiratory therapy costs in excess of limitation (chapter 14)			23. 00
24. 00	Adjustment for physical therapy costs in excess of limitation (chapter 14)			24. 00
25. 00	Utilization review - physicians'			25. 00
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT	0		26. 00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP	0		27. 00
28. 00	Non-physician Anesthetist			28. 00
29. 00	Physicians' assistant	0		29. 00
30. 00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	1 -1		30. 00
31. 00	Adjustment for speech pathology costs in excess of limitation (chapter 14)			31. 00
32. 00	CAH HIT Adjustment for Depreciation and	O		32. 00
33. 00	CORPORATE FINANCE BENEFITS	0		33. 00
	CORPORATE FINANCE EXPENSE	0		33. 00
	MARKETING WAGES AND OTHER EXPENSES	0		33. 01
33. 02	PASTORAL CARE			33. 02
	MEALS OFFSET (HOME)			33. 04
33. 05	MAINTENANCE MISC REVENUE	0		33. 04
50. 00	TOTAL (sum of lines 1 thru 49) (Transfer to	١		50.00
30.00	Worksheet A, column 6, line 200.)			30.00

Health Financial Systems	METHODIST HOSPI	TAL OF CHICAGO	In Lie	u of Form CMS-2	2552-10
PROVIDER BASED PHYSICIAN ADJUSTMENT		Provi der CCN: 140197	Peri od:	Worksheet A-8	-2
			From 10/01/2011 To 09/30/2012	Date/Time Pre 2/27/2013 1:0	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	
		I denti fi er	Remuneration	Component	
	1.00	2.00	3. 00	4. 00	
1. 00	30.00	ADULTS & PEDIATRICS	112, 400	112, 400	1. 00
2.00	31.00	INTENSIVE CARE UNIT	18, 000	18, 000	2. 00
3.00	50.00	OPERATING ROOM	15, 000	15, 000	3. 00
4. 00	53. 00	ANESTHESI OLOGY	119, 583	119, 583	4.00
5. 00	60.00	LABORATORY	181, 333	181, 333	5. 00
6. 00	69. 00	ELECTROCARDI OLOGY	52, 900	52, 900	6. 00
7. 00	91.00	EMERGENCY	827, 217	827, 217	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
200. 00			1, 326, 433	1, 326, 433	200. 00

Health Financial Systems METHODIST HOSPITAL OF CHICAGO In Lieu of Form CMS-2552-10
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 140197 Period: From 10/01/2011 To 09/30/2012 Date/Time Prepared:

				To			
	Drovi don	RCE Amount	Dhyoi oi on /Droy	Unadinated DCF		I DIII	
	Provi der	RCE AMOUNT		Unadjusted RCE			
	Component		ider Component	Limit	Unadjusted RCE		
			Hours		Li mi t		
	5. 00	6. 00	7.00	8. 00	9. 00		
1.00	0	0	0	0	0	1. 00	
2.00	0	0) C	0	0	2. 00	
3. 00	0	0) C	0	0	3. 00	
4. 00	0	0) C	0	0	4. 00	
5. 00	0	0) C	0	0	5. 00	
6. 00	0	0) c	0	0	6. 00	
7. 00	0	0) C	0	0	7. 00	
8. 00	0	0) C	0	0	8. 00	
9. 00	0	0) C	0	0	9. 00	
10. 00	0	0) C	0	0	10.00	
200. 00	0		c	0	0	200. 00	

Health Financial Systems	METHODIST HOSPI	TAL OF CHICAGO	In Lieu of Form CMS-2552-10			
PROVI DER BASED PHYSI CI AN ADJUSTMENT	Provi der CCN: 140197			Peri od: Worksheet /		-2
				From 10/01/2011 Fo 09/30/2012	Date/Time Prepared: 2/27/2013 1:01 pm	
	Cost of	Provi der	Physician Cos		Adjusted RCE	
	Memberships &		of Malpractic		Li mi t	
	Conti nui ng	Share of col.	Insurance	Share of col.		
	Educati on	12		14		
	12. 00	13. 00	14. 00	15. 00	16. 00	
1. 00	C)		0	0	1.00
2.00	C) (0	0	2. 00
3.00	C) (0	0	3. 00
4.00	C) (0	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				0	0	10.00
200.00				o o	0	200. 00

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT METHODIST HOSPITAL OF CHICAGO In Lieu of Form CMS-2552-10 Period: Worksheet A-8-2
From 10/01/2011
To 09/30/2012 Date/Time Prepared: 2/27/2013 1:01 pm Provider CCN: 140197

			2/2//2013 I:UI pm
	RCE	Adjustment	
	Di sal I owance		
	17. 00	18. 00	
1.00	0	112, 400	1.00
2. 00	0	18, 000	2.00
3. 00	0	15, 000	3.00
4. 00	0	119, 583	3 4.00
5. 00	0	181, 333	5. 00
6. 00	0	52, 900	6. 00
7. 00	0	827, 217	7 7.00
8. 00	o	0	8.00
9. 00	0	0	9.00
10. 00	0	0	10.00
200. 00	0	1, 326, 433	200. 00

In Lieu of Form CMS-2552-10
Worksheet B
Part I
30/2012 Date/Time Prepared:
2/27/2013 1:01 pm Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS METHODIST HOSPITAL OF CHICAGO Provider CCN: 140197 Peri od: From 10/01/2011 To 09/30/2012 CAPITAL RELATED COSTS

			CAPI TAL RE	LATED COSTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	NONPATI ENT	
	·	for Cost			BENEFI TS	TELEPHONES	
		Allocation (from Wkst A					
		col. 7)					
		0	1.00	2.00	4. 00	5. 01	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT	955, 430	955, 430				1. 00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	525, 875		525, 875			2. 00
4.00	00400 EMPLOYEE BENEFITS	2, 555, 280	l e		2, 566, 164		4. 00
5. 01	00510 NONPATI ENT TELEPHONES	301, 771	5, 300		15, 319	323, 505	5. 01
5. 02	00520 DATA PROCESSING	503, 543	1		35, 066		5. 02
5. 03 5. 04	00530 PURCHASING RECEIVING AND STORES 00540 ADMITTING	181, 567 281, 063	11, 486 6, 547	1	31, 088 29, 591	11, 836 5, 918	5. 03 5. 04
5. 05	00550 CASHI ERI NG/ACCOUNTS RECEI VABLE	557, 252			48, 330	19, 726	5. 05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL	5, 793, 530		1	64, 303	57, 204	5. 06
6. 00	00600 MAI NTENANCE & REPAI RS	0	0	0	0	0	6. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	2, 744, 815 251, 584	1	1	166, 729	17, 753 1, 973	7. 00 8. 00
9. 00	00900 HOUSEKEEPING	600, 470			50, 588	3, 945	9.00
10. 00	1	729, 790			94, 377	15, 781	10.00
11. 00	1	248, 723			16, 232	11, 836	11. 00
13.00	1	814, 842			92, 946		
14. 00 15. 00	· ·	135, 726 493, 963			14, 170 58, 414	3, 945 5, 918	
16. 00		768, 033		1	75, 544	17, 753	16. 00
17. 00	01700 SOCIAL SERVICE	346, 715	1		35, 211	9, 863	
18. 00		0	0	0	0	0	18. 00
19. 00		0	0	0	0	0	19.00
20. 00 21. 00		0		0	0	0	20. 00 21. 00
22. 00		0	Ö	Ö	0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	7 075 040		05.004	057 070	24 (22	
30. 00 31. 00		7, 375, 313 626, 923	1	1	857, 970 76, 464	21, 699 3, 945	30. 00 31. 00
32. 00		020, 723	14, 401	1	70, 404	0, 743	32. 00
33. 00	1	0	O	0	0	0	33. 00
34. 00		0	0	0	0	0	34.00
40. 00 41. 00	1	0	0	0	0	0	40. 00 41. 00
41.00	1	0		0	0	0	41.00
43. 00		0	Ö	ő	Ö	0	43. 00
44. 00		303, 621	51, 950	337	34, 132	3, 945	
45. 00		0	0	0	0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	0	<u> </u>	0	U	0	46. 00
50. 00		1, 547, 201	64, 650	57, 557	138, 576	9, 863	50. 00
51.00		0	O	0	0	0	51.00
52. 00		0	0	0	0	0	52.00
53. 00 54. 00		138, 886 1, 002, 219	l e	3, 349 110, 424	9, 834 65, 975	3, 945 21, 699	53. 00 54. 00
55. 00		1,002,219	29, 749	110, 424	05, 975	21, 099	55. 00
56. 00		0	Ö	0	0	0	56. 00
57. 00		0	0	0	0	0	57. 00
58. 00		0	0	0	0	0	58.00
59. 00 60. 00		1, 774, 891	13, 824	5, 931	102, 966	0 19, 726	59. 00 60. 00
60. 01		0	0,021	0, 751	0	0	60. 01
61. 00		0					61. 00
62. 00		0	0	0	0	0	62. 00
63.00	1	0	0	0	0	0	63.00
64. 00 65. 00	1	678, 783	6, 908	9, 044	73, 376	7, 890	64. 00 65. 00
66. 00	1	239, 319	1	1	27, 854	3, 945	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00	1	0	0	0	0	0	68. 00
69.00	1	288, 989	7, 491	7, 264	21, 266	1, 973	69.00
70. 00 71. 00	1	318, 381	l o		0	0	70. 00 71. 00
72. 00	1	240, 927	Ö	o o	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 103, 500	l e	0	0	0	73. 00
74.00		22, 798	i e	0	0	0	74.00
/5.00	07500 ASC (NON-DISTINCT PART)	0	l C	ıl Ol	O	0	75. 00

Health Financial Systems	METHODIST HOSPIT	TAL OF CHICAGO		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 140197	Peri od:	Worksheet B	
				From 10/01/2011	Part I	
				To 09/30/2012		pared:
					2/27/2013 1:0	1 pm
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	NONPATI ENT	
	for Cost			BENEFITS	TELEPHONES	
	Allocation					
	(from Wkst A					
	col. 7)	1. 00	2. 00	4.00	5. 01	
OUTPATIENT SERVICE COST CENTERS	U	1.00	2.00	4. 00	5. 01	
88. 00 08800 RURAL HEALTH CLINIC	0				0	88. 00
	0	0		0	·	00.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	O	0		0	0	89. 00
90. 00 09000 CLI NI C	0	0		0	0	90.00
90. 01 09001 PARTI AL HOSPI TALI ZATI ON	847, 079	8, 951	1, 95	77, 698	0	90. 01
91. 00 09100 EMERGENCY	1, 370, 979	17, 533	7, 96	9 222, 064	17, 753	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						1
94. 00 09400 HOME PROGRAM DIALYSIS	0	0		0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0		0 0	0	95. 00
	0	0	•	0	0	1
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	_	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0	0	97. 00
98.00 05950 OTHER REIMBURSABLE COST CENTERS	0	0		0	0	98. 00
99. 00 09900 CMHC	0	0		0	0	
99. 10 09910 CORF	0	0		0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0		0 0	0	105. 00
106.00 10600 HEART ACQUISITION	О	0		0 0	0	106. 00
107. 00 10700 LIVER ACQUISITION	0	0		0	0	107. 00
108.00 10800 LUNG ACQUISITION	0	0		0		108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0				109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0		110.00
	0	0		0		1
111. 00 11100 SLET ACQUISITION	U	0		0	U	111.00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0	0	115. 00
116. 00 11600 HOSPI CE	0	0		0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	37, 669, 781	953, 625	525, 87	2, 536, 083	323, 505	118. 00
NONREI MBURSABLE COST CENTERS						1
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1, 805		0 0	0	190. 00
191. 00 19100 RESEARCH	0	. 0		0	0	191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	l o	0				192. 00
193. 00 19300 NONPALD WORKERS	286, 668	0				193. 00
193. 01 19301 MARKETI NG	-286, 668	0		0 30, 081		193. 00
200.00 Cross Foot Adjustments	-200,000	U		30,001	U	200. 00
		^			_	1
201.00 Negative Cost Centers	27 //0 704	055 400	F0F 0-	0 5// 1/4		201. 00
202.00 TOTAL (sum lines 118-201)	37, 669, 781	955, 430	525, 87	2, 566, 164	323, 505	1202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

				Т	o 09/30/2012	Date/Time Pre 2/27/2013 1:0	
	Cost Center Description	DATA PROCESSI NG	PURCHASI NG RECEI VI NG AND STORES	ADMI TTI NG	CASHI ERI NG/ACC OUNTS RECEI VABLE	Subtotal) jiii
		5. 02	5. 03	5. 04	5. 05	5A. 05	
	GENERAL SERVI CE COST CENTERS	1					
1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 6. 00 7. 00 8. 00 9. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS 00510 NONPATIENT TELEPHONES 00520 DATA PROCESSING 00530 PURCHASING RECEIVING AND STORES 00540 ADMITTING 00550 CASHIERING/ACCOUNTS RECEIVABLE 00560 OTHER ADMINISTRATIVE AND GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICE (SPECIFY) 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRVD	748, 883 25, 540 74, 797 78, 446 288, 243 0 0 0 0 76, 621 0 39, 223 47, 432 0 0 0 0	264, 031 1, 287 492 1, 673 0 15, 643 0 7, 266 93, 955 646 557 6, 980 800 2, 088 294	400, 003	713, 855 0 0 0 0 0 0 0 0 0 0 0	6, 352, 733 0 3, 096, 119 255, 739 676, 603 1, 003, 328 298, 673 1, 008, 769 190, 482 606, 284 925, 667 402, 903 0 0	18. 00 19. 00 20. 00 21. 00
22. 00 23. 00	02200 1&R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECIFY)	0	0	C	0	0	22. 00 23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS				0	0	23.00
30. 00 31. 00 32. 00 33. 00 34. 00 41. 00 42. 00 43. 00 44. 00 45. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0 0 0 0 0 0 0 0 0	7 0 0 0 0 0 0 0 0 2, 730	9, 261	13, 720 0 0 0 0 0 0 0 0 0 5, 472	8, 981, 044 745, 216 0 0 0 0 0 0 0 405, 881 0	30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00 44. 00 45. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	52, 337	14, 664	45, 984	1, 930, 832	50.00
51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM 05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC 05500 RADIOLOGY-THERAPEUTIC 05500 RADIOLOGY-THERAPEUTIC 05500 CT SCAN 05800 MAGNETIC RESONANCE I MAGING (MRI)	29, 189 0 0 0 29, 189 0 0	0 0 2, 475	2, 129	0 0 9, 723	17, 730, 032 0 0 170, 341 1, 324, 832 0 0	51. 00 52. 00 53. 00
59. 00 60. 00 60. 01 61. 00	05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	89, 392 0	0 40, 098 0	69, 868 69, 868	0 139, 538 0	0 2, 256, 234 0 0	59. 00 60. 00 60. 01 61. 00
62. 00 63. 00 64. 00 65. 00 67. 00 68. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0 0 0 0 0 0 0 0 0 0	0	3, 233 C	5, 548 0 0 20, 407 0 13, 105 4, 362 105, 206	0 0 851, 606 291, 045 0 357, 962 0 339, 903 246, 409 2, 274, 942 23, 389 0	62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00
88. 00 89. 00 90. 00 90. 01	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09001 PARTIAL HOSPITALIZATION	0 0 0 0	0	C C	0 0	0 0 0 935, 906	88. 00 89. 00 90. 00 90. 01

| Period: | Worksheet B | From 10/01/2011 | Part | To 09/30/2012 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 140197

			Т	o 09/30/2012	Date/Time Pre 2/27/2013 1:0	
Cost Center Description	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/ACC	Subtotal	, p
· ·	PROCESSI NG	RECEIVING AND		OUNTS		
		STORES		RECEI VABLE		
	5. 02	5. 03	5. 04	5. 05	5A. 05	
91. 00 09100 EMERGENCY	C	7, 407	10, 291	31, 057	1, 685, 053	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92. 00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	C	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVI CES	C	0	0	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	C	0	0	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	C	0	0	0	0	97. 00
98.00 05950 OTHER REIMBURSABLE COST CENTERS	C	0	0	0	0	98. 00
99. 00 09900 CMHC	C	0	0	0	0	99. 00
99. 10 09910 CORF	C	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	C	0	0	0	0	100. 00
101.00 10100 HOME HEALTH AGENCY	C	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KIDNEY ACQUISITION	C	0	0	0		105. 00
106. 00 10600 HEART ACQUI SI TI ON	C	0	0	0		106. 00
107. 00 10700 LIVER ACQUISITION	C	0	0	0	0	107. 00
108.00 10800 LUNG ACQUISITION	C	0	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	C	0	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	C	0	0	0		110. 00
111.00 11100 I SLET ACQUI SI TI ON	C	0	0	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	C	0	0	0	0	115. 00
116. 00 11600 HOSPI CE	C	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	748, 883	264, 031	400, 003	713, 855	37, 637, 895	118. 00
NONREI MBURSABLE COST CENTERS	_					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0	0	0	· ·	190. 00
191. 00 19100 RESEARCH	C	0	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	C	0	0	0		192. 00
193. 00 19300 NONPALD WORKERS	C	0	0	0	286, 668	1
193. 01 19301 MARKETI NG	C	0	0	0	-256, 587	193. 01
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	C	0	0	0		201. 00
202.00 TOTAL (sum lines 118-201)	748, 883	264, 031	400, 003	713, 855	37, 669, 781	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140197 | Period: From 10/01/201

In Lieu of Form CMS-2552-10

Period:	Worksheet B	
From 10/01/2011	Part	
To 09/30/2012	Date/Time Prepared:	2/27/2013 1:01 pm

					0 09/30/2012	2/27/2013 1:0	
	Cost Center Description	OTHER	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		ADMI NI STRATI VE AND GENERAL	REPAI RS	PLANT	LINEN SERVICE		
		5. 06	6. 00	7. 00	8. 00	9. 00	
4 00	GENERAL SERVI CE COST CENTERS	1		T			1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS						4.00
5. 01	00510 NONPATI ENT TELEPHONES						5. 01
5. 02	00520 DATA PROCESSING						5. 02
5. 03	00530 PURCHASING RECEIVING AND STORES						5. 03
5.04	00540 ADMITTING						5. 04
5.05	00550 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL	6, 352, 733	1				5. 06
6.00	00600 MAI NTENANCE & REPAI RS	0	0				6.00
7.00	00700 OPERATION OF PLANT	622, 952	0	3, 719, 071			7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	51, 456 136, 135	0	12, 028 70, 495		884, 278	8. 00 9. 00
10.00	01000 DI ETARY	201, 874		344, 017	1, 045	25, 513	
11. 00	01100 CAFETERI A	60, 094	0	114, 898	1, 045	1, 713	ı
13. 00	01300 NURSI NG ADMI NI STRATI ON	202, 968	0	20, 077		12, 882	1
14.00	01400 CENTRAL SERVICES & SUPPLY	38, 326	0	154, 645	0	14, 778	14. 00
15.00	01500 PHARMACY	121, 987	0	43, 906	1, 045	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	186, 248	0	77, 368		5, 893	1
17. 00	01700 SOCIAL SERVICE	81, 066	0	55, 166	0	0	17. 00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19. 00 20. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19.00
20.00	02000 NURSI NG SCHOOL 02100 L&R SERVI CES-SALARY & FRI NGES APPRVD	0	0	0	0	0	20.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	0	1 0		0	0	22.00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS						20.00
30.00	03000 ADULTS & PEDIATRICS	1, 807, 015	0	1, 572, 537	195, 481	415, 908	30.00
31.00	03100 INTENSIVE CARE UNIT	149, 940	0	79, 809	18, 596	29, 327	31.00
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32. 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
40.00	04000 SUBPROVI DER – I PF	0	0	0	0	0	40.00
41. 00 42. 00	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER	0	0	0	0	0	41. 00 42. 00
43. 00	04300 NURSERY	0		0	0	0	43.00
44. 00	04400 SKILLED NURSING FACILITY	81, 665	0	286, 319	25, 806	68, 065	
45. 00	04500 NURSING FACILITY	0.7000	Ö	0	0	0	45. 00
46.00	04600 OTHER LONG TERM CARE	0	O	0	0	0	46. 00
	ANCILLARY SERVICE COST CENTERS	Ţ.					
50.00	05000 OPERATI NG ROOM	388, 491	0	356, 316	19, 912	141, 886	
51. 00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	34, 273	0	1/2 0/0	12 504	0	53.00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	266, 561 0		163, 960	12, 586	36, 225 0	
56. 00	05600 RADI OLOGI - MERAPEUTI C	0	1 0		0	0	56.00
57. 00	05700 CT SCAN	0	٥	0	o o	0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	O	o	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60.00	06000 LABORATORY	453, 963	0	76, 192	0	43, 466	1
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	_	_	_		_	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	0	62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY				0	0	63. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	171, 347		38, 073	1, 045	11, 580	65.00
66. 00	06600 PHYSI CAL THERAPY	58, 559	0	56, 070		13, 430	
67. 00	06700 OCCUPATI ONAL THERAPY	0	Ö	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	o	o	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	72, 023	0	41, 284	21, 190	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	68, 390	0	0	0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	49, 578	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	457, 727	0] 0	0	0	73.00
74. 00 75. 00	07400 RENAL DIALYSIS	4, 706	l e		0	0	74. 00 75. 00
73.00	O7500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS		1	ı _l 0	l U	0	/5.00
88. 00	08800 RURAL HEALTH CLINIC	1 0	n	0	n	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	ا م	n o	o o	0	
90. 00	09000 CLI NI C	0	0	Ō	O	0	90.00
90. 01	09001 PARTI AL HOSPI TALI ZATI ON	188, 308	0	49, 333	0	0	90. 01
-		_	_			-	

191. 00 19100 RESEARCH

193. 01 19301 MARKETI NG

200.00

201.00

202.00

193. 00 19300 NONPALD WORKERS

192.00 19200 PHYSICIANS' PRIVATE OFFICES

Cross Foot Adjustments

TOTAL (sum lines 118-201)

Negative Cost Centers

Health Financial Systems METHODIST HOSPITAL OF CHICAGO In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 140197 Peri od: Worksheet B From 10/01/2011 Part I 09/30/2012 Date/Time Prepared: 2/27/2013 1:01 pm Cost Center Description OTHER MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG ADMI NI STRATI VE **REPAI RS** PLANT LINEN SERVICE AND GENERAL 6.00 7.00 8. 00 9.00 5.06 91. 00 09100 EMERGENCY 339, 039 12, 174 58, 244 91 00 96, 630 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 0 000000000 09500 AMBULANCE SERVICES 0 95.00 0 0 0 0 0 0 0 0 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 0 0 97.00 0 05950 OTHER REIMBURSABLE COST CENTERS 98.00 98 00 0 0 0 99. 00 09900 CMHC 0 0 99.00 99. 10 09910 CORF 0 0 0 99. 10 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 100.00 0 ō 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 105. 00 0 0 0 0 0 0 106.00 10600 HEART ACQUISITION 00000 0 0 106. 00 107.00 10700 LIVER ACQUISITION 0 0 107.00 108.00 10800 LUNG ACQUISITION 0 108. 00 109.00 10900 PANCREAS ACQUISITION 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 C 111.00 11100 I SLET ACQUISITION 0 0 0 111.00 113. 00 11300 | INTEREST EXPENSE 113. 00 114.00 11400 UTI LI ZATI ON REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 C 0 0 0 115.00 116. 00 11600 HOSPI CE 0 0 0 116.00 SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS 6, 294, 691 3, 709, 123 319, 223 878, 910 118. 00 118.00 0 5, 368 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 363 0 9,948

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884, 278 202. 00

200.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

	Cost Conton Decement on	DIETADY	CAFETERIA	NURSI NG	CENTRAL	2/27/2013 1: C	
	Cost Center Description	DI ETARY	CAFETERI A	ADMI NI STRATI ON	CENTRAL SERVI CES &	PHARMACY	
		10.00	11. 00	13.00	SUPPLY 14. 00	15. 00	
	GENERAL SERVICE COST CENTERS	10.00		10.00		10.00	
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS						4. 00
5. 01	00510 NONPATIENT TELEPHONES						5. 01
5. 02	00520 DATA PROCESSING						5. 02
5. 03 5. 04	00530 PURCHASING RECEIVING AND STORES 00540 ADMITTING						5. 03 5. 04
5. 05	00550 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5. 06	00560 OTHER ADMINISTRATIVE AND GENERAL						5. 06
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9. 00
10. 00 11. 00	01000 DI ETARY	1, 574, 732	477 422				10.00
13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON		476, 423 15, 078				13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	7, 059		420, 074		14. 00
15. 00	01500 PHARMACY	0	10, 555		0	783, 777	15. 00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE		21, 027 10, 886		0	0	16. 00 17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	o	0	Ö	Ö	0	18. 00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19. 00
20. 00 21. 00	02000 NURSI NG SCHOOL 02100 I&R SERVI CES-SALARY & FRI NGES APPRVD	0	0	0	0	0	
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	o	Ö	Ö	Ö	0	
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
30. 00	O3000 ADULTS & PEDIATRICS	1, 468, 497	231, 360	707, 889	128, 695	0	30.00
31. 00	03100 NTENSI VE CARE UNI T	38, 162	9, 925		31	0	31. 00
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT		0	0	0	0	
40. 00	04000 SUBPROVI DER - I PF	0	0	0	O	0	1
41. 00 42. 00	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER	0	0	0	0	0	
43. 00	04300 NURSERY		0	0	0	0	43.00
44. 00	04400 SKILLED NURSING FACILITY	68, 073	0	47, 084	6, 554	0	44. 00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0	0	0 0	0	45. 00 46. 00
	ANCILLARY SERVICE COST CENTERS	31		-1	-		
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	25, 467 0	1	267, 391 0	0	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	1
53.00	05300 ANESTHESI OLOGY	0	994		4, 300	0	53.00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	15, 675 0		3, 895 0	0	
56. 00	05600 RADI OI SOTOPE		0	o o	o	0	
57. 00	05700 CT SCAN	o	0	0	0	0	
58. 00 59. 00	05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	
60.00	06000 LABORATORY	o	32, 493	- 1	909	0	1
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	1
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	61. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	o o	Ö	Ö	ő	0	63. 00
64.00	06400 NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		18, 823 5, 103		886 67	0	
67. 00	06700 OCCUPATI ONAL THERAPY	o	0		0	0	1
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY		5, 99 8	0	0	0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		Ö	Ö	ő	Ö	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	702 777	1
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS		0	0	0	783, 777 0	1
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	O	0	1
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		0	O	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0		0	0	
90.00	09000 CLINIC	0	0 25 104	0	0	0	
90. 01	09001 PARTI AL HOSPI TALI ZATI ON	<u> </u>	25, 186	0	683	0	90. 01

SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS

190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN

Cross Foot Adjustments

TOTAL (sum lines 118-201)

Negative Cost Centers

192.00 19200 PHYSICIANS' PRIVATE OFFICES

118.00

200.00

201.00

202.00

191. 00 19100 RESEARCH

193. 01 19301 MARKETI NG

193. 00 19300 NONPALD WORKERS

Health Financial Systems METHODIST HOSPITAL OF CHICAGO In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 140197 Peri od: Worksheet B From 10/01/2011 Part I 09/30/2012 Date/Time Prepared: 2/27/2013 1:01 pm Cost Center Description DI ETARY CAFETERI A NURSI NG CENTRAL **PHARMACY** ADMI NI STRATI ON SERVICES & **SUPPLY** 10.00 11.00 13.00 15.00 14.00 91. 00 09100 EMERGENCY 40, 794 173, 041 91 00 6,663 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 0 0 09500 AMBULANCE SERVICES 95.00 00000000 0 0 0 0 0 0 0 0 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 0 0 97.00 0 05950 OTHER REIMBURSABLE COST CENTERS 98.00 98 00 0 0 0 99.00 09900 CMHC 0 0 99.00 99. 10 09910 CORF 0 0 0 99. 10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 100.00 0 ō 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 105. 00 0 0 0 0 0 0 106.00 10600 HEART ACQUISITION 00000 0 0 106. 00 107.00 10700 LIVER ACQUISITION 0 0 107.00 108.00 10800 LUNG ACQUISITION 0 108. 00 109.00 10900 PANCREAS ACQUISITION 0 0 109.00 0 110.00 11000 INTESTINAL ACQUISITION C 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 111.00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTI LI ZATI ON REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 115.00 116. 00 11600 HOSPI CE 0 0 116.00

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| Peri od: | Worksheet B | From 10/01/2011 | Part | | To 09/30/2012 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 140197

				Ť	o 09/30/2012	Date/Time Pre 2/27/2013 1:0	
				OTHER GENERAL			
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	SERVI CE (SPECI FY)	NONPHYSI CI AN	NURSING SCHOOL	
	·	RECORDS &			ANESTHETI STS		
		16. 00	17. 00	18. 00	19. 00	20. 00	
	GENERAL SERVICE COST CENTERS		1				
1. 00 2. 00	OO100 CAP REL COSTS-BLDG & FIXT OO200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
2.00 4.00	00400 EMPLOYEE BENEFITS						4.00
5. 01	00510 NONPATI ENT TELEPHONES						5. 01
5.02	00520 DATA PROCESSING						5. 02
5. 03 5. 04	OO530 PURCHASING RECEIVING AND STORES OO540 ADMITTING						5. 03 5. 04
5. 05	00550 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL						5. 06
6. 00 7. 00	OO6OO MAINTENANCE & REPAIRS OO7OO OPERATION OF PLANT						6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON						11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
	01500 PHARMACY	1 240 420					15. 00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	1, 249, 420					16. 00 17. 00
	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	0			18. 00
	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	C		19.00
20. 00 21. 00	02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0		0	20. 00 21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	0	Ö	Ö	C		1
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	C	0	23. 00
30. 00	O3000 ADULTS & PEDIATRICS	399, 005	513, 605	0	C	0	30.00
31. 00	03100 INTENSIVE CARE UNIT	24, 015		Ō	C	1	31. 00
32. 00 33. 00	03200 CORONARY CARE UNIT	0	0	0	C	0	32. 00 33. 00
34. 00	03400 SURGI CAL INTENSIVE CARE UNIT		0	0	C	0	34. 00
40. 00	04000 SUBPROVI DER - I PF	0	0	0	C	0	40. 00
41. 00 42. 00	04100 SUBPROVI DER	0	0	0	C	0	41. 00 42. 00
43. 00	04300 NURSERY	0	ő	o o	C	Ö	1
44. 00	04400 SKILLED NURSING FACILITY	9, 578	20, 404		C	0	
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE		0	0	C	1	45. 00 46. 00
10.00	ANCILLARY SERVICE COST CENTERS						10.00
50.00	05000 OPERATI NG ROOM	80, 486			C	1	
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	0			C	_	
	05300 ANESTHESI OLOGY	17, 018	1	Ö	C	Ö	1
	05400 RADI OLOGY - DI AGNOSTI C	80, 875	0	0	C	0	
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0	0		0	55. 00 56. 00
57. 00	05700 CT SCAN	Ö	Ö	Ö	C	ő	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	C	0	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	244, 231	0	0	C	0	59. 00 60. 00
60. 01	06001 BLOOD LABORATORY	244, 231	Ö	Ö	C	ő	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	C	0	62. 00 63. 00
64. 00	06400 I NTRAVENOUS THERAPY		0	0	C	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	79, 079	0	0	C	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	9, 710	0	0	C	0	66.00
67. 00 68. 00	O6700 OCCUPATIONAL THERAPY O6800 SPEECH PATHOLOGY		0) o	C	0	67. 00 68. 00
	06900 ELECTROCARDI OLOGY	35, 719	Ö	Ö	C	ő	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	C	0	70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	22, 938 7, 634	0	0		0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	184, 139	0	0	C	0	73. 00
74. 00	07400 RENAL DIALYSIS	635	0	0	C	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	0	0	0	C	0	75. 00
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	C	0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	С	0	89. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 10/01/2011 | Part | To 09/30/2012 | Date/Time Prepared: 2/27/2013 1:01 pm Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS METHODIST HOSPITAL OF CHICAGO Provider CCN: 140197

					2/2//2013 1.0	ı pili
			OTHER GENERAL			
			SERVI CE			
Cost Center Description		SOCIAL SERVICE	(SPECI FY)		NURSING SCHOOL	
	RECORDS &			ANESTHETI STS		
	LI BRARY 16. 00	17. 00	18. 00	19. 00	20.00	
90. 00 09000 CLI NI C	10.00	17.00		19.00		90. 00
90. 01 09001 PARTI AL HOSPI TALI ZATI ON	0	0	0	0		90.00
91. 00 09100 EMERGENCY	54, 358	0	0	0		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	34, 330		J	0	١	92.00
OTHER REIMBURSABLE COST CENTERS						72.00
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	ň	0		95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	o o	0		96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	o o	0		97. 00
98. 00 05950 OTHER REIMBURSABLE COST CENTERS	0	0	o o	0	Ö	98. 00
99. 00 09900 CMHC	0	0	o o	0		99. 00
99. 10 09910 CORF	0	0	o o	0		99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	o o	o o	0	ا ا	100.00
101.00 10100 HOME HEALTH AGENCY	0	o o	o o	0		101. 00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105. 00
106.00 10600 HEART ACQUI SI TI ON	0	0	0	0	0	106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0		111. 00
113.00 11300 INTEREST EXPENSE					l I	113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115. 00
116. 00 11600 H0SPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1, 249, 420	550, 021	0	0	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	•	190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
193. 01 19301 MARKETI NG	0	0	0	0		193. 01
200.00 Cross Foot Adjustments	_		_	0		200. 00
201.00 Negative Cost Centers	1 240 422	550 001	0	0		201. 00
202.00 TOTAL (sum lines 118-201)	1, 249, 420	550, 021	0	0	0	202. 00

Health Financial Systems METHODIST HOSPITAL OF CHICAGO In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 140197 Peri od: Worksheet B From 10/01/2011 Part I 09/30/2012 Date/Time Prepared: 2/27/2013 1:01 pm INTERNS & RESIDENTS SERVI CES-SALAR SERVI CES-OTHER PARAMED ED Subtotal Intern & Cost Center Description Residents Cost Y & FRINGES PRGM COSTS PRGM & Post Stepdown Adjustments 21. 00 22.00 23. 00 24. 00 25. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS 4.00 00510 NONPATIENT TELEPHONES 5 01 5 01 5.02 00520 DATA PROCESSING 5.02 5.03 00530 PURCHASING RECEIVING AND STORES 5.03 5.04 00540 ADMITTING 5.04 00550 CASHI ERI NG/ACCOUNTS RECEI VABLE 5 05 5 05 5.06 00560 OTHER ADMINISTRATIVE AND GENERAL 5.06 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11.00 11.00 13 00 01300 NURSING ADMINISTRATION 13 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 140197 Peri od: Worksheet B From 10/01/2011 Part I 09/30/2012 Date/Time Prepared: 2/27/2013 1:01 pm INTERNS & RESIDENTS SERVI CES-SALAR SERVI CES-OTHER PARAMED ED Cost Center Description Subtotal Intern & Residents Cost Y & FRINGES PRGM COSTS PRGM & Post Stepdown Adjustments 21. 00 22.00 23.00 24. 00 25. 00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88 00 88 00 0 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89.00 90.00 09000 CLI NI C 0 0 0 0 0 90.00 09001 PARTIAL HOSPITALIZATION 0 0 1, 199, 416 90. 01 90 01 0 09100 EMERGENCY 0 91.00 91.00 C 2, 465, 996 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 0 94.00 000000 0 0 95.00 09500 AMBULANCE SERVICES 0 0 0 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 96.00 0 0 0 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 0 98.00 05950 OTHER REIMBURSABLE COST CENTERS 0 98.00 0 0 99.00 09900 CMHC 0 0 0 99.00 99. 10 09910 CORF 99. 10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 0 0 0 105. 00 0 106. 00 10600 HEART ACQUISITION 0 0 106.00 00000 0 107.00 10700 LIVER ACQUISITION 0 0 107. 00 108.00 10800 LUNG ACQUISITION 0 0 0 0 108. 00 109.00 10900 PANCREAS ACQUISITION 0 0 109.00 0 110.00 110.00 11000 INTESTINAL ACQUISITION 0 0 111.00 11100 I SLET ACQUISITION 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 0 115.00 116. 00 11600 HOSPI CE 0 0 116.00 SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS 0 0 118.00 118.00 0 37, 564, 537 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 17, 484 191. 00 19100 RESEARCH 0 0 0 191.00 0 0 0 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 193. 00 19300 NONPALD WORKERS 0 0 0 193. 00 344, 347 193. 01 19301 MARKETI NG 0 -256, 587 0 193. 01 200.00 Cross Foot Adjustments 0 0 200.00 0 201.00 Negative Cost Centers 0 0 201.00

0

37, 669, 781

0 202. 00

202.00

TOTAL (sum lines 118-201)

Provider CCN: 140197

		Coot Conton Docarintian	Total	2/21/2013 1.0	Гріп
		Cost Center Description	Total		
	I		26. 00		
		AL SERVICE COST CENTERS			
1.00	1	CAP REL COSTS-BLDG & FLXT			1. 00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS			4.00
5. 01	00510	NONPATIENT TELEPHONES			5. 01
5.02	00520	DATA PROCESSING			5. 02
5.03	00530	PURCHASING RECEIVING AND STORES			5. 03
5.04	1	ADMITTING			5. 04
5. 05	1	CASHI ERI NG/ACCOUNTS RECEI VABLE			5. 05
5. 06	1	OTHER ADMINISTRATIVE AND GENERAL			5. 06
6. 00	1	MAINTENANCE & REPAIRS			6. 00
	1	i e			
7.00	1	OPERATION OF PLANT			7. 00
8.00	1	LAUNDRY & LINEN SERVICE			8. 00
9.00		HOUSEKEEPI NG			9. 00
10. 00	1	DIETARY			10. 00
11. 00	01100	CAFETERI A			11. 00
13. 00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)			18.00
19.00		NONPHYSICIAN ANESTHETISTS			19.00
20. 00	1	NURSI NG SCHOOL			20. 00
21. 00		I &R SERVICES-SALARY & FRINGES APPRVD			21. 00
22. 00	1	I&R SERVICES-OTHER PRGM COSTS APPRVD			22. 00
23. 00		PARAMED ED PRGM-(SPECIFY)			23. 00
		IENT ROUTINE SERVICE COST CENTERS	44 404 004		
30. 00		ADULTS & PEDIATRICS	16, 421, 036		30. 00
31. 00		INTENSIVE CARE UNIT	1, 217, 176		31. 00
32. 00	1	CORONARY CARE UNIT	0		32.00
33. 00	03300	BURN INTENSIVE CARE UNIT	0		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		34.00
40.00	04000	SUBPROVIDER - IPF	0		40.00
41.00	04100	SUBPROVIDER - IRF	0		41.00
42.00	04200	SUBPROVI DER	o		42.00
43.00	1	NURSERY	0		43.00
44. 00		SKILLED NURSING FACILITY	1, 019, 429		44. 00
45. 00		NURSING FACILITY	1,017,127		45. 00
46. 00	1	OTHER LONG TERM CARE	o		46. 00
40.00		LARY SERVICE COST CENTERS	O _I		40.00
50. 00		OPERATI NG ROOM	3, 356, 403		50. 00
51.00		RECOVERY ROOM	3, 350, 403		51. 00
	1	i e	0		
52. 00	1	DELIVERY ROOM & LABOR ROOM	040 445		52.00
53. 00		ANESTHESI OLOGY	242, 445		53. 00
54.00		RADI OLOGY-DI AGNOSTI C	1, 915, 171		54.00
55.00		RADI OLOGY-THERAPEUTI C	0		55.00
56.00	05600	RADI OI SOTOPE	0		56.00
57.00	05700	CT SCAN	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		58.00
59.00	05900	CARDI AC CATHETERI ZATI ON	O		59.00
60.00	06000	LABORATORY	3, 110, 208		60.00
60. 01	06001	BLOOD LABORATORY	o		60. 01
61.00	1	PBP CLINICAL LAB SERVICES-PRGM ONLY	0		61.00
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELLS			62. 00
63. 00	1	BLOOD STORING, PROCESSING & TRANS.	0		63. 00
64. 00	1	INTRAVENOUS THERAPY	0		64. 00
65. 00	1	RESPIRATORY THERAPY	1, 175, 632		65. 00
66.00	1	PHYSI CAL THERAPY	443, 282		66. 00
67. 00	1	OCCUPATIONAL THERAPY	0		67. 00
68.00		SPEECH PATHOLOGY	0		68. 00
69. 00	1	ELECTROCARDI OLOGY	534, 176		69. 00
70. 00		ELECTROENCEPHALOGRAPHY	0		70. 00
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	431, 231		71. 00
72. 00	07200	IMPL. DEV. CHARGED TO PATIENTS	303, 621		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3, 700, 585		73.00
74.00	1	RENAL DIALYSIS	28, 730		74.00
75. 00		ASC (NON-DISTINCT PART)	0		75. 00
		TIENT SERVICE COST CENTERS	<u> </u>		
88 00		RURAL HEALTH CLINIC	0		88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	0		89. 00
90.00		CLINIC	0		90.00
90.00		PARTIAL HOSPITALIZATION	1, 199, 416		90. 00
	1	l control of the cont			
91.00	1	EMERGENCY	2, 465, 996		91.00
92. 00	109200	OBSERVATION BEDS (NON-DISTINCT PART)			92. 00

| Peri od: | Worksheet B | From 10/01/2011 | Part | To 09/30/2012 | Date/Time Prepared:

		То	09/30/2012 Date/Ti	me Prepared: 013 1:01 pm
Cost Center Description	Total		2/2//20	713 1.01 pili
oost denter bescription	26, 00			
OTHER REIMBURSABLE COST CENTERS				
94. 00 09400 HOME PROGRAM DIALYSIS	0			94. 00
95. 00 09500 AMBULANCE SERVICES	o			95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0			96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0			97. 00
98.00 05950 OTHER REIMBURSABLE COST CENTERS	o			98. 00
99. 00 09900 CMHC	o			99. 00
99. 10 09910 CORF	0			99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	O			100. 00
101.00 10100 HOME HEALTH AGENCY	0			101. 00
SPECIAL PURPOSE COST CENTERS				
105. 00 10500 KIDNEY ACQUISITION	0			105. 00
106. 00 10600 HEART ACQUI SI TI ON	0			106. 00
107.00 10700 LIVER ACQUISITION	0			107. 00
108.00 10800 LUNG ACQUISITION	0			108. 00
109. 00 10900 PANCREAS ACQUISITION	0			109. 00
110.00 11000 INTESTINAL ACQUISITION	0			110. 00
111.00 11100 ISLET ACQUISITION	0			111. 00
113. 00 11300 I NTEREST EXPENSE				113. 00
114.00 11400 UTILIZATION REVIEW-SNF				114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0			115. 00
116. 00 11600 HOSPI CE	0			116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	37, 564, 537			118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	17, 484			190. 00
191. 00 19100 RESEARCH	0			191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0			192. 00
193.00 19300 NONPALD WORKERS	344, 347			193. 00
193. 01 19301 MARKETI NG	-256, 587			193. 01
200.00 Cross Foot Adjustments	0			200. 00
201.00 Negative Cost Centers	0			201. 00
202.00 TOTAL (sum lines 118-201)	37, 669, 781			202. 00

| Peri od: | Worksheet B | From 10/01/2011 | Part II | To 09/30/2012 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 140197

			Ť	09/30/2012	Date/Time Pre 2/27/2013 1:0	
		CAPI TAL REI	LATED COSTS		2/2//2013 1.0	Грії
Cost Center Description	Directly	BLDG & FLXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFI TS	
	Capital Related Costs					
	0	1. 00	2.00	2A	4. 00	
GENERAL SERVICE COST CENTERS 1. 00 O0100 CAP REL COSTS-BLDG & FLXT			I			1. 00
2. 00 00200 CAP REL COSTS-BEDG & TTXT						2. 00
4.00 00400 EMPLOYEE BENEFITS	0	9, 845			10, 884	4. 00
5. 01 00510 NONPATI ENT TELEPHONES 5. 02 00520 DATA PROCESSI NG	0	5, 300 4, 906			65 149	5. 01 5. 02
5. 03 00530 PURCHASING RECEIVING AND STORES	1, 236	11, 486			132	5. 02
5. 04 00540 ADMI TTI NG	4, 759	6, 547			125	5. 04
5. 05 00550 CASHI ERI NG/ACCOUNTS RECEI VABLE 5. 06 00560 OTHER ADMINI STRATI VE AND GENERAL	0 0	9, 246 114, 771	363 33, 009	•	205 273	5. 05 5. 06
6. 00 00600 MAI NTENANCE & REPAI RS	0	0	33,007	147, 780	0	6. 00
7.00 00700 OPERATION OF PLANT	0	118, 537			707	7. 00
8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG	0	2, 182 12, 791		2, 182 14, 334	0 214	8. 00 9. 00
10. 00 01000 DI ETARY	0	62, 419			400	10.00
11. 00 01100 CAFETERI A	0	20, 847		•	69	11. 00
13.00 O1300 NURSING ADMINISTRATION 14.00 O1400 CENTRAL SERVICES & SUPPLY	0	3, 643 28, 059			394 60	13. 00 14. 00
15. 00 01500 PHARMACY	0	7, 966			248	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	14, 038	779	14, 817	320	16. 00
17. 00 01700 SOCI AL SERVI CE 18. 00 01850 OTHER GENERAL SERVI CE (SPECI FY)	0	10, 009	811	10, 820	149 0	17. 00 18. 00
19. 00 01830 OTHER GENERAL SERVICE (SPECIFY) 19. 00 01900 NONPHYSI CLAN ANESTHETI STS	0			0	0	19. 00
20. 00 02000 NURSI NG SCHOOL	0	0	0	0	0	20.00
21.00 02100 L&R SERVICES-SALARY & FRINGES APPRVD 22.00 02200 L&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	21. 00
22.00 02200 1&R SERVICES-OTHER PRGM COSTS APPRVD 23.00 02300 PARAMED ED PRGM-(SPECIFY)	0		0	_	0	22. 00 23. 00
INPATIENT ROUTINE SERVICE COST CENTERS				_		
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT	0	285, 323 14, 481			3, 640	30. 00 31. 00
32. 00 03200 CORONARY CARE UNIT	0	14, 481	415 0	14, 896	324 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
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	0	0		0	0	40. 00 41. 00
42. 00 04200 SUBPROVI DER	0	Ö	Ö	0	0	42. 00
43. 00 04300 NURSERY	0	0	0	0	0	43.00
44.00 04400 SKILLED NURSING FACILITY 45.00 04500 NURSING FACILITY	0 0	51, 950 0	337	52, 287 0	145 0	44. 00 45. 00
46. 00 04600 OTHER LONG TERM CARE	0	0	Ö	0	0	46. 00
ANCILLARY SERVICE COST CENTERS	100			400 (05		
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM	488	64, 650 0	1		588 0	50. 00 51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	Ö	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	2, 936	0	3, 349		42	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	0	29, 749	110, 424	140, 173	280 0	54. 00 55. 00
56. 00 05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00 05700 CT SCAN	0	0	0	0	0	57. 00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00 59. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	11, 647	13, 824	5, 931	31, 402	437	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0		61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	62. 00 63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	Ö	0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	8, 379	6, 908			311	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	10, 173	1	11, 051	118	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0) 0	0	0	0	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	7, 491	7, 264	14, 755	90	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATTENTS	0	0		0	0	73. 00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75. 00 O7500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	0	0] 0	0	0	75. 00
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
		•				

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 140197 Peri od: Worksheet B From 10/01/2011 Part II Date/Time Prepared: 09/30/2012 2/27/2013 1:01 pm CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Directly BLDG & FIXT MVBLE EQUIP Subtotal Assigned New **BENEFITS** Capi tal Related Costs 0 1.00 2.00 2A 4.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 90. 00 09000 CLINIC 90.00 0 0 0 90. 01 09001 PARTIAL HOSPITALIZATION 8, 951 1, 954 329 90.01 123, 263 134, 168 91.00 09100 EMERGENCY 17, 533 7, 969 25, 502 942 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 95.00 09500 AMBULANCE SERVICES 0 0 0 0 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 00000 0 0 96.00 0 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 97.00 0 98.00 05950 OTHER REIMBURSABLE COST CENTERS 0 0 0 98.00 09900 CMHC 0 99.00 99.00 0 0 0 0 99. 10 09910 CORF 99. 10 Ω 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 0 105.00 105. 00 10500 KI DNEY ACQUI SI TI ON 0 Ω 0 0 106.00 10600 HEART ACQUISITION 0 0 0 0 106.00 0000 107.00 10700 LIVER ACQUISITION 0 0 0 0 107. 00 108.00 10800 LUNG ACQUISITION 0 0 0 108. 00 109.00 10900 PANCREAS ACQUISITION 0 109.00 0 0 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113. 00 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 115.00 116. 00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS 118.00 152, 708 953, 625 525, 875 1, 632, 208 10, 756 118. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1, 805 1, 805 0 190. 00 191. 00 19100 RESEARCH 0 0 0 191. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192. 00 C 0 193. 00 19300 NONPALD WORKERS 0 C 0 0 193. 00 193. 01 19301 MARKETI NG 0 0 o 128 193. 01 C 200.00 Cross Foot Adjustments 200.00 0 201.00 Negative Cost Centers Γ 0 201.00 202.00 TOTAL (sum lines 118-201) 152, 708 955, 430 525, 875 1, 634, 013 10, 884 202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

	Cost Center Description	NONPATI ENT TELEPHONES	DATA PROCESSI NG	PURCHASI NG RECEI VI NG AND STORES	ADMI TTI NG	2/27/2013 1: 0 CASHI ERI NG/ACC OUNTS RECEI VABLE	1 pm
		5. 01	5. 02	5. 03	5. 04	5. 05	
1 00	GENERAL SERVICE COST CENTERS						1 00
1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 6. 00 7. 00 8. 00 9. 00 11. 00 13. 00 14. 00 15. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS 00510 NONPATIENT TELEPHONES 00520 DATA PROCESSING 00530 PURCHASING RECEIVING AND STORES 00540 ADMITTING 00550 CASHIERING/ACCOUNTS RECEIVABLE 00560 OTHER ADMINISTRATIVE AND GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	6, 480 158 237 119 395 1, 142 0 356 40 79 316 237 316 79 119	202, 691 6, 913 20, 244 21, 232 78, 015 0 0 0 0 20, 738 0 10, 616 12, 838	22, 518 110 42 143 0 1, 334 0 620 8, 011 55 48 595	32, 704 0 0 0 0 0 0 0 0 0	31, 483 0 0 0 0 0 0 0 0	1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 6. 00 7. 00 8. 00 9. 00 11. 00 11. 00 14. 00 15. 00
17. 00	01700 SOCIAL SERVICE	198	0	i I	0	0	17. 00
	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL	0	0	0	0	0	19. 00 20. 00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	o	O	0	0	0	21. 00
22. 00 23. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0 0	22. 00 23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			0	0	23.00
30.00	03000 ADULTS & PEDI ATRI CS	435	0	-,	12, 584	10, 046	30.00
31. 00 32. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	79 0	0		757 0	605	31. 00 32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	o	0		0	0	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	0	0	0	0	0 0	40. 00 41. 00
42. 00	04200 SUBPROVI DER	o o	0	Ö	0	0	42. 00
43.00	04300 NURSERY	0	0	0	0	0	43.00
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	79 0	0	233	302 0	241 0	44. 00 45. 00
46. 00	04600 OTHER LONG TERM CARE	O	0		0	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	198	0	4, 464	1, 199	2, 029	50. 00
51. 00	05100 RECOVERY ROOM	0	0	0	0	2,027	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	79 435	7, 900	211 154	174 1, 436	429 2, 039	53. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	7, 700	1	0	2,037	55. 00
	05600 RADI OI SOTOPE	0	0	0	0	0	56.00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	o	O	0	0	0	59. 00
60. 00 60. 01	06000 LABORATORY	395	24, 195	3, 420	5, 711	6, 157	60.00
61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	l o	C		U	0	60. 01 61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	О	0	0	0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0 158	0	126	0 2, 367	0 1, 994	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	79	0	8	264	245	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	40	0	8	0 856	0 900	68. 00 69. 00
	07000 ELECTROENCEPHALOGRAPHY	o	0	0	0	0	70. 00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	688	578	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	92 5, 414	192 4, 642	72. 00 73. 00
74.00	07400 RENAL DIALYSIS	0	0		19	16	74. 00
75. 00	07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	75. 00
88. 00	08800 RURAL HEALTH CLINIC	ol	C	O	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	O	0		0	0	89. 00
90. 00 90. 01	09000 CLI NI C 09001 PARTI AL HOSPI TALI ZATI ON	0	0		0	0	90. 00 90. 01
70.01	JOSES ANTON	<u>, </u>		1 17	0	<u> </u>	75. 51

| Peri od: | Worksheet B | From 10/01/2011 | Part II | To 09/30/2012 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS METHODIST HOSPITAL OF CHICAGO Provider CCN: 140197

			10	09/30/2012	2/27/2013 1:0	
Cost Center Description	NONPATI ENT	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/ACC	
·	TELEPHONES	PROCESSI NG	RECEIVING AND		OUNTS	
			STORES		RECEI VABLE	
	5. 01	5. 02	5. 03	5. 04	5. 05	
91. 00 09100 EMERGENCY	356	0	632	841	1, 370	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00 05950 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10 09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	o	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	o	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
116. 00 11600 HOSPI CE	0	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	6, 480	202, 691	22, 518	32, 704	31, 483	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
193. 01 19301 MARKETI NG	0	0	0	0	0	193. 01
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	o	0	0	o	0	201. 00
202.00 TOTAL (sum lines 118-201)	6, 480	202, 691	22, 518	32, 704	31, 483	202. 00
	,		· ·			

Provider CCN: 140197

Peri od:

From 10/01/2011

Part II

09/30/2012 Date/Time Prepared: 2/27/2013 1:01 pm Cost Center Description OTHER MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG ADMI NI STRATI VE REPAI RS **PLANT** LINEN SERVICE AND GENERAL 6.00 7.00 8. 00 9. 00 5.06 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS 4.00 4.00 5.01 00510 NONPATIENT TELEPHONES 5.01 00520 DATA PROCESSING 5.02 5.02 5.03 00530 PURCHASING RECEIVING AND STORES 5.03 00540 ADMITTING 5.04 5 04 5.05 00550 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 5.06 00560 OTHER ADMINISTRATIVE AND GENERAL 227, 353 5 06 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7 00 22 295 175.871 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 1,842 569 4,633 8.00 9.00 00900 HOUSEKEEPI NG 4,872 3, 334 23, 468 9 00 15 01000 DI ETARY 677 16, 268 10.00 10.00 7, 225 11.00 01100 CAFETERI A 2, 151 5, 433 45 11.00 13.00 01300 NURSING ADMINISTRATION 949 7, 264 342 13.00 01400 CENTRAL SERVICES & SUPPLY 0 1,372 7, 313 392 14.00 14.00 01500 PHARMACY 15 15.00 4, 366 2.076 Ω 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 6,666 3,659 0 156 16.00 01700 SOCIAL SERVICE 17.00 2,901 2,609 0 0 17.00 01850 OTHER GENERAL SERVICE (SPECIFY) 18.00 18.00 0 C 0 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 0 0 19.00 0 20.00 02000 NURSING SCHOOL 0 0 0 0 20.00 0 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD ol 22 00 0 0 O 22 00 0 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 74, 365 2, 836 11, 040 30.00 64,664 03100 INTENSIVE CARE UNIT 31.00 5, 366 C 3,774 270 778 31.00 32.00 03200 CORONARY CARE UNIT 0 0 0 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 33.00 0 34 00 03400 SURGICAL INTENSIVE CARE UNIT 0 Ω O 34 00 0 04000 SUBPROVIDER - IPF 0 0 40.00 0 0 0 40.00 04100 SUBPROVIDER - IRF 0 0 0 0 41.00 0 41.00 42.00 04200 SUBPROVI DER 0 0 o 42.00 0 04300 NURSERY 43 00 0 Ω 0 43 00 0 0 04400 SKILLED NURSING FACILITY 44.00 2,923 0 13, 540 375 1,806 44.00 04500 NURSING FACILITY 45.00 45.00 46.00 04600 OTHER LONG TERM CARE 0 0 0 0 46, 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 13, 904 16, 850 289 3, 766 50.00 51.00 05100 RECOVERY ROOM 0 C 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 52.00 0 0 0 0 05300 ANESTHESI OLOGY 53 00 1, 227 0 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 9,540 0 7, 753 183 961 54.00 55 00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 05600 RADI OI SOTOPE 56,00 0 0 0 56,00 0 57 00 05700 CT SCAN 0 C 0 0 0 57 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 58.00 0 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 0 0 C 59.00 06000 LABORATORY 60.00 16, 247 0 3,603 1, 154 60.00 60.01 06001 BLOOD LABORATORY 0 0 60.01 C 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0 0 0 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 63.00 06400 I NTRAVENOUS THERAPY 0 64.00 64.00 06500 RESPIRATORY THERAPY 1,800 15 307 65.00 6.132 65.00 66,00 06600 PHYSI CAL THERAPY 2.096 2,651 135 356 66,00 06700 OCCUPATI ONAL THERAPY 67.00 0 67.00 C 0 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 06900 ELECTROCARDI OLOGY 1, 952 308 69.00 69.00 2.578 0 07000 ELECTROENCEPHALOGRAPHY 70.00 C C 0 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2,448 0 0 0 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 1,774 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 16.382 0 0 0 73.00 07400 RENAL DIALYSIS 0 0 74.00 168 0 0 74.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 75.00 0 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC n 88 00 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89.00 09000 CLI NI C 0 90.00 90.00 0 90.01 09001 PARTIAL HOSPITALIZATION 0 2, 333 0 0 90.01 6.739

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 140197 Peri od: Worksheet B From 10/01/2011 Part II 09/30/2012 Date/Time Prepared: 2/27/2013 1:01 pm LAUNDRY & Cost Center Description OTHER MAINTENANCE & OPERATION OF HOUSEKEEPI NG ADMI NI STRATI VE **REPAIRS** PLANT LINEN SERVICE AND GENERAL 6.00 7.00 8. 00 9.00 5.06 91. 00 09100 EMERGENCY 177 12.134 4,570 1,546 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 0 000000000 09500 AMBULANCE SERVICES 0 95.00 0 0 0 0 0 0 0 0 0 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 0 0 97.00 0 98.00 05950 OTHER REIMBURSABLE COST CENTERS 98.00 0 0 0 99. 00 09900 CMHC 0 0 99.00 99. 10 09910 CORF 0 0 0 99. 10 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 100.00 0 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0000000 0 105. 00 0 0 0 0 0 0 106.00 10600 HEART ACQUISITION 0 0 106. 00 107.00 10700 LIVER ACQUISITION 0 0 107. 00 108.00 10800 LUNG ACQUISITION 0 108. 00 109.00 10900 PANCREAS ACQUISITION 0 0 109.00 0 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 111.00 113. 00 11300 | INTEREST EXPENSE 113. 00 114.00 11400 UTI LI ZATI ON REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 C 0 0 0 115.00 116. 00 11600 HOSPI CE 0 0 0 0 116.00 SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS 225, 276 175, 401 23, 326 118. 00 118.00 0 4, 633 142 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 13 0 470 0 191. 00 19100 RESEARCH 0 0 0 0 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192.00 0 193. 00 19300 NONPALD WORKERS 0 0 0 0 193. 00 2,064 193. 01 19301 MARKETI NG 0 0 0 193. 01 200.00 Cross Foot Adjustments 200.00

227, 353

0

0

0

175, 871

0

4, 633

0 201 00

23, 468 202. 00

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118-201)

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140197

Period: Worksheet B
From 10/01/2011 Part II
To 09/30/2012 Date/Time Prepared:

In Lieu of Form CMS-2552-10

2/27/2013 1:01 pm Cost Center Description DI ETARY CAFETERI A NURSI NG CENTRAL **PHARMACY** ADMI NI STRATI ON SERVICES & **SUPPLY** 10.00 11.00 13.00 15.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS 4.00 5.01 00510 NONPATIENT TELEPHONES 5.01 00520 DATA PROCESSING 5.02 5.02 5.03 00530 PURCHASING RECEIVING AND STORES 5.03 00540 ADMITTING 5.04 5 04 5.05 00550 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 5.06 00560 OTHER ADMINISTRATIVE AND GENERAL 5 06 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7 00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 102, 322 10.00 11.00 01100 CAFETERI A 29, 241 11.00 13.00 01300 NURSING ADMINISTRATION 925 0 38, 998 13.00 01400 CENTRAL SERVICES & SUPPLY 0 433 40, 363 14.00 458 14.00 01500 PHARMACY 0 15.00 648 26, 122 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 1, 291 1, 028 0 16.00 01700 SOCIAL SERVICE 17.00 0 0 0 0 0 17.00 668 0 01850 OTHER GENERAL SERVICE (SPECIFY) 18.00 18.00 0 0 01900 NONPHYSICIAN ANESTHETISTS 19.00 C 0 0 19.00 0 20.00 02000 NURSING SCHOOL C 0 0 0 20.00 0 0 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 21.00 0 0 22 00 02200 & SERVICES-OTHER PRGM COSTS APPRVD O ol 22 00 C 0 02300 PARAMED ED PRGM-(SPECIFY) 23.00 C 0 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 95, 419 14, 201 21, 915 12, 366 0 30.00 03100 INTENSIVE CARE UNIT 31.00 2,480 609 3, 286 0 31.00 32.00 03200 CORONARY CARE UNIT 0 0 32.00 0 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 33.00 0 34 00 03400 SURGICAL INTENSIVE CARE UNIT C O 34 00 0 04000 SUBPROVI DER - I PF 0 0 0 40.00 C 0 40.00 04100 SUBPROVIDER - IRF 0 0 0 0 41.00 41.00 0 42.00 04200 SUBPROVI DER 0 0 0 0 0 42.00 04300 NURSERY 0 0 43 00 Ω 0 43 00 0 44.00 04400 SKILLED NURSING FACILITY 4, 423 C 1, 457 630 0 44.00 04500 NURSING FACILITY 45.00 45.00 0 46, 00 04600 OTHER LONG TERM CARE 0 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 563 4, 508 25, 693 0 50.00 0 51.00 05100 RECOVERY ROOM 0 C 0 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 52.00 0 0 0 05300 ANESTHESI OLOGY 53 00 61 480 413 0 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 962 327 374 0 54.00 55 00 05500 RADI OLOGY-THERAPEUTI C 55.00 05600 RADI OI SOTOPE 0 0 0 56,00 0 56,00 0 0 57 00 05700 CT SCAN C 0 0 0 57 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 58.00 0 05900 CARDIAC CATHETERIZATION o 59.00 0 0 0 0 59.00 1, 994 06000 LABORATORY 60.00 84 87 0 60.00 60.01 06001 BLOOD LABORATORY 0 0 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 C 0 0 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. r 0 0 0 63.00 06400 I NTRAVENOUS THERAPY 0 0 64.00 0000000 64.00 06500 RESPIRATORY THERAPY 85 65.00 1.155 65.00 66,00 06600 PHYSI CAL THERAPY 313 0 6 0 66,00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 0 0 0 06900 ELECTROCARDI OLOGY 0 69.00 368 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 C Ω 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS C 0 0 71.00 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 26, 122 73.00 07400 RENAL DIALYSIS 0 0 74.00 C 0 74.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 75.00 OUTPATIENT SERVICE COST CENTERS 88 00 0 n 88 00 08800 RURAL HEALTH CLINIC 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 C 0 0 89.00 09000 CLI NI C 0 0 0 90.00 90.00 0 90.01 09001 PARTIAL HOSPITALIZATION 0 0 0 90.01 1.546 66

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 140197 Peri od: Worksheet B From 10/01/2011 Part II 09/30/2012 Date/Time Prepared: 2/27/2013 1:01 pm Cost Center Description DI ETARY CAFETERI A NURSI NG CENTRAL **PHARMACY** ADMI NI STRATI ON SERVICES & **SUPPLY** 10.00 11.00 13.00 15.00 14.00 91. 00 09100 EMERGENCY 5, 356 91 00 2.504 640 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 0 0 0 0 0 0 0 0 0 09500 AMBULANCE SERVICES 0 95.00 0 0 0 0 0 0 0 0 0 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 0 0 97.00 0 05950 OTHER REIMBURSABLE COST CENTERS 98.00 98 00 0 0 0 99.00 09900 CMHC 0 0 99.00 99. 10 09910 CORF 0 0 0 99. 10 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 100.00 0 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 105. 00 0 0 0 0 0 0 106.00 10600 HEART ACQUISITION 00000 0 0 106. 00 107.00 10700 LIVER ACQUISITION 0 107. 00 0 108.00 10800 LUNG ACQUISITION 0 108. 00 109.00 10900 PANCREAS ACQUISITION 0 0 109.00 0 110.00 11000 INTESTINAL ACQUISITION C 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 111.00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTI LI ZATI ON REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 115.00 116. 00 11600 HOSPI CE 0 0 0 116.00 SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS 102, 322 29, 241 38, 998 40, 363 26, 122 118. 00 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 0 0 0 191. 00 19100 RESEARCH 0 0 0 0 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192.00 0 193. 00 19300 NONPALD WORKERS 0 0 0 0 193. 00 C 193. 01 19301 MARKETI NG 0 0 0 0 193. 01 200.00 Cross Foot Adjustments 200.00

0

29, 241

102, 322

O

38, 998

0

40, 363

0 201 00

26, 122 202. 00

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118-201)

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 10/01/2011 | Part II | To 09/30/2012 | Date/Time Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 140197

				1	o 09/30/2012	2 Date/lime Pre 2/27/2013 1:0	
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	, ,	NONPHYSI CI AN ANESTHETI STS	NURSI NG SCHOOL	i pili
		16. 00	17. 00	18. 00	19. 00	20.00	
	GENERAL SERVICE COST CENTERS	T	1	T	T	T	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS						4. 00
5. 01	00510 NONPATIENT TELEPHONES						5. 01
5.02	00520 DATA PROCESSING						5. 02
5.03	00530 PURCHASING RECEIVING AND STORES						5. 03
5.04	00540 ADMI TTI NG						5. 04
5.05	00550 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL						5. 06
6.00	00600 MAINTENANCE & REPAIRS						6. 00
7.00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
	1 1						
15.00	01500 PHARMACY	44 200					15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	41, 309	1				16.00
17. 00	01700 SOCIAL SERVICE	C	17, 370				17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	C	0	0			18. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	C	0	0	()	19. 00
20. 00	02000 NURSI NG SCHOOL	C	0	0		0	20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	C) 0	0			21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	C		0			22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	C	0	0			23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	13, 200	16, 220	0			30.00
31.00	03100 INTENSIVE CARE UNIT	794	506	0			31.00
32.00	03200 CORONARY CARE UNIT	C	0	0			32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	C	0	0			33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT		0	0			34.00
40. 00	04000 SUBPROVI DER - I PF		0	0			40.00
41. 00	04100 SUBPROVI DER - I RF		0	0			41.00
42. 00	04200 SUBPROVI DER						42. 00
43. 00	04300 NURSERY		_				43. 00
44. 00	04400 SKILLED NURSING FACILITY	317					44. 00
45. 00	04500 NURSING FACILITY	317	1	1			45. 00
46. 00	04600 OTHER LONG TERM CARE						46. 00
40.00	ANCI LLARY SERVI CE COST CENTERS		,	1 0			40.00
50. 00	05000 OPERATING ROOM	2 440	0	0			50.00
	05100 RECOVERY ROOM	2, 660	1				
51.00	1 1	C	1	1			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	C		_			52.00
	05300 ANESTHESI OLOGY	562	l .				53.00
	05400 RADI OLOGY - DI AGNOSTI C	2, 673	0	0			54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C		0	0			55. 00
56. 00	05600 RADI OI SOTOPE	C	0	0			56. 00
57. 00	05700 CT SCAN	C	0	0			57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	C	0	0			58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	C	0) O			59. 00
60. 00	06000 LABORATORY	8, 073	0	0			60. 00
60. 01	06001 BLOOD LABORATORY	C	0	0			60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	C	0	0			62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	C	0	0			63.00
64.00	06400 I NTRAVENOUS THERAPY	C	0	0			64.00
65.00	06500 RESPI RATORY THERAPY	2, 614	. 0	0			65. 00
66.00	06600 PHYSI CAL THERAPY	321	1	0			66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	1	Ō			67. 00
68. 00	06800 SPEECH PATHOLOGY	"	ا ا	l o			68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 181	0	١			69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 101					70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	758					71.00
	1 1	252					71.00
72. 00	07200 NPL. DEV. CHARGED TO PATIENTS		l .]			
	07300 DRUGS CHARGED TO PATIENTS	6, 086	1	1 0			73.00
74.00	07400 RENAL DIALYSIS	21	1	0			74.00
75. 00	07500 ASC (NON-DISTINCT PART)	C	0	0			75. 00
	OUTPATIENT SERVICE COST CENTERS		ı	1		_	
88. 00	08800 RURAL HEALTH CLINIC	C	l .				88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	<u> </u>	0	0	<u> </u>	<u> </u>	89. 00
_							

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 10/01/2011 | Part II | To 09/30/2012 | Date/Time Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS METHODIST HOSPITAL OF CHICAGO Provider CCN: 140197

			'	0 07/30/2012	2/27/2013 1:0	
			OTHER GENERAL			
			SERVI CE			
Cost Center Description	MEDI CAL	SOCIAL SERVICE		NONPHYSI CLAN	NURSING SCHOOL	
oost contor becomparen	RECORDS &	0001712 021111 02	(6. 25)	ANESTHETI STS		
	LI BRARY			7.11.20111.211.010		
	16. 00	17. 00	18. 00	19. 00	20.00	
90. 00 09000 CLI NI C	0	0	C			90. 00
90. 01 09001 PARTI AL HOSPI TALI ZATI ON	0	0)		90. 01
91. 00 09100 EMERGENCY	1, 797	0		y .		91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	.,	_	Ī			92. 00
OTHER REIMBURSABLE COST CENTERS			I.			
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0			94. 00
95. 00 09500 AMBULANCE SERVICES	0	0		1		95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	١			96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0				97. 00
98. 00 05950 OTHER REIMBURSABLE COST CENTERS	0					98. 00
99. 00 09900 CMHC	0					99. 00
99. 10 09910 CORF	0					99. 10
100.00 10000 &R SERVICES-NOT APPRVD PRGM	0					100. 00
101.00 10100 HOME HEALTH AGENCY	0	0				100.00
SPECIAL PURPOSE COST CENTERS		1 0		4		101.00
105. 00 10500 KI DNEY ACQUI SI TI ON		0				105. 00
106.00 10600 HEART ACQUISITION	0					105. 00
107. 00 10700 LIVER ACQUISITION	0					108. 00
107. 00 10700 ETVER ACQUISTITION 108. 00 10800 LUNG ACQUISTITION	0	0				107. 00
109. 00 10900 PANCREAS ACQUISITION	0	0				108.00
	0					109.00
110. 00 11000 NTESTI NAL ACQUI SI TI ON	0					
111. 00 11100 SLET ACQUI SI TI ON	U	0				111. 00
113. 00 11300 INTEREST EXPENSE						113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	Ü	0				115. 00
116. 00 11600 HOSPI CE	0	0				116. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	41, 309	17, 370	C	0	0	118. 00
NONREI MBURSABLE COST CENTERS	0		1 0		I	100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C			190. 00
191. 00 19100 RESEARCH	0	0				191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	Ü	0				192. 00
193. 00 19300 NONPALD WORKERS	0	0		'		193. 00
193. 01 19301 MARKETI NG	0	0	1	1		193. 01
200.00 Cross Foot Adjustments	_	_	_	0		200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118-201)	41, 309	17, 370	C	0	0	202. 00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 140197 Peri od: Worksheet B From 10/01/2011 Part II 09/30/2012 Date/Time Prepared: 2/27/2013 1:01 pm INTERNS & RESIDENTS Cost Center Description SERVI CES-SALAR SERVI CES-OTHER PARAMED ED Subtotal Intern & Residents Cost Y & FRINGES PRGM COSTS PRGM & Post Stepdown Adjustments 21. 00 22.00 23. 00 24. 00 25. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FIXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS 4.00 00510 NONPATIENT TELEPHONES 5 01 5 01 5.02 00520 DATA PROCESSING 5.02 5.03 00530 PURCHASING RECEIVING AND STORES 5.03 5.04 00540 ADMITTING 5.04 00550 CASHI ERI NG/ACCOUNTS RECEI VABLE 5 05 5 05 5.06 00560 OTHER ADMINISTRATIVE AND GENERAL 5.06 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11.00 11.00 13 00 01300 NURSING ADMINISTRATION 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16,00 01700 SOCIAL SERVICE 17.00 17.00 01850 OTHER GENERAL SERVICE (SPECIFY) 18.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 20.00 02000 NURSING SCHOOL 20.00 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 675, 551 31.00 03100 INTENSIVE CARE UNIT 34, 528 0 31.00 03200 CORONARY CARE UNIT 32.00 Λ 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 0 34.00 04000 SUBPROVIDER - IPF 0 40.00 40.00 0 04100 SUBPROVI DER - I RF 0 41.00 0 41.00 42.00 04200 SUBPROVI DER 0 0 42.00 43.00 04300 NURSERY 0 0 43.00 04400 SKILLED NURSING FACILITY 44 00 79 402 0 44 00 04500 NURSING FACILITY 45.00 0 45.00 46.00 04600 OTHER LONG TERM CARE 0 46.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM n 50 00 200, 406 51.00 05100 RECOVERY ROOM 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 53.00 05300 ANESTHESI OLOGY 9, 963 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 175, 190 0 54 00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 05600 RADI OI SOTOPE 56.00 0 56.00 05700 CT SCAN 57.00 57.00 0 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 06000 LABORATORY 60.00 102, 959 0 60.00 60.01 06001 BLOOD LABORATORY 60 01 0 0 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 0 63.00 06400 I NTRAVENOUS THERAPY 64.00 0 64.00 65.00 06500 RESPIRATORY THERAPY 41, 494 0 65.00 06600 PHYSI CAL THERAPY 66.00 17,643 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 67.00 06800 SPEECH PATHOLOGY 68.00 0 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 23, 036 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 4, 472 71.00 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 2, 310 0 72.00 07300 DRUGS CHARGED TO PATIENTS 58, 646 0 73.00 07400 RENAL DIALYSIS 74.00 74.00 224 0 75.00 |07500 | ASC (NON-DISTINCT PART) 0 75.00 0

Health Financial Systems	METHODIST HOSPI	TAL OF (CHI CAGO		In Lie	eu of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Pr	rovi der	CCN: 140197	Peri od:	Worksheet B	
					From 10/01/2011	Part II	
					To 09/30/2012	Date/Time Pre	pared:
						2/27/2013 1:0	1 pm
	INTERNS &	RESI DEN	NTS				
Cost Center Description	SERVI CES-SALAR	SERVI CE	S-OTHER	PARAMED ED	Subtotal	Intern &	
oust contain beson per on	Y & FRINGES	1	COSTS	PRGM	Sabtotal	Residents Cost	
	I & INTINGES	FRGIVI	00313	FRGIVI			
						& Post	
						Stepdown	
						Adjustments	
	21.00	22.	. 00	23. 00	24.00	25. 00	
OUTPATIENT SERVICE COST CENTERS							
88. 00 08800 RURAL HEALTH CLINIC					0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER					0	0	89. 00
90. 00 09000 CLI NI C					0	Ö	90.00
					145 200		
90. 01 09001 PARTI AL HOSPI TALI ZATI ON					145, 200		90. 01
91. 00 09100 EMERGENCY					58, 367	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						0	92.00
OTHER REIMBURSABLE COST CENTERS							
94. 00 09400 HOME PROGRAM DIALYSIS					0	0	94. 00
95. 00 09500 AMBULANCE SERVICES					0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED					0	ĺ	96.00
			-		0		
97.00 09700 DURABLE MEDICAL EQUIP-SOLD					0	0	97. 00
98. 00 05950 OTHER REIMBURSABLE COST CENTERS					0	0	98. 00
99. 00 09900 CMHC					0	0	99. 00
99. 10 09910 CORF		İ			0	0	99. 10
100.00 10000 L&R SERVICES-NOT APPRVD PRGM		İ			0	0	100.00
101. 00 10100 HOME HEALTH AGENCY					0		101. 00
SPECIAL PURPOSE COST CENTERS					0	0	101.00
					1		105 00
105. 00 10500 KIDNEY ACQUISITION					0		105. 00
106. 00 10600 HEART ACQUISITION					0		106. 00
107. 00 10700 LI VER ACQUI SI TI ON					0	0	107. 00
108.00 10800 LUNG ACQUISITION					0	0	108.00
109.00 10900 PANCREAS ACQUISITION					0	0	109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON					0	l	110.00
111. 00 11100 SLET ACQUI SI TI ON					0	l	111. 00
					U	0	
113. 00 11300 I NTEREST EXPENSE							113. 00
114.00 11400 UTILIZATION REVIEW-SNF							114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)					0	0	115. 00
116. 00 11600 HOSPI CE					0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	J	0		0 1, 629, 391		118. 00
NONREI MBURSABLE COST CENTERS		1	<u> </u>		0 1,027,371	0	110.00
			-		2 420		100 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN					2, 430		190. 00
191. 00 19100 RESEARCH					0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES					0	l e	192. 00
193.00 19300 NONPALD WORKERS					2, 064	0	193. 00
193. 01 19301 MARKETI NG					128	0	193. 01
200.00 Cross Foot Adjustments	0		n		0 0		200. 00
201.00 Negative Cost Centers	Ö	I .	0		0 0		201. 00
1 1 9		1	0			l e	
202.00 TOTAL (sum lines 118-201)	0	1	0	I	0 1, 634, 013	l 0	202. 00

1		Cost Center Description	Total	2/21/2013 1.01 piii	
DEBENS SERVICE OST CERTES		coot conton boson per on			
2.00		GENERAL SERVICE COST CENTERS			_
4.00 000000	1.00	00100 CAP REL COSTS-BLDG & FIXT		1. (00
5.01 0.0010 0.0	2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.0	00
5 - 00 000000	4.00	00400 EMPLOYEE BENEFITS		4. 0	00
5.03 0.0030 PURCHAST IN RECEIVING AND STORES 5.03	5. 01	00510 NONPATI ENT TELEPHONES		5. 0	01
0.0040 ADMITTING 0.005	5.02	00520 DATA PROCESSING		5. 0	02
D. S. O. DOSSO CASH LEEN MACACCURUS SECTUMBLE S. C. O.		1			
5.06		1			
6.00 DOSCOM MITEMANICE & REPAIR S 7.00 DOSCOM CALLED MATERIAL SERVICE 8.00 DOSCOM CALLED MATERIAL SERVICE 9.00 DOSCOM CALLED MATERIAL SERVICE 9.00 DOSCOM CALLED MATERIAL SERVICE S 9.00 DOSCOM CALLED MATERIAL SERVICE S 9.00 DOSCOM CALLED MATERIAL SERVICE S 9.00 DOSCOM CALLED MATERIAL SERVICE S 9.00 DOSCOM CALLED MATERIAL SERVICE COST CENTERS 9.00 DOSCOM CALLED MATERIAL SERVICE C		1			
2,00 00700 DOPERATION OF PLANT		1			
8.00 00800 AJMONY & LINEN SERVICE 3.00 00900 DETARY 10.00 10.00 DETARY 11.00					
9.00 00900 005EREPING		1			
10.00 01000 DETARY					
11.00 01100 CAFTERIA 11.00 13.00		1			
13.00 1300 MURSI NR. AMM NI STRATI ON 11.00 14.00		1			
14. 00 1400 CENTRAL SERVICES & SUPPLY 15. 00 1600 HEDI CALL RECORDS & LI BRARY 15. 00 1600 HEDI CALL RECORDS & LI BRARY 15. 00 1600 HEDI CALL RECORDS & LI BRARY 17. 00 1700 18			ŀ		
15.00			·		
16. 00 1000 MEDI CAL RECORDS & LIBRARY 10. 00 17					
17.00 1700 SOCIAL SERVICE 17.00 18.00 19.00 1900 MORHYSICI AN ARESTHETISTS 19.00 19.00 19.00 MORHYSICI AN ARESTHETISTS 22.00 20.00 20.00 MURSIN SCHOOL 20.00 20.00 20.00 18.7 SERVICE SALARY & FRINCES APPRVD 22.00 20.0					
18.00 1850 OTHER CRIMENTS I SERVICE (SPECIFY) 18.00 1900 1900 OTHER CRIMENTS I STAN MASSINETISTS 19.00 1900 1900 OTHER SERVICES-SALARY & FRINCES APPRVD 22.00					
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21.00 02100 RR SERVICES - SALARY & FRINGES APPRVD 22.00 02300 RR SERVICES - SOTHER PRISON COSTS APPRVD 22.00 02300 PARAMED ED PRIZU-(SPECIFY) 23.00 INPART LEVIN ROUTH BE SERVICE COST CENTERS 30.00 030000 ADULTS & PEDIATRICS 31.00 31	19. 00	1			
22.00	20.00	02000 NURSI NG SCHOOL		20.0	00
22. 00	21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRVD		21. 0	00
INPATI ENT ROUTI NE SERVICE COST CENTERS 30.00 31.00 3	22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD		22.0	00
30.00	23.00	02300 PARAMED ED PRGM-(SPECIFY)		23. 0	00
31.00					
32.00 03200 CORONARY CARE UNIT 0 33.00 33.00 03300 SURN INTENSIVE CARE UNIT 0 34.0			•		
33.00 03300 03300 0340		1	•		
34. 00 03400 SURGICAL INTENSIVE CARE UNIT 0 43.00		1	-		
40.00 04000 SUBBROVI DER - I PF		1	-		
11 00 04100 SUBPROVI DER 1 FF 0 42, 00 420 4		1			
42 00 04200 SUBROVI DER 0		1			
43. 00 04300 NURSERY 0 44. 00 440.			•		
44. 00 04400 SKILLED NURSING FACILITY 79, 402 45. 00 046. 00 046.00 046.00 046.00 046.00 046.00 046.00 046.00 046.00 046.00 046.00 046.00 046.00 050.00		1	•		
45. 00 04500 NURSI NG FACILITY					
46. 00 04600 OTHER LONG TERM CARE 0			•		
ANCILLARY SERVICE COST CENTERS S0.00					
SOLO 05000 05000 05000 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05200	10. 00		5	10. 0	00
51.00 0520	50.00		200, 406	50.0	00
53.00 05300 AMESTHESIOLOGY 9,963 53.00			•		
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55.00 05500 RADI OLOGY-THERAPEUTI C 0 056.00 RADI OLSOTOPE 0 0 05700 CT SCAN 0 05900 CARDIAC CATHETERI ZATI ON 0 59.00 CARDIAC CATHETERI ZATI ON 0 59.00 CARDIAC CATHETERI ZATI ON 0 59.00 CABORATORY 102, 959 060.00 CABORATORY 102, 959 060.00 CABORATORY 100, 00 06000 LABORATORY 100, 00 06000 LABORATORY 100, 00 06000 CABORATORY 100, 00 06000 CABORATORY 100, 00 06000 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 063.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 064.00 064.00 064.00 064.00 070, 00	53.00	05300 ANESTHESI OLOGY	9, 963	53.0	00
56. 00 05600 RADI OI SOTOPE 0 0 57. 00 05700 CT SCAN 0 0 0 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 0 0 0 0 0	54.00	05400 RADI OLOGY-DI AGNOSTI C	175, 190	54.0	00
57. 00 05700 CT SCAN 0 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 55. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 55. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 0 0 0	55. 00	05500 RADI OLOGY-THERAPEUTI C	0	55. C	00
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI) 0 0 59. 00 05900 CARDI AC CATHETER ZATI ON 0 0 59. 00 05000 CARDI AC CATHETER ZATI ON 0 102,959 60. 00 06000 LABORATORY 0 0 102,959 60. 00 06000 LABORATORY 0 0 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 61. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 064. 00 O6400 INTRAVENOUS THERAPY 0 0 06500 RESPIRATORY THERAPY 17, 643 065. 00 06500 RESPIRATORY THERAPY 17, 643 065. 00 06500 RESPIRATORY THERAPY 17, 643 065. 00 06600 PHYSI CAL THERAPY 17, 643 067. 00 06700 OCCUPATI ONAL THERAPY 0 0 06800 SPEECH PATHOLOGY 0 06800 SPEECH PATHOLOGY 0 06800 SPEECH PATHOLOGY 0 06800 SPEECH PATHOLOGY 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 310 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 2, 310 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 2, 310 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 2, 310 73. 00 07300 DRUGS CHARGED TO PATIENTS 2, 310 74. 00 75. 00 07400 RENAL DIALYSI S 224 74. 00 75. 00 07400 RENAL DIALYSI S 224 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0000 CLI NIT SERVICE COST CENTERS 89. 00 09000 CLI NIT C 0 0 09000 CLI NIT C 0 0 0000 09000 CLI NIT C 0 0 0000 0000 0000 CLI NIT C 0 0 0000 0000 0000 CLI NIT C 0 0 000					
59,00 05900 CARDI AC CATHETERIZATION 0 060.00 060000 06000 06000 06000 06000 06000 060			-		
60. 00 06000 LABORATORY 102,959 60. 00 60. 01 60. 01 60. 01 60. 01 60. 01 60. 01 60. 01 60. 00 60. 01 60. 00			-		
60. 01 06001 BLOOD LABORATORY 0 61. 00 61. 00 660. 01 61. 00 660. 01 61. 00 62. 00 06200 WhOLE BLOOD & PACKED RED BLOOD CELLS 0 62. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63. 00 64. 00 64. 00 64. 00 64. 00 65. 00 65. 00 65. 00 66. 0					
61. 00					
62. 00			U		
63. 00 64. 00 664. 00 664. 00 665. 00 666. 00 666. 00 667. 00 667. 00 668. 00 669. 00 669. 00 669. 00 669. 00 669. 00 669. 00 670. 00 670. 00 670. 00 670. 00 670. 00 670. 00 670. 00 670. 00 680. 00 690. 00					
64. 00			0		
65. 00		1	-		
66. 00		1	-		
67. 00 06700 0CCUPATI ONAL THERAPY 0 068. 00 06800 SPEECH PATHOLOGY 0 068. 00 06900 ELECTROCARDI OLOGY 23, 036 69. 00 07000 ELECTROENCEPHALOGRAPHY 0 70. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 4, 472 71. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 2, 310 72. 00 07300 DRUGS CHARGED TO PATI ENTS 58, 646 73. 00 07400 RENAL DI ALYSI S 224 74. 00 07500 ASC (NON-DI STI NCT PART) 0 00 07500 ASC (NON-DI STI NCT PART) 0 00 07500 ASC (NON-DI STI NCT PART) 0 00 08800 RURAL HEALTH CLINI C 0 08800 RURAL HEALTH CLINI C 0 090. 00 09000 CLI NI C 0 090. 01 09001 PARTI AL HOSPI TALI ZATI ON 145, 200 99. 01 09001 EMERGENCY 58, 367 99. 00 99. 01 EMERGENCY 58, 367		1	•		
68. 00			•		
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 70. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 72. 00 72. 00 72. 00 72. 00 72. 00 73. 00 73. 00 73. 00 73. 00 74. 00 75	68. 00		o		
71. 00	69. 00		23, 036		
72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 2, 310 73. 00 7300 DRUGS CHARGED TO PATI ENTS 58, 646 73. 00 7400 RENAL DI ALYSI S 224 74. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0000 0000 CLI NI C 0 88. 00 08900 RURAL HEALTH CLI NI C 0 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 90. 00 09000 CLI NI C 0 09000 09000 CLI NI C 0 09000 09000 DRATI AL HOSPI TALI ZATI ON 145, 200 99. 00 99. 00 09100 EMERGENCY 58, 367 91. 00			О		
73. 00			•		
74. 00			•		
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0			•		
SERVICE COST CENTERS SERVICE COST CENTERS			•		
88. 00 08800 RURAL HEALTH CLINIC 0 88. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 90. 00 90. 01 09001 PARTIAL HOSPITALIZATION 145, 200 91. 00 09100 EMERGENCY 58, 367 91. 00 91. 00 09100 09	75. 00		0	75. 0	00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89. 00 90. 00 09000 CLINIC 0 90. 00 90. 01 09001 PARTIAL HOSPITALIZATION 145, 200 90. 01 91. 00 09100 EMERGENCY 58, 367 91. 00	00.00				00
90. 00 09000 CLINIC 0 90. 00 90. 01 90. 01 91. 00					
90. 01 09001 PARTI AL HOSPI TALI ZATI ON 145, 200 91. 00 09100 EMERGENCY 58, 367 91. 00			-		
91. 00 09100 EMERGENCY 58, 367 91. 00			-		
72.00			30, 307		
		12 221222	l l	72.0	

| Peri od: | Worksheet B | From 10/01/2011 | Part II | To 09/30/2012 | Date/Time Prepared:

		10	
Cost Center Description	Total	272772010 110	Din.
·	26.00		
OTHER REIMBURSABLE COST CENTERS			
94.00 09400 HOME PROGRAM DIALYSIS	0		94.00
95. 00 09500 AMBULANCE SERVICES	0		95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0		96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0		97.00
98. 00 05950 OTHER REIMBURSABLE COST CENTERS	0		98.00
99. 00 09900 CMHC	0		99. 00
99. 10 09910 CORF	0		99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	1	100.00
101.00 10100 HOME HEALTH AGENCY	0	1	101. 00
SPECIAL PURPOSE COST CENTERS			
105.00 10500 KIDNEY ACQUISITION	0		105. 00
106.00 10600 HEART ACQUISITION	0		106. 00
107.00 10700 LIVER ACQUISITION	0		107. 00
108.00 10800 LUNG ACQUISITION	0		108.00
109.00 10900 PANCREAS ACQUISITION	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0		111. 00
113.00 11300 INTEREST EXPENSE			113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF			114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0		115. 00
116. 00 11600 HOSPI CE	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1, 629, 391	1	118. 00
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 430		190. 00
191. 00 19100 RESEARCH	0		191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0		192. 00
193. 00 19300 NONPALD WORKERS	2, 064		193. 00
193. 01 19301 MARKETI NG	128		193. 01
200.00 Cross Foot Adjustments	0		200.00
201.00 Negative Cost Centers	0		201. 00
202.00 TOTAL (sum lines 118-201)	1, 634, 013	[2	202. 00

	ALLOCATION - STATISTICAL BASIS	ILTHODIST HOSET		CCN: 140197 F	Peri od:	Worksheet B-1	
				F	rom 10/01/2011 o 09/30/2012	Date/Time Pre	pared:
		CAPITAL RE	LATED COSTS			2/27/2013 1:0	ı pm
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	_ EMPLOYEE	NONPATI ENT	DATA	
		(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS	TELEPHONES	PROCESSI NG	
				(GROSS SALARI ES)	(NUMBER OF PHONES)	(MACHINE TIME)	
	ASSUEDAN ASSUEDA	1.00	2.00	4.00	5. 01	5. 02	
1.00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT	116, 454					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		599, 738	1			2. 00
4. 00 5. 01	OO400	1, 200 646					4. 00 5. 01
5.02	00520 DATA PROCESSING	598	225, 218	270, 823	4	4, 105	5. 02
5. 03 5. 04	00530 PURCHASING RECEIVING AND STORES 00540 ADMITTING	1, 400 798					ı
5.05	00550 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 127	414	373, 267	10	430	5. 05
5. 06 6. 00	00560 OTHER ADMINISTRATIVE AND GENERAL 00600 MAINTENANCE & REPAIRS	13, 989	37, 645	496, 631	29		5. 06 6. 00
7. 00	00700 OPERATION OF PLANT	14, 448	37, 227	1, 287, 695		Ö	7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	266 1, 559	l .	390, 706	1	0	8. 00 9. 00
10.00	01000 DI ETARY	7, 608	1			Ö	1
11.00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	2, 541	l .				
13. 00 14. 00	01400 CENTRAL SERVICES & SUPPLY	3, 420	l ·			0	1
15.00	01500 PHARMACY	971		1	3	215	1
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	1, 711 1, 220			1	260 0	1
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	l		0	1	
19. 00 20. 00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL					0	
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	(0	0	21. 00
22. 00 23. 00	02200 1 &R SERVI CES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECIFY)	0					
	INPATIENT ROUTINE SERVICE COST CENTERS	-					
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	34, 777 1, 765		1 ' '			
32.00	03200 CORONARY CARE UNIT	0		o c	0	0	32. 00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	(
40. 00	04000 SUBPROVI DER – I PF	0			Ö	0	1
41. 00 42. 00	04100 SUBPROVI DER	0	(0	
43. 00	04300 NURSERY				0	0	43. 00
44. 00 45. 00	04400 SKILLED NURSING FACILITY	6, 332	384	263, 612		0	
46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0			0		
F0 00	ANCILLARY SERVICE COST CENTERS	7.000		1 070 055	_		F0 00
	05000 OPERATING ROOM 05100 RECOVERY ROOM	7, 880	65, 641 (1, 070, 255	0	0	50. 00 51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	(0	0	0	52. 00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY - DI AGNOSTI C	3, 626	3, 819 125, 934			0 160	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	, () C	0	0	55. 00
56. 00 57. 00	05600	0	() (0	0	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0		o c	0	0	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	1, 685	6, 764	0 1 795, 237) 0 ' 10	-	
60. 01	06001 BLOOD LABORATORY	1,000	0, 70-	773, 237	0	0	1
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS					0	61. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0			Ö	ő	1
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	842	10, 314)	0	0	
66. 00	06600 PHYSI CAL THERAPY	1, 240		1		0	1
67. 00	06700 OCCUPATIONAL THERAPY	0	(0	0	
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	913	8, 284	164, 245	5 1	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	(0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 MPL. DEV. CHARGED TO PATIENTS) (0	0 0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS				O	0	73. 00
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0				0	
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	ıl () C	0	1 0	88. 00

| Peri od: | Worksheet B-1 | From 10/01/2011 | To 09/30/2012 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 140197

				To	09/30/2012	Date/Time Pre 2/27/2013 1:0	
		CAPITAL REL	ATED COSTS			2/2//2013 1.0	ı piii
Cook Cooker December 1		BLDG & FIXT	MVDLE FOLLID	EMDL OVEE	NONDATI ENT	DATA	
Cost Center Description			MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS	NONPATI ENT TELEPHONES	DATA PROCESSI NG	
		SQUARE TEET)	(DOLLAR VALUE)	(GROSS	(NUMBER OF	(MACHINE TIME)	
				SALARI ES)	PHONES)	(
		1. 00	2. 00	4.00	5. 01	5. 02	
89.00 08900 FEDERALLY QUALIFIED HEALTH CE	NTER	0	0	-	0	0	89. 00
90. 00 09000 CLI NI C		0	0	0	0	0	90. 00
90. 01 09001 PARTI AL HOSPI TALI ZATI ON		1, 091	2, 228		0	0	90. 01
91. 00 09100 EMERGENCY	T DADT)	2, 137	9, 088	1, 715, 056	9	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTING OTHER REIMBURSABLE COST CENTERS	I PART)						92. 00
94. 00 09400 HOME PROGRAM DIALYSIS		٥	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVI CES		0	0	-	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0	0	0	0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		Ö	0	Ö	0	0	97. 00
98. 00 05950 OTHER REIMBURSABLE COST CENTE	RS	ol	0	0	0	0	98. 00
99. 00 09900 CMHC		o	0	0	0	0	99. 00
99. 10 09910 CORF		o	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM		o	0	0	0	0	100. 00
101.00 10100 HOME HEALTH AGENCY		0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS							
105.00 10500 KIDNEY ACQUISITION		0	0	-	0		105. 00
106. 00 10600 HEART ACQUI SI TI ON		0	0	-	0		106. 00
107.00 10700 LIVER ACQUISITION 108.00 10800 LUNG ACQUISITION		U O	0	0	0		107. 00
109. 00 10900 PANCREAS ACQUISITION		0	0	0	0		108. 00 109. 00
110. 00 11000 NTESTINAL ACQUISITION		0	0	0	0		1109.00
111. 00 11100 SLET ACQUI SI TI ON		Ö	0	0	0		111. 00
113. 00 11300 NTEREST EXPENSE		Ĭ	· ·	Š	J		113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF							114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D	. P.)	o	0	0	0	0	115. 00
116. 00 11600 HOSPI CE		o	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	116, 234	599, 738	19, 586, 900	164	4, 105	118. 00
NONREI MBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & C	ANTEEN	220	0	-	0		190. 00
191. 00 19100 RESEARCH		0	0	0	0	_	191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		0	0	0	0		192. 00
193. 00 19300 NONPALD WORKERS 193. 01 19301 MARKETING		U O	0	232, 326	0		193. 00 193. 01
200.00 Cross Foot Adjustments		٩	U	232, 320	U	U	200. 00
201.00 Negative Cost Centers							200.00
202.00 Cost to be allocated (per Wks	t. B.	955, 430	525, 875	2, 566, 164	323, 505	748, 883	
Part I)		7007 100	020,070	2,000,101	020, 000	, , , , , , ,	202.00
203.00 Unit cost multiplier (Wkst. B	, Part I)	8. 204355	0. 876841	0. 129479	1, 972. 591463	182. 431912	203. 00
204.00 Cost to be allocated (per Wks	t. B,			10, 884	6, 480	202, 691	204. 00
Part II)							
205.00 Unit cost multiplier (Wkst. B	, Part			0. 000549	39. 512195	49. 376614	205. 00
11)		l					l

| Period: | Worksheet B-1 | From 10/01/2011 | To 09/30/2012 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 140197

				' T	o 09/30/2012	Date/Time Pre 2/27/2013 1:0	
	Cost Center Description	PURCHASI NG		CASHI ERI NG/ACC	Reconciliation	OTHER	ı piii
		RECEIVING AND	(I NPATI ENT	OUNTS		ADMI NI STRATI VE	
		STORES (SUPPLIES	CHARGES)	RECEI VABLE (GROSS		AND GENERAL (ACCUM. COST)	
		EXPENSE)		CHARGES)		(71000111111111111111111111111111111111	
	JOSUS DAL OS DE CONTROLO DE LA CONTROLO DEL LA CONTROLO DE LA CONT	5. 03	5. 04	5. 05	5A. 06	5. 06	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT	<u> </u>		T		Γ	1.00
2.00	00200 CAP REL COSTS-BEBG & TTXT						2.00
4.00	00400 EMPLOYEE BENEFITS						4. 00
5. 01	00510 NONPATI ENT TELEPHONES						5. 01
5. 02 5. 03	00520 DATA PROCESSING 00530 PURCHASING RECEIVING AND STORES	2, 908, 139					5. 02 5. 03
5. 04	00540 ADMITTING	14, 181	51, 171, 701				5. 03
5. 05	00550 CASHI ERI NG/ACCOUNTS RECEI VABLE	5, 423	01, 171, 701				5. 05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL	18, 427	0	0	-6, 352, 733	31, 573, 635	5. 06
6.00	00600 MAINTENANCE & REPAIRS	172 200	0	0	0	0	6.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	172, 299	0	0	0	3, 096, 119 255, 739	7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	80, 035	0	Ö	0	676, 603	9. 00
10.00	01000 DI ETARY	1, 034, 847	0	0	0	1, 003, 328	10. 00
11. 00	01100 CAFETERI A	7, 112	0	0	0	298, 673	11.00
13. 00 14. 00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	6, 135 76, 883	0	0	0	1, 008, 769 190, 482	13. 00 14. 00
15. 00	01500 PHARMACY	8, 809	0	Ö	0	606, 284	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	22, 996	0	0	0	925, 667	16. 00
17. 00	+ I	3, 238	0	0	0	402, 903	•
18. 00 19. 00	01850 OTHER GENERAL SERVICE (SPECIFY) 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 0	18. 00 19. 00
20. 00	+ I		0	0	0		20.00
21. 00		o	0	Ö	0	0	21. 00
22. 00	· · · · · · · · · · · · · · · · · · ·	0	0	0	0	0	22. 00
23. 00		0	0	0	0	0	23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	260, 011	19, 684, 565	19, 684, 565	0	8, 981, 044	30.00
31. 00	1 1	75	1, 184, 741		0	745, 216	31.00
32. 00	· · · · · · · · · · · · · · · · · · ·	0	0	0	0	0	32. 00
33. 00	1	0	0	0	0	0	33.00
34. 00 40. 00	03400 SURGI CAL INTENSI VE CARE UNIT 04000 SUBPROVI DER - I PF		0	0	0	0	34. 00 40. 00
41. 00	04100 SUBPROVI DER – I RF	o	0	Ö	0	Ö	41.00
42. 00	04200 SUBPROVI DER	0	0	0	0	0	42. 00
43.00		20.074	472 500	472 500	0	405 001	43.00
44. 00 45. 00		30, 074	472, 500 0	472, 500 0	0	405, 881 0	44. 00 45. 00
46. 00	04600 OTHER LONG TERM CARE	Ö	0	Ö	0	1	46. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00 51. 00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM	576, 459 0	1, 875, 929	3, 970, 683 0	0	1, 930, 832 0	50. 00 51. 00
51.00	1 1		0	0	0	0	51.00
53. 00	· · · · · · · · · · · · · · · · · · ·	27, 256	272, 318	839, 550	0	170, 341	
54. 00	+ I	19, 851	2, 247, 462	3, 989, 903	0	1, 324, 832	54. 00
55. 00 56. 00	1 1	0	0	0	0	0 0	55. 00 56. 00
57. 00	+ I		0	0	0	0	57.00
58. 00	+ I	o	0	Ö	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	441, 661	8, 937, 969	12, 048, 911	0	2, 256, 234 0	60. 00 60. 01
61. 00		١	Ü	0	0	0	61.00
62. 00		o	0	0	0	0	62.00
63. 00		0	0	0	0	0	63. 00
64.00	1	14 221	2 702 570	2 001 240	0	0	64.00
65. 00 66. 00	+ I	16, 221 1, 041	3, 703, 579 413, 550		0	851, 606 291, 045	65. 00 66. 00
67. 00	1 1	0	0	0	0	0	67. 00
68. 00		0	0	0	0	0	68. 00
69.00		1, 055	1, 340, 188	1, 762, 148	0	357, 962	69.00
70. 00 71. 00	1		0 1, 076, 744	0 1, 131, 627	0	0 339, 903	70. 00 71. 00
72. 00			143, 215		0	246, 409	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	8, 473, 353	9, 084, 326	0	2, 274, 942	73. 00
74.00		0	29, 135	31, 320	0		74.00
75. 00	07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	0	0	1 0	0	0	75. 00
88. 00		0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	o	0	0	0	0	89. 00

COST ALLOCATION - STATISTICAL BASIS

Provi der CCN: 140197

Period: Worksheet B-1 From 10/01/2011

200.00

201.00

6, 352, 733 202. 00

0. 201204 203. 00

0.007201 205.00

227, 353 204. 00

09/30/2012 Date/Time Prepared: 2/27/2013 1:01 pm Cost Center Description PURCHASI NG ADMI TTI NG CASHIERING/ACC Reconciliation OTHER (I NPATI ENT OUNTS ADMI NI STRATI VE RECEIVING AND STORES CHARGES) RECEI VABLE AND GENERAL (SUPPLIES (GROSS (ACCUM. COST) EXPENSE) CHARGES) 5.06 5.03 5.04 5.05 5A. 06 90. 00 09000 CLINIC 90.00 09001 PARTIAL HOSPITALIZATION 90. 01 2, 464 0 0 935, 906 90.01 09100 EMERGENCY 1, 316, 453 2, 681, 678 0 1, 685, 053 91.00 91.00 81,586 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 0000000 09500 AMBULANCE SERVICES 0 0 95.00 95.00 0 0 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 97.00 98.00 05950 OTHER REIMBURSABLE COST CENTERS 0 0 98.00 0 09900 CMHC 0 99.00 99.00 C 0 99. 10 09910 CORF 0 Ω 99. 10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 100.00 0 0 0 101.00 10100 HOME HEALTH AGENCY 0 Ω 0 0 0 101 00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 105. 00 000000 0 0 106. 00 10600 HEART ACQUISITION 0 0 106, 00 Ω 0 107.00 10700 LIVER ACQUISITION 0 107, 00 108.00 10800 LUNG ACQUISITION 0 0 0 108. 00 0 109.00 10900 PANCREAS ACQUISITION 0 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 111.00 11100 | SLET ACQUISITION 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 115.00 116. 00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1-117) 2, 908, 139 51, 171, 701 61, 638, 859 -6, 352, 733 31, 285, 162 118. 00 118.00 NONREI MBURSABLE COST CENTERS 1, 805 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 Ω 0 0 0 191. 00 19100 RESEARCH 0 0 0 0 191. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192. 00 0 0 286, 668 193. 00 193. 00 19300 NONPALD WORKERS 0 0 193. 01 19301 MARKETI NG 0 0 256, 587 0 193. 01

264, 031

0.090790

0.007743

22, 518

400,003

0.007817

0.000639

32, 704

713, 855

31, 483

0.011581

0.000511

200.00

201.00

202.00

203.00

204.00

205.00

Cross Foot Adjustments

Negative Cost Centers

Part I)

Part II)

11)

Cost to be allocated (per Wkst. B,

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

Unit cost multiplier (Wkst. B, Part I)

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140197 | Period:

Period: Worksheet B-1 From 10/01/2011

Date/Time Prepared:

09/30/2012

2/27/2013 1:01 pm Cost Center Description MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY REPAI RS PLANT LINEN SERVICE (HOURS OF (MEALS SERVED) (SQUARE FEET) (SQUARE FEET) (POUNDS OF SERVICE) LAUNDRY) 7.00 6.00 9.00 10.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFLTS 4.00 4 00 5.01 00510 NONPATIENT TELEPHONES 5.01 00520 DATA PROCESSING 5.02 5 02 00530 PURCHASING RECEIVING AND STORES 5.03 5.03 00540 ADMITTING 5.04 5.04 5.05 00550 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 00560 OTHER ADMINISTRATIVE AND GENERAL 5.06 5.06 00600 MAINTENANCE & REPAIRS 6.00 96.696 6.00 7.00 00700 OPERATION OF PLANT 14, 448 82, 248 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 266 266 432, 749 8.00 00900 HOUSEKEEPI NG 1,559 1, 559 38, 715 9.00 1.417 9.00 77, 495 01000 DI FTARY 10.00 7,608 7,608 \cap 1, 117 10.00 11.00 01100 CAFETERI A 2,541 2, 541 1, 417 75 0 11.00 13.00 01300 NURSING ADMINISTRATION 444 444 564 0 13.00 C 01400 CENTRAL SERVICES & SUPPLY 14 00 3 420 3.420 647 14 00 C 0 15.00 01500 PHARMACY 971 971 1, 417 0 15.00 01600 MEDICAL RECORDS & LIBRARY 1,711 1, 711 258 16.00 C 16.00 17.00 01700 SOCIAL SERVICE 17.00 1,220 1, 220 0 0 0 01850 OTHER GENERAL SERVICE (SPECIFY) 0 O 18 00 0 C 0 18 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 0 0 19.00 02000 NURSING SCHOOL 20.00 0 0 0 0 20.00 0 0 0 21 00 02100 I &R SERVICES-SALARY & FRINGES APPRVD Ω 0 21 00 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 0 C 0 0 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30 00 34, 777 34, 777 264 999 18 209 72 267 30 00 31.00 03100 INTENSIVE CARE UNIT 1,765 1, 765 25, 210 1, 284 1,878 31.00 03200 CORONARY CARE UNIT 32.00 32.00 0 0 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 0 0 C 0 34 00 40.00 04000 SUBPROVIDER - IPF 0 C 0 0 40.00 0 04100 SUBPROVIDER - IRF 0 0 41.00 41.00 42.00 04200 SUBPROVI DER 0 0 0 42.00 0 04300 NURSERY 43.00 0 0 0 0 43.00 44.00 04400 SKILLED NURSING FACILITY 34, 983 2, 980 3, 350 44.00 6, 332 6, 332 45 00 04500 NURSING FACILITY C 0 45.00 04600 OTHER LONG TERM CARE 46.00 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 7, 880 7, 880 26, 993 6, 212 0 50.00 51.00 05100 RECOVERY ROOM 0 51.00 C 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 C 0 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 3,626 3,626 17,062 1,586 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 C 0 0 55.00 0 56.00 05600 RADI OI SOTOPE 0 C 0 0 0 56.00 05700 CT SCAN 57.00 57.00 0 0 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0 C 0 0 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 0 0 0 0 59.00 60.00 06000 LABORATORY 1, 685 1,685 1, 903 0 60.00 60.01 06001 BLOOD LABORATORY 0 0 0 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0 0 0 Λ 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 63.00 C 06400 INTRAVENOUS THERAPY 64.00 0 0 0 64.00 06500 RESPIRATORY THERAPY 507 65.00 842 842 1.417 0 65.00 06600 PHYSI CAL THERAPY 66.00 1,240 1, 240 12,604 588 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 0 06800 SPEECH PATHOLOGY 68.00 0 0 68.00 C 69 00 06900 ELECTROCARDI OLOGY 913 913 28, 726 69 00 0 07000 ELECTROENCEPHALOGRAPHY 0 70.00 C 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 71.00 C 0 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73 00 Ω 0 73 00 74.00 07400 RENAL DIALYSIS 0 C 0 0 0 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 0 0 75.00 OUTPATIENT SERVICE COST CENTERS 88 00 88.00 08800 RURAL HEALTH CLINIC 0 Ω 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89.00 90. 00 09000 CLINIC 0 0 0 90.00

Period: Worksheet B-1 Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS METHODIST HOSPITAL OF CHICAGO Provi der CCN: 140197

Cost Center Description					T ₀	rom 10/01/2011 o 09/30/2012		
REPAIRS SQUARE FEET SQUARE FEET SQUARE FEET CPUNDS OF SERVICE CPUNDS OF SE				005047101105	LAUNDBY A			1 pm
SOUARE FEET COUARE FEET COUARE FEET COUNS OF LANDRRY SERVICE SER		Cost Center Description						
90. 01 09001 PARTIAL HOSPITALIZATION 1,091 1,091 1,091 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							(MEALS SERVED)	
90. 01 09001 PARTIAL HOSPITALIZATION 1,091 1,091 1,091 16,504 2,550 0 90. 01 90. 00 90. 0			(SQUARE FEET)	(SQUARE FEET)	,	SERVICE)		
90. 01 09001 PARTIAL HOSPITALIZATION 1,091 1,091 0 0 0 90. 01 91. 00 09100 EMERGENCY 2,137 16,504 2,550 0 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 72. 137 16,504 2,550 0 91. 00 09400 HOME PROGRAM DI ALYSIS 0 0 0 0 0 0 95. 00 09500 AMBULANCE SERVICES 0 0 0 0 0 0 0 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 98. 00 09590 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 99. 00 09900 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 0 0 99. 00 09900 CMHC 0 0 0 0 0 0 0 0 99. 00 09900 CMHC 0 0 0 0 0 0 0 0 99. 10 09910 CORF 0 0 0 0 0 0 0 0 99. 10 09910 CORF 0 0 0 0 0 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 0 101. 00 10500 KI DNEY ACQUISITION 0 0 0 0 0 0 0 105. 00 10500 KI DNEY ACQUISITION 0 0 0 0 0 0 0 106. 00 10600 HART ACQUISITION 0 0 0 0 0 0 0 107. 00 10700 LIVER ACQUISITION 0 0 0 0 0 0 0 108. 00 10800 LUNG ACQUISITION 0 0 0 0 0 0 0 110. 00 11000 NITESTI NAL ACQUISITION 0 0 0 0 0 0 110. 00 11000 NITESTI NAL ACQUISITION 0 0 0 0 0 0 110. 00 11000 MABULATORY SURGICAL CENTER (D.P.) 0 0 0 0 0 0 110. 00 11000 MITESTI NAL ACQUISITION 0 0 0 0 0 110. 00 11000 MITESTI NAL ACQUISITION 0 0 0 0 0 110. 00 11000 0 0 0 0 0 0 0			6.00	7. 00		9. 00	10.00	
92.00 09200 085ERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 9400 600 9400 94.00 95.00 09500 09500 09500 000 0 0 0 0 0 0 0	90. 01 0900	PARTIAL HOSPITALIZATION			0	0	0	90. 01
OTHER REI MBURSABLE COST CENTERS	91.00 09100	EMERGENCY	2, 137	2, 137	16, 504	2, 550	0	91.00
94. 00 09400 IOME PROGRAM DI ALYSIS 0 0 0 0 0 0 0 94. 00 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 0 0 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 0 0 98. 00 05950 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 99. 00 09900 CMHC 0 0 0 0 0 0 0 0 99. 10 09910 CORF 0 0 0 0 0 0 0 99. 10 09910 CORF 0 0 0 0 0 0 0 101. 00 10100 IAWE SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 101. 00 10100 IAWE SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 101. 00 10100 IAWE HEALTH AGENCY 0 0 0 0 0 0 105. 00 10500 KI DINEY ACQUI SI TI ON 0 0 0 0 0 105. 00 10500 LARA CAQUI SI TI ON 0 0 0 0 0 0 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 0 0 101. 00 10100 LIVA CACQUI SI TI ON 0 0 0 0 0 0 101. 00 111. 00 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 0 111. 00 11100 LSLET ACQUI SI TI ON 0 0 0 0 0 0 111. 00 11100 LSLET ACQUI SI TI ON 0 0 0 0 0 0 111. 00 11100 SUBTALE CONTESS SUBGICAL CENTER (D. P.) 0 0 0 0 0 0 115. 00 1500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0 0 0 115. 00 1500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0 0 0 110. 00 1900 CRESEARCH 0 0 0 0 0 0 0 191. 00 1900 CRESEARCH 0 0 0 0 0 0 192. 00 1930 ON 1930 ON 1930 ON 1940 ON 1930 92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 0 0 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 96. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 0 97. 00 98. 00 09500 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 98. 00 99. 00 09900 CMHC 0 0 0 0 0 0 0 0 99. 00 99. 10 09910 CORF 0 0 0 0 0 0 0 0 99. 00 100. 00 10000 1	OTHER	R REIMBURSABLE COST CENTERS						
96. 00 99600 DURABLE MEDI CAL EQUIP P-RENTED 0 0 0 0 0 97. 00 9700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 0 97. 00 98. 00 05950 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 99. 00 99. 00 99900 CMHC 0 0 0 0 0 0 0 0 99. 00 99. 00 99910 CORF 0 0 0 0 0 0 0 0 0			0	0	0	0	0	94. 00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 97. 00 98. 00 05950 OTHER REMBURSABLE COST CENTERS 0 0 0 0 0 0 98. 00 99. 00 09900 CORF 0 0 0 0 0 0 0 99. 00 99. 10 09910 CORF 0 0 0 0 0 0 0 0 99. 10 100. 00 10000 18R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 0 SPECIAL PURPOSE COST CENTERS			-	1	_	0	0	
98. 00 05950 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 98. 00 99. 00 09900 CMHC 0 0 0 0 0 0 0 0 99. 10 09910 CORF 0 0 0 0 0 0 0 100. 00 10000 L&R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 SPECIAL PURPOSE COST CENTERS			0	0	0	0	0	ł
99. 00		i e	0	0	0	0	0	
99. 10 09910 CORF 0 0 0 0 0 0 0 0 0 0 0 0 0 100.00 1 8 R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 0 100.00 1 100.0			0	0	0	0	0	1
100. 00 10000 1&R SERVICES-NOT APPRVD PRGM 0 0 0 0 0 1010.00			0	0	0	0	0	
101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 101.00			0	0	0	0	0	
SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 0 0 105.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 108.00 108.00 108.00 108.00 109.00 109.00 109.00 109.00 109.00 107			0	0	0	0		
105. 00 10500 KIDNEY ACQUISITION 0 0 0 0 0 0 105. 00 106. 00 106. 00 106. 00 106. 00 10600 HEART ACQUISITION 0 0 0 0 0 0 106. 00 107. 00 10700 LIVER ACQUISITION 0 0 0 0 0 0 0 107. 00 107. 00 108.00 LUNG ACQUISITION 0 0 0 0 0 0 0 108.00 109.00 PANCREAS ACQUISITION 0 0 0 0 0 0 109.00 109.00 PANCREAS ACQUISITION 0 0 0 0 0 0 110. 00 110.00 LIVET ACQUISITION 0 0 0 0 0 0 110. 00 111. 00 LIVET ACQUISITION 0 0 0 0 0 0 111. 00 111. 00 LIVET ACQUISITION 0 0 0 0 0 0 111. 00 113. 00 130.00 LIVET ACQUISITION 0 0 0 0 0 0 111. 00 113. 00 130.00 LIVET ACQUISITION 0 0 0 0 0 0 111. 00 113. 00 130.00 LIVET ACQUISITION 0 0 0 0 0 0 111. 00 113. 00 130.00 LIVET ACQUISITION 0 0 0 0 0 0 115. 00 115.00 130.00			0	0	0	0	0	101. 00
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108. 00 10800 LUNG ACQUISITION 0 0 0 0 108. 00 109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 109. 00 109. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 111. 00 111. 00 111. 00 111. 00 113. 00 113. 00 113. 00 113. 00 114. 00 114. 00 114. 00 115.			0	-	_	0		
109. 00 10900 PANCREAS ACQUISITION	1	II	0	0	0	0	-	
110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 0 0 110.00			0	0	0	0		
111. 00 11100 ISLET ACQUISITION			0	0	0	0		l
113.00			0	0	0	0		1
114.00			0	0	0	0	0	l
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)								l
116. 00 11600 HOSPI CE 0 0 0 0 0 0 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1-117) 96, 476 82, 028 432, 749 38, 480 77, 495 118. 00 NONREI MBURSABLE COST CENTERS								
118.00 SUBTOTALS (SUM OF LINES 1-117) 96,476 82,028 432,749 38,480 77,495 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 220 220 0 235 0 190.00 191.00 19100 RESEARCH 0 0 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 0 0 193.00 193.01 19301 MARKETI NG 0 0 0 0 193.01 200.00 Cross Foot Adjustments 200.00			0	0	0	0		
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 220 220 0 235 0 190. 00 191. 00 19100 RESEARCH 0 0 0 0 0 0 191. 00 192. 00 19200 PhySI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00 193. 01 19301 MARKETI NG 0 0 0 0 193. 01 200. 00 Cross Foot Adjustments 200. 00 0 0 0 0 0 0 0 0	1		0	0	0	0		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 220 220 0 235 0 190. 00 191. 00 191. 00 191. 00 192. 00 192. 00 192. 00 193. 00 193. 00 19300 NONPAID WORKERS 0 0 0 0 0 193. 01 193. 01 19301 MARKETING 0 0 0 0 193. 01 200. 00 Cross Foot Adjustments 200. 00 193. 01 200. 00 193. 01 200. 00 193. 01			96, 476	82, 028	432, 749	38, 480	//, 495	1118.00
191. 00 19100 RESEARCH			220	220	0	225	1 0	100 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES			220	ł	0	235		
193. 00			0	0	0	0		
193. 01 19301 MARKETING 0 0 0 0 193. 01 200. 00 Cross Foot Adjustments 0 0 0 0 200. 00	4	l .	0	0	0	0		1
200.00 Cross Foot Adjustments 200.00			0	0	0	0		
			0	U	0	U	0	1
201.00								
202.00 Cost to be allocated (per Wkst. B, 0 3,719,071 319,223 884,278 1,574,732 202.00			0	2 710 071	210 222	001 270	1 574 722	
202.00 Cost to be allocated (per wkst. b, 0 3,714,071 314,223 864,276 1,374,732 202.00	202.00			3, / 17, 0/ 1	317, 223	004, 270	1, 5/4, /32	202.00
203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 45.217768 0.737663 22.840708 20.320434 203.00	203 00		0 000000	45 217768	0 737663	22 840708	20 320434	203 00
204. 00 Cost to be allocated (per Wkst. B, 0 175, 871 4, 633 23, 468 102, 322 204. 00			0.00000	l				•
Part II) 173, 671 4, 663 25, 466 162, 522 254. 66	201.00			1,3,071	1, 055	20, 400	102, 322	
205.00 Unit cost multiplier (Wkst. B, Part 0.000000 2.138301 0.010706 0.606173 1.320369 205.00	205. 00		0. 000000	2. 138301	0. 010706	0. 606173	1. 320369	205. 00

Cost Cambridge		ALLOCATION - STATISTICAL BASIS	METHODIST HOSPI		CCN: 140107 D		Workshoot P 1	
Cost Center Description	COST	MELOCATION - STATISTICAL BASIS		Provi der	F			pared:
DESTRUCTION STRUCT COST CUTTIES 11.00 13.00 14.00 15.00 16.00 10		Cost Center Description		ADMINISTRATION (DIRECT NURS.	SERVICES & SUPPLY (COSTED	(COSTED	MEDI CAL RECORDS & LI BRARY (GROSS	·
1.00 001000 CAP REL (0015) - BLIED & FIXX 2.00			11. 00			15. 00		
2.00 DOZDO CAP PIEL DOSTS-WINEL EDUIP 4.00 DOZDO CAP PIEL DOSTS-WINEL EDUIP 5.01 DOZDO CAP PIEL DOSTS-WI			T	1				
30.00 03000 ADULTS & PEDI ATRI CS 13,903 3,404,406 303,546 0 19,681,565 30,00 30,00 300 07,000 07,00 0 0 0 0 0 0 0 0 0	2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 6. 00 7. 00 8. 00 9. 00 11. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS 00510 NONPATIENT TELEPHONES 00520 DATA PROCESSING 00530 PURCHASING RECEIVING AND STORES 00540 ADMITTING 00550 CASHIERING/ACCOUNTS RECEIVABLE 00560 OTHER ADMINISTRATIVE AND GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICE (SPECIFY) 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I &R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECIFY)	910 426 637 1, 269 657 0 0	6, 165, 384 72, 353 0 162, 564 0 0 0 0 0	990, 803 0 0 0 0 0 0 0 0	100 0 0 0 0 0 0	0 0 0 0 0	2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00
50.00	31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00 44. 00 45. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	599 C C C C C C	519, 467 0 0 0 0 0 0 0 0 0 0 230, 429	73 0 0 0 0 0 0 15, 458	0 0 0 0 0 0 0	1, 184, 741 0 0 0 0 0 0 0 472, 500	31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00 44. 00 45. 00
51-00 05100 RECOVERY ROOM 0 0 0 0 0 0 0 0 52.00	50.00		1 537	712 682	630 678	٥	3 070 683	50.00
61. 00	51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0 60 946 0 0 0	0 0 75, 951 51, 690 0 0 0	0 0 10, 143 9, 187 0 0 0 0	0 0 0 0 0 0	0 0 839, 550 3, 989, 903 0 0 0 0 12, 048, 911	51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 88. 00	61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	308 0 362 0 0 0		158 0 0 0 0 0 0 0	0 0 0 0 0 0 0 100	0 0 3, 901, 268 479, 028 0 1, 762, 148 0 1, 131, 627 376, 611 9, 084, 326 31, 320	61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00
	88. 00		C	ol	0	O	0	88. 00
				1				

ilear tii TTilaiici ar Systems	WETHODIST HOSFT				u or rorm cws	
COST ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 140197	Peri od:	Worksheet B-1	
				From 10/01/2011	Doto/Time Dro	nonad.
				Γο 09/30/2012	Date/Time Pre 2/27/2013 1:0	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	i piii
COST CENTER DESCRIPTION	(FTE)	ADMI NI STRATI ON		(COSTED	RECORDS &	
	(112)	ADMINI STRATION	SUPPLY	REQUIS.)	LI BRARY	
		(DIRECT NURS.	(COSTED	KLQUI 3.)	(GROSS	
		SALAR)	REQUIS.)		CHARGES)	
	11.00	13. 00	14.00	15. 00	16.00	
90. 00 09000 CLI NI C	11.00		14.00	15.00	10.00	90.00
90. 01 09001 PARTI AL HOSPI TALI ZATI ON	1, 520	1	1, 612		0	
91. 00 09100 EMERGENCY	2, 462	l .			2, 681, 678	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,402	040,009	15, 713		2,001,070	92.00
OTHER REIMBURSABLE COST CENTERS						92.00
94. 00 09400 HOME PROGRAM DIALYSIS	0		\		0	94.00
95. 00 09500 AMBULANCE SERVICES					0	
					-	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED					0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0			0	0	97. 00
98. 00 05950 OTHER REIMBURSABLE COST CENTERS	0	0		0	0	98. 00
99. 00 09900 CMHC	0	0		0	0	
99. 10 09910 CORF	0	0)	0	0	
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	_)	0		100. 00
101.00 10100 HOME HEALTH AGENCY	0	0) (0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0)	0		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0)	0		106. 00
107.00 10700 LIVER ACQUISITION	0	0)	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0) (0		108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0) (0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0) (0		110. 00
111. 00 11100 I SLET ACQUI SI TI ON	0	0) (0	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0)	0	0	115. 00
116. 00 11600 HOSPI CE	0	0) (0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	28, 753	6, 165, 384	990, 803	100	61, 638, 859	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0) (0		190. 00
191. 00 19100 RESEARCH	0	0) (0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0)	0	0	192. 00
193.00 19300 NONPALD WORKERS	0	0)	0		193. 00
193. 01 19301 MARKETI NG	0	0)	0	0	193. 01
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	476, 423	1, 259, 774	420, 074	1 783, 777	1, 249, 420	202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I) 16. 569506	0. 204330	0. 423973	7, 837. 770000	0. 020270	203. 00
204.00 Cost to be allocated (per Wkst. B,	29, 241	38, 998	40, 363	26, 122	41, 309	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	1. 016972	0. 006325	0. 040738	261. 220000	0. 000670	205. 00

Cost Center Description		Financial Systems ! LLOCATION - STATISTICAL BASIS	METHODIST HOSPI		CCN: 140197 F	In Lie Period:	worksheet B-1	
Control Control Description	0031 7	ELEGATION STATISTICAL BASIS		1 TOVI dei		rom 10/01/2011		
Const. Center Description				OTHER CENERAL		10 077 007 2012		
CASH CANADA CASH CASH CANADA CASH CASH CANADA CASH								
DATIENT DAYS CASSIGNED TIME)		Cost Center Description	SOCIAL SERVICE			NURSI NG SCHOOL		
Company Comp			(PATIENT DAYS)	(TIME SIENT)	(ASSI GNED			
DEPARTMENT SERVICE COST CENT ENT. 1.00 DOTO OF THE COST SERVICE SOUTH 1.00 D			17 00	18 00				
2.00			177.00	10.00	177.00	20.00		
4.00 OGROD PAPENTER INFELTIS 5.00 OGROD PAPENTER PAPENTER PENTER 5.00 OGROD PAPENTER PAPEN								1
5 00 000500 PURINEASIN RECEIVING AND STORES 5 00 000500 PURINEASIN RECEIVING AND STORES 5 0.0 000500 PURINEASIN	4.00	00400 EMPLOYEE BENEFITS						4. 00
5.03 000500 PURCHASINE RECEIVING AND STORES 5.03 5.04 000540 CASHI FAR MAYACCIDIES RECEIVABLE 5.05 5.05 000500 CASHI FAR MAYACCIDIES RECEIVABLE 5.05 5.06 000500 CASHI FAR MAYACCIDIES RECEIVABLE 5.05 6.07 000500 CASHI FAR MAYACCIDIES RECEIVABLE 5.05 6.08 0005000 CALINDRY AL LINES RESERVICE 6.00 6.00 000500 CALINDRY AL LINES RESERVICE 6.00 6.00 000500 CALINDRY AL LINES RESERVICE 6.00 6.00 000500 CALINDRY AL LINES SERVICE 6.00 6.00 000500 CARREST SERVICE 6.00 6.00 000500 CARREST SERVICE 6.00 6.00 000500 CARREST SERVICE 6.00 6.00 000500 CARREST SERVICE 6.00 6.00 000500 CARREST SERVICE 6.00 6.00 000500 CARREST SERVICE 6.00 6.00 000500 CARREST SERVICE 6.00 6.00 000500 CARREST SERVICE 6.00 6.00 000500 CARREST SERVICE 6.00 6.00 000500 CARREST SERVICE 6.00 6.00 CARREST SE		1 1						
5.05 0.0550 CASH LERING/ACCOUNTS RECEIVABLE 5.06								
5.06 00.5600 OTHER ADMINISTRATI VE AND GENERAL 5.06 00.0000 OUTSIDE STREAM 7.00 00.000 OUTSIDE STREAM 7.00 OUTSID		1 1						
0.00 0.000 DAN INTENNICE & REPAIRS 0.00 0.000 DENTITION OF PERMITTION OF THE SERVICE 0.00 0.000 DENTITION OF THE SERVICE DESTITION OF THE SERVICE DENTITION OF THE SERVICE DESTITION OF THE SERVICE		1 1						
8.00 0.0800 LANDRY & LINEN SERVICE 9.00 0.0900 DETARY 10.00 11	6.00	00600 MAINTENANCE & REPAIRS						6. 00
9.00 00900 MUSSIKEEPT INS		1 1						
11.00 11.00 CAFETERIA 11.00 13.00		00900 HOUSEKEEPI NG						1
13.00 1300 MURSING ADMINISTRATION 14.00 1400 01500 01500 PHARMACY 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 16.00 1600 0161CAL RECORDS & LIBRARY 15.00 17.00 17.00 17.00 18.00 1								
14. 00 10400 (ENTRAL SERVICES & SUPPLY 15. 00 10500 (PHRAMACY 15. 00 10500 (PHRAMACY 15. 00 10500 (PHRAMACY 15. 00 10500 (PHRAMACY 16. 00 17. 00 170. 00 170. 00 170. 00 170. 00 170. 00 170. 00 18. 00 185. 0								
16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 17.00 170.00 17	14.00	01400 CENTRAL SERVICES & SUPPLY						1
17.00 01700 SOCIAL SERVICE 25,797 0 119.00 19.00								1
19.00 01900 NON-HYSIC IAN AMESTHETI STS 0 0 0 0 0 20.00 20.00 20.00 UNISSIN IS CSHOOL 0 0 0 0 0 21.00 20.00 20.00 20.00 18.7 SERVI CES-SALARY & FRI NGES APPRVD 0 0 0 22.00 22.00 22.00 22.00 18.7 SERVI CES-SALARY & FRI NGES APPRVD 0 0 22.00 22			25, 797					1
20. 00 20000 NURSI NS SCHOOL 0 0 20. 00 22. 0		1 1	0	0				
21.00						1 0		1
23. 00 02300 PARAMED ED PROM_CSPECIFY) 0 0	21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	0	O				21. 00
INPATIENT ROUTINE SERVICE COST CENTERS		1 1			1			1
31.00 03100 INTENSIVE CARE UNIT	20.00	INPATIENT ROUTINE SERVICE COST CENTERS			1			20.00
32.00 03200 03200 03200 0300NARY CARE UNIT 0 0 0 0 32.00 033.00 03300 03400					1			1
34. 00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 34. 00 04.00 04.00 04.00 SUBPROVIDER - I PF 0 0 0 0 04.00 04			1		1		l	1
40. 00 0.4000 0.4000 0.4000 0.4000 0.41000 0.41000 0.41000 0.41000 0.41000 0.420		1 1	0	O		0		
11. 00 04100 SUBPROVI DER 1 RF 0			0	0		0		1
43.00 04300 NURSERY 0 0 0 44.00	41.00	04100 SUBPROVI DER - I RF	0	O		0		41.00
44. 00 04400 SKLLED NURSI NG FACILITY 957 0 0 0 45. 00 04500 0		1 1	-	0		0		1
46. 00 04600 OTHER LONG TERM CARE 0 0 0 0 0 0 0 0 0		1 1	1			0		1
ANCI LLARY SERVICE COST CENTERS			-	-			1	1
50.00 05000 0FERATING ROOM 0 0 0 0 50.00 51.00 05100 RECOVERY ROOM LABOR ROOM 0 0 0 0 0 52.00 05200 DELI VERY ROOM LABOR ROOM 0 0 0 0 53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 56.00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 57.00 05500 CT SCAN 0 0 0 0 0 58.00 05500 CT SCAN 0 0 0 0 0 57.00 05500 CT SCAN 0 0 0 0 0 58.00 05800 MAGNETI C RESONANCE MAGI NG (MRI) 0 0 0 0 0 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 60.01 06000 LABORATORY 0 0 0 0 0 0 60.01 06000 BLOOD LABORATORY 0 0 0 0 0 60.01 06000 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 0 0 0 63.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 0 66.00 06600 RESPI RATORY THERAPY 0 0 0 0 0 66.00 06600 PRISI CAL THERAPY 0 0 0 0 0 67.00 06500 RESPI RATORY THERAPY 0 0 0 0 0 68.00 06600 SPEECH PATHOLOGY 0 0 0 0 68.00 06600 SPEECH PATHOLOGY 0 0 0 0 69.00 06600 SPEECH PATHOLOGY 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 71.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 72.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 07500 ASC (NON-DI STINCT PART) 0 0 0 0 07500 07500 ASC (NON-DI STINCT PART) 0 0 0 0 07500 07500	46.00] 0	[0	<u>) </u>] 0		46.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 52. 00 53. 00 05300 ANESTHESI OLOGY 0 0 0 0 0 54. 00 05400 RADI OLOGY-DI AGNOSTIC 0 0 0 0 55. 00 05500 RADI OLOGY-THERAPEUTIC 0 0 0 0 56. 00 05500 RADI OLOGY-THERAPEUTIC 0 0 0 0 57. 00 05700 CT SCAN 0 0 0 0 58. 00 05700 CT SCAN 0 0 0 0 59. 00 05700 CT SCAN 0 0 0 0 59. 00 05700 CARDIAC CATHETERIZATION 0 0 0 60. 00 06000 LABORATORY 0 0 0 0 60. 01 06000 LABORATORY 0 0 0 0 60. 01 06000 LABORATORY 0 0 0 60. 01 06000 BUOD LABORATORY 0 0 0 61. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 64. 00 06400 NTREVRONUS THERAPY 0 0 0 0 65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 66. 00 06600 RESPIRATORY THERAPY 0 0 0 0 66. 00 06600 PASCEL THERAPY 0 0 0 0 67. 00 06700 CCUPATIONAL THERAPY 0 0 0 0 68. 00 06600 SPEECH PATHOLOGY 0 0 0 69. 00 0700 CCUPATIONAL THERAPEY 0 0 0 69. 00 0700 CCUPA		05000 OPERATING ROOM	0	0		0		
53. 00 05300 AMESTHESI OLOGY 0 0 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 55. 00 05500 RADI OLOGY-DI AGNOSTI C 0 0 0 0 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 55. 00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 55. 00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 56. 00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 57. 00 05700 05700 0 0 0 0 0 58. 00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 0 0 0 0 0 59. 00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 0 0 0 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 60. 00 05000 LABORATORY 0 0 0 0 0 60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 61. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 70. 00 70. 00 70. 00 71. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 72. 00 07200 MPLD LAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 75. 00 0000 0000 0000 0000 0000 76. 00 07400 RENAL DI ALYSI S 0 0 0 0 77. 00 07400 RENAL DI ALYSI S 0 0 0 0 78. 00 0000 0000 0000 0000 0000 79. 00 0000 0000 0000 0000 0000 79. 00 0000 0000 0000 0000 0000 79. 00 00000 00000 00000 00000 00000 79. 00 00000 0000			0	0		0		1
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 55. 00 56. 00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 56. 00 57. 00 05700 CT SCAN 0 0 0 0 0 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 60. 00 06000 LABORATORY 0 0 0 0 0 60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 61. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 70. 00 07000 ELECTROCARDI OLOGY 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 73. 00 07400 RENAL DI ALYSIS 0 0 0 0 74. 00 07400 RENAL DI ALYSIS 0 0 0 0UTPATI ENT SERVICE COST CENTERS	53.00	05300 ANESTHESI OLOGY	0	o		o o		
56. 00 05600 RADI OI SOTOPE 0 0 0 0 0 0 556. 00 5700 CT SCAN 0 0 0 0 0 5700 CT SCAN 0 0 0 0 0 0 5700 CT SCAN 0 0 0 0 0 0 5700 CT SCAN 0 0 0 0 0 0 5700 CT SCAN 0 0 0 0 0 0 0 5700 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 59. 00 60. 00 6000 LABORATORY 0 0 0 0 0 0 0 0 60. 00 60. 00 6000 LABORATORY 0 0 0 0 0 0 0 0 60. 00 60. 01 60.			0	0		0		
58. 00			0	o				1
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 59. 00 60. 00 6			0	0		0		
60. 00 06000 LABORATORY 0 0 0 0 0 0 0 0 0			0					1
61. 00		06000 LABORATORY	0	O		0		60.00
62. 00			0	C		0		1
64. 00	62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	o		0		62. 00
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 0 0 0 66. 00 66. 00 06. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0		0		1
67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 68. 00 068.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68. 00 069.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0			0	o				
68. 00			0	O		0		1
69. 00		1 1	0					1
71. 00	69. 00	06900 ELECTROCARDI OLOGY	0	O		o o		69. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0		1 1	0	0		0		1
74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 75. 00 00TPATI ENT SERVI CE COST CENTERS	72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0			o o		72. 00
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 75. 00 0 0 0 0 0 75. 00			0	0		0		1
OUTPATIENT SERVICE COST CENTERS			0					1
88. UU U88UU KUKAL HEALIH CLINIC U U U U 88. 00		OUTPATIENT SERVICE COST CENTERS		I				
	გგ. UU	JOOOUJ KUKAL HEALIH CLINIC	1 0	1 0	<u>'</u>	<u>U</u>	I	<u> </u> δδ. UU

Health Financial Systems	METHODIST HOSPI	TAL OF CHICAGO		In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 140197 P	eri od:	Worksheet B-1
			Ę	rom 10/01/2011	
			T	o 09/30/2012	Date/Time Prepared: 2/27/2013 1:01 pm
		OTHER GENERAL			2/2//2013 1:01 piii
		SERVI CE			
Cost Center Description	SOCI AL SERVI CE		NONPHYSICIAN	NURSING SCHOOL	
		(TIME SPENT)	ANESTHETI STS		
	(PATIENT DAYS)		(ASSI GNED	(ASSI GNED	
			TIME)	TIME)	
00.00 00000 550504444 004445450 054450	17. 00	18. 00	19. 00	20.00	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	1	1		89.00
90. 00 09000 CLI NI C 90. 01 09001 PARTI AL HOSPI TALI ZATI ON	0	0	1	0	90.00
91. 00 09100 PARTIAL HOSPITALIZATION 91. 00 09100 EMERGENCY		0	1	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	1	U	92.00
OTHER REIMBURSABLE COST CENTERS					72.00
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES		0	1	_	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0	_	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0	1	0	97.00
98. 00 05950 OTHER REIMBURSABLE COST CENTERS	0	l o	ō	0	98.00
99. 00 09900 CMHC	0	0	o	0	99.00
99. 10 09910 CORF	0	0	o	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS					
105.00 10500 KIDNEY ACQUISITION	0	-			105. 00
106. 00 10600 HEART ACQUISITION	0	0	1	0	106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0	1	_	107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0	108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	110.00
111. 00 11100 SLET ACQUI SI TI ON	0	0	1	0	111.00
113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTILIZATION REVIEW-SNF					113. 00 114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)				0	115.00
116. 00 11600 HOSPI CE			0		116.00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	25, 797		1	_	118.00
NONREI MBURSABLE COST CENTERS	20,777		1 0	J	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0	o	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	193. 00
193. 01 19301 MARKETI NG	0	0	0	0	193. 01
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers					201. 00
202.00 Cost to be allocated (per Wkst. B,	550, 021	0	0	0	202. 00
Part I)					
203.00 Unit cost multiplier (Wkst. B, Part I	'	l e	0.000000	0.000000	203. 00
204.00 Cost to be allocated (per Wkst. B,	17, 370	0	'l 0	0	204. 00
Part II) 205.00 Unit cost multiplier (Wkst. B. Part	0 472224	0 000000	0 000000	0 000000	205. 00
205.00 Unit cost multiplier (Wkst. B, Part	0. 673334	0. 000000	0.000000	0. 000000	205.00
1 1117	1	I	ı	1	ı

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 140197

In Lieu of Form CMS-2552-10
Worksheet B-1 Peri od: Worksheet B-1 From 10/01/2011 To 09/30/2012 Date/Ti me Prepared: 2/27/2013 1:01 pm

					2/27/2013 1: 0	
		INTERNS &	RESI DENTS			
	Cost Center Description	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED		
	oust defiter bescription	Y & FRI NGES	PRGM COSTS	PRGM		
		(ASSI GNED	(ASSI GNED	(ASSI GNED		
		TI ME) 21.00	TI ME) 22. 00	TI ME) 23. 00	-	
	GENERAL SERVICE COST CENTERS	21.00	22.00	23.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2. 00
4.00	00400 EMPLOYEE BENEFITS					4.00
5. 01 5. 02	00510 NONPATI ENT TELEPHONES 00520 DATA PROCESSI NG					5. 01 5. 02
5. 02	00530 PURCHASING RECEIVING AND STORES					5. 02
5. 04	00540 ADMI TTI NG					5. 04
5.05	00550 CASHI ERI NG/ACCOUNTS RECEI VABLE					5. 05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL					5. 06
6. 00 7. 00	00600 MAI NTENANCE & REPAIRS 00700 OPERATION OF PLANT					6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE					8.00
9. 00	00900 HOUSEKEEPI NG					9. 00
10. 00	01000 DI ETARY					10.00
11.00	01100 CAFETERI A					11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY					13.00
15. 00	01500 PHARMACY					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY					16. 00
17. 00	01700 SOCIAL SERVICE					17. 00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)					18.00
19. 00 20. 00	01900 NONPHYSI CLAN ANESTHETI STS 02000 NURSI NG SCHOOL					19.00
21. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD	0				21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD		0			22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)			C	0	23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	1 0	0			30.00
31. 00	03100 I NTENSI VE CARE UNI T					31.00
32. 00	03200 CORONARY CARE UNIT	0	l	d		32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	C		33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	C		34. 00
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	0	0			40.00
42. 00	04200 SUBPROVI DER	0	0			42. 00
43.00	04300 NURSERY	0	0	C		43. 00
44. 00	04400 SKILLED NURSING FACILITY	0		C		44. 00
45. 00	04500 NURSING FACILITY	0	ł			45. 00
46. 00	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	0)	46. 00
50.00	05000 OPERATI NG ROOM	0	0	C		50.00
	05100 RECOVERY ROOM	0	l e			51. 00
		0	0	C		52. 00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY - DI AGNOSTI C	0	0			53. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0			55. 00
56. 00	05600 RADI OI SOTOPE	0	0	C		56. 00
57. 00	05700 CT SCAN	0	0	C -		57. 00
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	0			58. 00 59. 00
60.00	06000 LABORATORY		0			60.00
60. 01	06001 BLOOD LABORATORY	0	0	Č		60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	C		62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY		0			63. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	0	0			65. 00
66. 00	06600 PHYSI CAL THERAPY	0	Ö	ď		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	C		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	C		68.00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	0			69.00
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		l 0			71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	ď		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	C		73. 00
74.00	07400 RENAL DIALYSIS	0	0	C		74.00
75. 00	07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	0	0	C	<u>'</u>	75. 00
88. 00	08800 RURAL HEALTH CLINIC	0	0	С		88. 00
		·			•	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10 Provider CCN: 140197

					10 09/30/20	2/27/2013	
		INTERNS &	RESI DENTS				
	Cost Center Description		SERVI CES-OTHER				
		Y & FRINGES	PRGM COSTS	PRGM			
		(ASSI GNED	(ASSI GNED	(ASSI GNED			
		TI ME) 21. 00	TI ME) 22. 00	TI ME) 23. 00			
89. 00 08900	FEDERALLY QUALIFIED HEALTH CENTER	21.00	22.00		0		89. 00
	CLINIC	0	0		0		90.00
	PARTI AL HOSPI TALI ZATI ON	0	0		0		90. 01
	EMERGENCY	0	0		0		91. 00
	OBSERVATION BEDS (NON-DISTINCT PART)		Ŭ	· ·			92. 00
	REIMBURSABLE COST CENTERS						72.00
	HOME PROGRAM DIALYSIS	0	0	(ol		94. 00
	AMBULANCE SERVICES	0	0		Ö		95. 00
	DURABLE MEDICAL EQUIP-RENTED	0	0	(0		96. 00
	DURABLE MEDICAL EQUIP-SOLD	0	o		o		97. 00
	OTHER REIMBURSABLE COST CENTERS	0	0		o		98. 00
99.00 09900		0	0		0		99. 00
99. 10 09910	CORF	0	o		o		99. 10
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	О		0		100. 00
101.00 10100	HOME HEALTH AGENCY	0	o		0		101. 00
SPECI	AL PURPOSE COST CENTERS						
105. 00 10500	KIDNEY ACQUISITION	0	0	(0		105. 00
106.00 10600	HEART ACQUISITION	0	0	(0		106. 00
107. 00 10700	LIVER ACQUISITION	0	0	(0		107. 00
108.00 10800	LUNG ACQUISITION	0	0	(0		108. 00
109. 00 10900	PANCREAS ACQUISITION	0	0	(0		109. 00
110.00 11000	INTESTINAL ACQUISITION	0	0	(0		110. 00
	ISLET ACQUISITION	0	0	(0		111. 00
	I NTEREST EXPENSE						113. 00
	UTILIZATION REVIEW-SNF						114. 00
	AMBULATORY SURGICAL CENTER (D. P.)	0	0		0		115. 00
116. 00 11600	l control of the cont	0	0		0		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	0	0	(0		118. 00
	IMBURSABLE COST CENTERS	_					
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
191. 00 19100		0	0	9	0		191.00
	PHYSICIANS' PRIVATE OFFICES	0	0	9	0		192.00
	NONPAI D WORKERS	0	0	9	0		193. 00
193. 01 19301	l control of the cont	0	0	(U		193. 01
200.00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers		ا	ļ ,			201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	0	0		0		202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	0. 000000			203. 00
204. 00	Cost to be allocated (per Wkst. B,	0.000000	0.000000		0		203.00
204.00	Part II)			·			204.00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 000000	0		205. 00
_55.05		2. 223000	3. 333000	2. 220000	-		[200.00
	1 *			•	1		

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Period: From 10/01/2011 To 09/30/2012	Worksheet C Part I Date/Time Pre 2/27/2013 1:0	
		Title	e XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1. 00	2.00	3. 00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
0. 00 03000 ADULTS & PEDI ATRI CS	16, 421, 036		16, 421, 03		16, 421, 036	
31. 00 03100 INTENSIVE CARE UNIT	1, 217, 176		1, 217, 17		1, 217, 176	
32. 00 03200 CORONARY CARE UNIT	0			0	0	32.0
33.00 03300 BURN INTENSIVE CARE UNIT	0			0	0	33.0
4.00 03400 SURGICAL INTENSIVE CARE UNIT 0.00 04000 SUBPROVIDER - IPF	0			0	0	34. C
1. 00 04100 SUBPROVI DER	0			0 0	0	41. 0
12. 00 04200 SUBPROVI DER				0 0	0	42.0
3. 00 04300 NURSERY	o o			0 0	0	43.0
4.00 04400 SKILLED NURSING FACILITY	1, 019, 429		1, 019, 42	9 0	1, 019, 429	1
5.00 04500 NURSING FACILITY	0			0 0	0	45. (
6.00 04600 OTHER LONG TERM CARE	o			0 0	0	46. (
ANCILLARY SERVICE COST CENTERS						
0.00 05000 OPERATING ROOM	3, 356, 403		3, 356, 40	0	3, 356, 403	50. (
1. 00 05100 RECOVERY ROOM	0			0	0	51. (
2. 00 05200 DELIVERY ROOM & LABOR ROOM	0			0	0	52. (
3. 00 05300 ANESTHESI OLOGY	242, 445		242, 44		242, 445	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 915, 171		1, 915, 17		1, 915, 171	54.
5. 00 05500 RADI OLOGY-THERAPEUTI C	0			0	0	55.0
6. 00 05600 RADI 01 SOTOPE .7. 00 05700 CT SCAN	0			0 0	0	56.0
7.00 05700 CT SCAN 8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	57. (58. (
9. 00 05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	59. (
0. 00 06000 LABORATORY	3, 110, 208		3, 110, 20	٥	3, 110, 208	
0. 01 06001 BLOOD LABORATORY	0, 110, 200			0 0	0, 110, 200	60.
1.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	O			0 0	0	61.
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	O			0 0	0	62.
3.00 06300 BLOOD STORING, PROCESSING & TRANS.	0			0	0	63.
4.00 06400 INTRAVENOUS THERAPY	0			0	0	64.
5. 00 06500 RESPI RATORY THERAPY	1, 175, 632	0	1, 175, 63		1, 175, 632	1
6. 00 06600 PHYSI CAL THERAPY	443, 282	0	443, 28		443, 282	1
7. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	67.
8. 00 06800 SPEECH PATHOLOGY	0	0		0	0	68. (
9. 00 06900 ELECTROCARDI OLOGY	534, 176		534, 17		534, 176	1
0.00 07000 ELECTROENCEPHALOGRAPHY	421 221			0	421 221	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	431, 231 303, 621		431, 23 303, 62		431, 231 303, 621	
3.00 07300 DRUGS CHARGED TO PATIENTS	3, 700, 585		3, 700, 58		3, 700, 585	
4. 00 07400 RENAL DIALYSIS	28, 730		28, 73		28, 730	
5. 00 07500 ASC (NON-DISTINCT PART)	20, 730			0 0	20, 730	
OUTPATIENT SERVICE COST CENTERS	<u> </u>					1
B. 00 08800 RURAL HEALTH CLINIC	0			0 0	0	88.
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	O			0 0	0	89.
0. 00 09000 CLI NI C	0			0 0	0	90.
D. 01 09001 PARTIAL HOSPITALIZATION	1, 199, 416		1, 199, 41	6 0	1, 199, 416	90.
1.00 09100 EMERGENCY	2, 465, 996		2, 465, 99	0	2, 465, 996	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1 0				0	92.1

Health Financial Systems	METHODIST HOSPI	TAL OF CHICAGO		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Period: From 10/01/2011 To 09/30/2012	Worksheet C Part I Date/Time Pre 2/27/2013 1:0	
		Ti tl	e XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3. 00	4. 00	5. 00	
200.00 Subtotal (see instructions) 201.00 Less Observation Beds 202.00 Total (see instructions)	37, 564, 537 0 37, 564, 537		37, 564, 53 37, 564, 53	o	37, 564, 537 0 37, 564, 537	201. 00

In Lieu of Form CMS-2552-10
Worksheet C
Part I
B0/2012 Date/Time Prepared: 2/27/2013 1:01 pm
tal PPS Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES METHODIST HOSPITAL OF CHICAGO Provider CCN: 140197 Peri od: From 10/01/2011 To 09/30/2012 Title XVIII Hospi tal

				e XVIII	Hospi tal	PPS	
	Cost Center Description	I npati ent	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient	
		4.00	7.00	0.00	0.00	Ratio	
	INPATIENT ROUTINE SERVICE COST CENTERS	6. 00	7. 00	8.00	9. 00	10. 00	
	03000 ADULTS & PEDI ATRI CS	19, 684, 565		19, 684, 565			30. 00
31. 00	03100 INTENSIVE CARE UNIT	1, 184, 741		1, 184, 741			31. 00
	03200 CORONARY CARE UNIT	0		0			32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	o		0			33.00
	03400 SURGICAL INTENSIVE CARE UNIT	0		0			34. 00
40.00	04000 SUBPROVI DER - I PF	0		0			40. 00
	04100 SUBPROVI DER - I RF	0		0			41. 00
	04200 SUBPROVI DER	0		0			42. 00
43.00	04300 NURSERY	472 500		472 500			43. 00
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	472, 500		472, 500 0	l .		44. 00 45. 00
	04600 OTHER LONG TERM CARE						46. 00
40.00	ANCILLARY SERVICE COST CENTERS	٩					40.00
50.00	05000 OPERATI NG ROOM	1, 875, 929	2, 615, 174	4, 491, 103	0. 747345	0. 000000	50.00
51.00	05100 RECOVERY ROOM	o	0	0	0. 000000	0. 000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		0. 000000	1
53.00	05300 ANESTHESI OLOGY	272, 318	567, 232			0. 000000	
54. 00	05400 RADI OLOGY - DI AGNOSTI C	2, 247, 462	1, 742, 441	_		0.000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0	0		0.000000	
56. 00 57. 00	05700 CT SCAN	0	0	0	0. 000000 0. 000000	0. 000000 0. 000000	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0		0. 000000	0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON		0	0	0. 000000	0. 000000	
60. 00	06000 LABORATORY	8, 937, 969	3, 110, 942	12, 048, 911	0. 258132	0. 000000	1
60. 01	06001 BLOOD LABORATORY	0	0	0	0. 000000	0. 000000	1
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0. 000000	0. 000000	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0. 000000	0. 000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0		0. 000000	
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	
65. 00	06500 RESPI RATORY THERAPY	3, 703, 579	197, 689			0.000000	
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	413, 550	65, 478	479, 028 0		0. 000000 0. 000000	
68. 00	06800 SPEECH PATHOLOGY		0	0	l	0. 000000	1
69. 00	06900 ELECTROCARDI OLOGY	1, 340, 188	421, 960	-	l .	0. 000000	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	l	0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 076, 774	54, 853	1, 131, 627		0. 000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	143, 215	233, 396	376, 611	0. 806193	0. 000000	72.00
	07300 DRUGS CHARGED TO PATIENTS	8, 473, 353	610, 973			0. 000000	
	07400 RENAL DIALYSIS	29, 135	2, 185			0. 000000	1
	07500 ASC (NON-DISTINCT PART)	0	0	0	0. 000000	0. 000000	75. 00
	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	l ol	0	0			88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0			89. 00
90. 00	09000 CLINIC		0	Ö		0. 000000	1
	09001 PARTI AL HOSPI TALI ZATI ON	0	0	0	l .		1
91.00	09100 EMERGENCY	1, 316, 453	1, 365, 225	2, 681, 678	0. 919572	0. 000000	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	293, 436	293, 436	0. 000000	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS	1 0		1	0.000000	0.00000	04.00
	09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES	0	0				1
	09600 DURABLE MEDICAL EQUIP-RENTED		0	0		0. 000000 0. 000000	
	09700 DURABLE MEDICAL EQUIP-SOLD		0	0		0. 000000	1
	05950 OTHER REIMBURSABLE COST CENTERS		0	Ö		0. 000000	
	09900 CMHC	l o	0	Ö		0.00000	99. 00
99. 10	09910 CORF	0	0	0			99. 10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0			100. 00
101. 00	10100 HOME HEALTH AGENCY	0	0	0			101. 00
105.00	SPECIAL PURPOSE COST CENTERS						105.00
	10500 KIDNEY ACQUISITION	0	0				105.00
	10600 HEART ACQUISITION 10700 LIVER ACQUISITION		0	0			106. 00 107. 00
	10800 LUNG ACQUISITION		0				107.00
	10900 PANCREAS ACQUISITION		0	١			109.00
	11000 NTESTINAL ACQUISITION		0	Ö			110.00
	11100 SLET ACQUISITION	0	0	0			111. 00
	11300 INTEREST EXPENSE						113. 00
	11400 UTILIZATION REVIEW-SNF						114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0			115.00
	11600 HOSPI CE	0	11 200 004	0			116. 00 200. 00
200.00	Subtotal (see instructions)	51, 171, 731	11, 280, 984	62, 452, 715			1200.00

Health Financial Systems	METHODIST HOSPIT	TAL OF CHICAGO		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Peri od:	Worksheet C	
				From 10/01/2011	Part I	
				To 09/30/2012	Date/Time Pre 2/27/2013 1:0	
		Ti tl	e XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Rati o	
	6.00	7. 00	8.00	9. 00	10.00	
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	51, 171, 731	11, 280, 984	62, 452, 71	5		202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 10/01/2011 | Part | To 09/30/2012 | Date/Time Prepared: | 2/27/2013 1:01 pm

IRPATILEST ROUTHER SERVICE COST CENTERS 11.00				Title XVIII	Hospi tal	2/2//2013 1: 0 PPS	ıı pm
Nation 11.00 11.		Cost Center Description	PPS Inpatient	THE AVIII	1103pi tai	113	
INPATE PAT BOUTH IN: SERVICE COST CENTERS 30.00 31.00 30.100 MULTIS A PEDIATRIC S 31.00 31.00 31.00 MULTIS A PEDIATRIC S 31.00 31.00 31.00 MULTIS A PEDIATRIC S 31.00 31		p					
30.00		T	11.00				
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32.00		1 1					1
33.0 03300 BURN INTENSIVE CARE UNIT		1 1					
34.00 03400 SURPGICULE TIPE		1 1					
40.00 04000 SUBPROVI DER - I PF		1 1					34. 00
42.00 04200 SUBPROVI DER 42.00 04400 NURSENY 43.00 04400 NURSENY 45.00 04500 NURSENY 62.00 04500 NURSENY 62.01 177		1 1					40.00
43.00 04300 NURSERY 44.00 04400 SKILLEN DIJUSI NG FACI LITY 44.00 04500 OHEN DUSI NG FACI LITY 45.00 04500 OHEN DUSI NG FACI LITY 46.00 04500 OHEN DUSIN REDWING TERM CARE 46.00 05100 OSTOO OFERATI NG ROOM 0.000000 51.00 05100 OSTOO OFERATI NG ROOM 0.000000 52.00 05200 OELI VERY ROOM & LABOR ROOM 0.000000 52.00 05200 OELI VERY ROOM & LABOR ROOM 0.000000 0.288780 0.3500 ORADIO LIGHOY THERAPEUTI C 0.400004 0.5500 OSTOO ORADIO LIGHOY THERAPEUTI C 0.400004 0.5500 OSTOO ORADIO LIGHOY THERAPEUTI C 0.000000 0.5500 OSTOO ORADIO LIGHORATORY 0.286132 0.00000 0.5900 OSTOO O	41.00	04100 SUBPROVI DER - I RF					41.00
44. 00 04400 SKILLED NURSING FACILITY		1 1					42. 00
45.00 04500 OHSDO OHRER LONG TERM CARE 46.00		1 1					43. 00
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ANCILLARY SERVICE COST CENTERS 50.0		1 1					1
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60. 01 0c001 BLOOD LABORATORY 0.000000 61. 00 0c10 0pp CLINI CAL LAB SERVICES-PRGM ONLY 0.000000 62. 00 0c200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 62. 00 0c200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 63. 00 0c300 BLOOD STORI NG, PROCESSING & TRANS. 0.000000 64. 00 0c400 INTRAVENOUS THERAPY 0.000000 64. 00 0c400 INTRAVENOUS THERAPY 0.000000 65. 00 0c500 RESPIRATORY THERAPY 0.301346 0.000000 0c700 0c7000 0c700 0c7000 0c700 0c7000 0c7000 0c7000 0c7000 0c7000 0c70000 0c70000 0c700000 0c700000 0c700000 0c7000000 0c7000000 0c70000000 0c70000000 0c700000000			1				1
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65. 00 06500 RESPIRATORY THERAPY 0. 301346 66. 00 06600 PHYSI CAL THERAPY 0. 925378 66. 00 06600 PHYSI CAL THERAPY 0. 9000000 67. 00 06700 OCCUPATI ONAL THERAPY 0. 0000000 67. 00 06700 OCCUPATI ONAL THERAPY 0. 0000000 67. 00 06800 SPEECH PATHOLOGY 0. 0000000 68. 00 06900 ELECTROCRARIO OLOGY 0. 303139 69. 00 07000 ELECTROCRARIO OLOGY 0. 303139 70. 00 07000 ELECTROCRARIO DESPIRAÇIO PATIENTS 0. 381072 71. 00 07000 ELECTROCRARIO DESPIRAÇIO PATIENTS 0. 381072 71. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 806193 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 806193 72. 00 07300 DRUGS CHARGED TO PATIENTS 0. 407359 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 907305 PURSC CHARGED TO PATIENTS 0. 9017305 74. 00 07500 JASC (NON-DISTINCT PART) 0. 0000000 75500 JASC (NON-DISTINCT PART) 0. 0000000 75500 JASC (NON-DISTINCT PART) 0. 0000000 7500 JASC (NON-DISTINCT PART) 0. 0000000 7500 DRAFI LEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLIN C 0. 000000 99. 00 09000 CLIN	63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63. 00
66.00 06600 PHYSI CAL THERAPY 0.925378 66.0 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 67.0 68.00 06800 SPEECH PATHOLOGY 0.000000 68.0 69.00 06900 ELECTROCARDI OLOGY 0.303139 69.0 70.00 07000 ELECTROCREPHALOGRAPHY 0.000000 71.00 ELECTROCHCPHALOGRAPHY 0.000000 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.381072 71.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.806193 72.0 07200 DRUGS CHARGED TO PATI ENTS 0.407359 73.0 07300 DRUGS CHARGED TO PATI ENTS 0.407359 73.0 07400 RENAL DI ALYSI S 0.917305 73.0 07500 ASC (MON-DI STI NCT PART) 0.000000 07500 ASC (MON-DI STI NCT PART) 0.000000 07500 ASC (MON-DI STI NCT PART) 0.000000 07500 EMERGENCY 0.919572 89.0 09000 CLI NI C 0.000000 090.0 091.0 09000 CLI NI C 0.000000 091.0 09000 EMERGENCY 0.919572 991.0 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 07HER REI MBURSABLE COST CENTERS 99.0 09900 OMBULANCE SERVI CES 0.000000 99.0 09900 OMBULANCE		1 1	1				64. 00
67. 00 06700 0CCUPATI ONAL THERAPY 0.000000 67. 0 68. 00 06800 SPEECH PATHOLOGY 0.000000 68. 0 69. 00 06900 ELECTROCARD IOLOGY 0.303139 69. 0 70. 00 07000 ELECTROCARD IOLOGY 0.000000 70. 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.381072 71. 0 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0.806193 72. 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.407359 73. 0 74. 00 07400 RENAL DI ALYSI S 0.917305 74. 0 75. 00 07500 ASC (NON-DI STI NCT PART) 0.000000 75. 0 00TPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLI NI C 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLI NI C 0.000000 99. 0 90. 01 09001 PARTI AL HOSPI TALI ZATI ON 0.000000 99. 0 91. 00 09100 DEMERGENCY 0.91572 91. 0 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 99. 0 0THER REI MBURSABLE COST CENTERS 95. 0.000000 99. 0 97. 00 09500 DURABLE MEDI CAL EQUI P-RENTED 0.000000 99. 0 97. 00 09700 DURABLE MEDI CAL EQUI P-RENTED 0.000000 99. 0 98. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 99. 0 99. 00 09900 OTHER REI MBURSABLE COST CENTERS 0.000000 99. 0 99. 00 09900 DURABLE MEDI CAL EQUI P-SOLD 0.000000 99. 0 99. 00 09900 OTHER REI MBURSABLE COST CENTERS 0.000000 99. 0 99. 00 09900 OTHER REI MBURSABLE COST CENTERS 0.000000 99. 0 99. 00 09900 OTHER REI MBURSABLE COST CENTERS 0.000000 99. 0 99. 00 09900 OTHER REI MBURSABLE COST CENTERS 0.000000 99. 0 99. 00 09900 OTHER REI MBURSABLE COST CENTERS 0.000000 99. 0 99. 00 09900 OTHER REI MBURSABLE COST CENTERS 0.000000 99. 0 99. 00 09900 OTHER REI MBURSABLE COST CENTERS 0.000000 99. 0 99. 00 09900 OTHER REI MBURSABLE COST CENTERS 0.000000 99. 0 99. 00 09900 OTHER REI MBURSABLE COST CENTERS 0.000000 99. 0 99. 00 09900 OTHER REI MBURSABLE COST CENTERS 0.000000 99. 0 99. 00 09900 OTHER REI MBURSABLE COST CENTERS 0.000000 99. 0 99. 00 09900 OTHER REI MBURSABLE COST CENTERS 0.000000 99. 0 99. 00 09900 OTHER REI MBURSABLE COST CENTERS 0.0000000 99. 0 99. 00 09900 OTHER REI MBURSABLE COST CENTERS 0.0000000 99. 0		1 1	1				65. 00
68. 00		1 1	1				66.00
69. 00		1 1	1				
70. 00		1 1	1				
71. 00		l l	1				1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 806193 72. 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 407359 73. 0 74. 00 07400 RENAL DI ALYSIS 0. 917305 74. 0 75. 00 07500 ASC (NON-DISTINCT PART) 0. 000000 75. 0 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 88. 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC 90. 00 90. 01 09001 PARTI ALL HOSPI TALIZATI ON 0. 000000 90. 0 91. 00 09100 EMERGENCY 0. 919572 91. 0 92. 00 09200 DESERVATI ON BEDS (NON-DISTINCT PART) 0. 000000 92. 0 94. 00 09400 HOME PROGRAM DIALYSIS 0. 000000 95. 0 95. 00 09500 AMBULANCE SERVICES 0. 000000 95. 0 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0. 000000 97. 0 98. 00 05950 OTHER REI MBURSABLE COST CENTERS 0. 000000 97. 0 99. 00 09900 CMHC		1 1	1				1
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 407359 74. 00 07400 RENAL DIALYSIS 0. 917305 74. 00 07500 ASC (NON-DISTINCT PART) 0. 0000000 75. 00 07500 ASC (NON-DISTINCT PART) 0. 0000000 75. 00 09800 RURAL HEALTH CLINIC 88. 00 08800 RURAL HEALTH CENTER 89. 00 09900 CLINIC 0. 0000000 90. 00 09000 CLINIC 0. 0000000 90. 00 09000 PARTIAL HOSPITALIZATION 0. 0000000 90. 00 09100 EMERGENCY 0. 919572 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 0000000 0THER REIMBURSABLE COST CENTERS 0. 0000000 99. 00 09500 AMBULANCE SERVICES 0. 0000000 99. 00 09500 AMBULANCE SERVICES 0. 0000000 99. 00 09700 DURABLE MEDICAL EQUIP-RENTED 0. 0000000 99. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0. 0000000 99. 00 09900 CMHC 99. 00 09900 CMHC		1 1	1				72. 00
75. 00 07500 ASC (NON-DISTINCT PART) 0. 000000 75. 0 OUTPATIENT SERVICE COST CENTERS 88. 00 08900 RURAL HEALTH CLINIC 89. 00 09900 CLINIC 0.000000 90. 01 09001 PARTIAL HOSPITALIZATION 0. 000000 90. 01 09100 EMERGENCY 0. 91572 91. 0 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0. 000000 92. 0 OTHER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DIALYSIS 0. 000000 92. 0 95. 00 09500 AMBULANCE SERVICES 0. 000000 95. 0 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0. 000000 97. 00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0. 000000 97. 0 98. 00 05950 OTHER REIMBURSABLE COST CENTERS 99. 0. 000000 99. 0 99. 00 09900 CMHC 99. 0		1 1	1				73. 00
SERVICE COST CENTERS SERVICE COST CENTERS	74.00	07400 RENAL DIALYSIS	0. 917305				74. 00
88. 00	75. 00		0. 000000				75. 00
89. 00							
90. 00 09000 CLI NI C 0. 000000 90. 00		1 1					1
90. 01 09001 PARTI AL HOSPI TALI ZATI ON 0.000000 91. 00 91. 00 91. 00 91. 00 92. 00 92. 00 09200 085ERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 92. 00 09400 HOME PROGRAM DI ALYSI S 0.000000 94. 00 95. 00 09500 AMBULANCE SERVI CES 0.000000 95. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 96. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 98. 00 09900 CMHC 0.000000 99. 00 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.00000000			0.000000				
91. 00 09100 EMERGENCY 0. 919572 0. 000000 92. 00			1				1
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0. 000000 0THER REI MBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S 0. 000000 95. 00 09500 AMBULANCE SERVI CES 0. 000000 95. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0. 000000 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0. 000000 97. 00 09900 0700 07000 07000 07000 07000 07000 07000 07000 07000 07000 0700000 0700000 07000000 07000000 07000000 07000000 07000000 070000000 070000000 070000000 070000000 070000000 070000000 070000000 070000000 070000000 070000000 070000000 070000000 0700000000		i i	1				91.00
94. 00 09400 HOME PROGRAM DI ALYSI S 0.000000 94. 0 95. 00 09500 AMBULANCE SERVI CES 0.000000 95. 0 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 96. 0 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 97. 0 98. 00 05950 OTHER REI MBURSABLE COST CENTERS 0.000000 98. 0 99. 00 09900 CMHC 99. 0							92.00
95. 00 09500 AMBULANCE SERVICES 0. 000000 95. 0 96. 00 96. 00 97. 00 97. 00 97. 00 97. 00 97. 00 98. 00 05950 OTHER REIMBURSABLE COST CENTERS 0. 000000 98. 00 99. 00 09900 CMHC 99. 00 09900 CMHC 99. 00 99. 0							
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0. 000000 97. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0. 000000 97. 00 98. 00 05950 OTHER REI MBURSABLE COST CENTERS 0. 000000 98. 00 99. 00 09900 CMHC 99. 00 99. 00 09900 CMHC 99. 00 99.		i i	1				94. 00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0. 000000 98. 00 05950 OTHER REI MBURSABLE COST CENTERS 0. 000000 99. 00 09900 CMHC 99. 00 09900 CMHC 99. 00 09900 CMHC 99. 00 09900 0			1				95. 00
98. 00 05950 OTHER REI MBURSABLE COST CENTERS 0. 000000 99. 00 09900 CMHC 99. 00 99. 0		1 1					96.00
99. 00 09900 CMHC 99. 0		1 1	1				
		1 1	0.000000				
99. 10 09910 CORF 99. 10							99. 10
							100.00
		1 1					101.00
SPECIAL PURPOSE COST CENTERS		SPECIAL PURPOSE COST CENTERS					
		1 1					105. 00
							106. 00
		1 1					107. 00
							108.00
		1 1					109. 00 110. 00
		1 1					111.00
		1 1					113. 00
		1 1					114. 00
		1 1					115. 00
116. 00 11600 H0SPI CE 116. 0	116.00	11600 H0SPI CE					116. 00
							200. 00
							201.00
202.00 Total (see instructions) 202.00	202.00	ווסדמו (see instructions)					202. 00

Health Financial Systems M	ETHODIST HOSPIT	TAL OF CHICAGO		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	Provi der		Period: From 10/01/2011	Worksheet D Part I		
				Го 09/30/2012		
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	,					
30. 00 03000 ADULTS & PEDI ATRI CS	675, 551	(675, 55	-		
31.00 03100 INTENSIVE CARE UNIT	34, 528		34, 52	751		
32. 00 03200 CORONARY CARE UNIT	0			0	0.00	
33.00 03300 BURN INTENSIVE CARE UNIT	0			0	0.00	
34.00 03400 SURGI CAL INTENSI VE CARE UNIT	0			0		34. 00
40. 00 04000 SUBPROVI DER - 1 PF	0	(0	0.00	
41. 00 04100 SUBPROVI DER - I RF	0	(0	0.00	
42. 00 04200 SUBPROVI DER	0	(0	0.00	
43. 00 04300 NURSERY	0			0	0.00	
44.00 04400 SKILLED NURSING FACILITY	79, 402		79, 40	957	82. 97	44.00
45.00 O4500 NURSING FACILITY	0			0	0.00	
200.00 Total (lines 30-199)	789, 481		789, 48	1 25, 797		200. 00

Health Financial Systems	METHODIST HOSPITAL O	F CHI CAGO		In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAP	TAL COSTS	Provider CCN:	140197	Peri od: From 10/01/2011 To 09/30/2012	Worksheet D Part I Date/Time Prepared: 2/27/2013 1:01 pm

					2/27/2013 1:01	pm
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	12, 300	344, 892				30.00
31.00 03100 INTENSIVE CARE UNIT	470	21, 611				31.00
32. 00 03200 CORONARY CARE UNIT	0	0				32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0				33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0				34.00
40. 00 04000 SUBPROVI DER - 1 PF	0	0)			40.00
41. 00 04100 SUBPROVI DER - RF	0	0)			41.00
42. 00 04200 SUBPROVI DER	0	0				42.00
43. 00 04300 NURSERY	0	0				43.00
44.00 04400 SKILLED NURSING FACILITY	950	78, 822				44.00
45.00 04500 NURSING FACILITY	0	0)			45.00
200.00 Total (lines 30-199)	13, 720	445, 325			2	200. 00

Health Financial Systems N	ETHODIST HOSPI	TAL OF	CHI CAGO		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS		Provi der	CCN: 140197	Peri od:	Worksheet D	
					From 10/01/2011	Part II	
					To 09/30/2012	Date/Time Pre	pared:
						2/27/2013 1:0	1 pm
			Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total	Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from	Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,			(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.		8)	2)	, and the second		
	26)						
	1.00		2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS							
50. 00 05000 OPERATING ROOM	200, 406		4, 491, 103	0.04462	752, 721	33, 589	50.00
51. 00 05100 RECOVERY ROOM	0	İ	., ., .,	i		0	51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0		0	i		Ö	52.00
53. 00 05300 ANESTHESI OLOGY	9, 963	ŀ	839, 550	1		1, 401	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	175, 190		3, 989, 903	1		58, 063	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	173, 170	ŀ	3, 707, 703 N	1		30,003	55.00
	0	ŀ	0	0.00000		Ŭ	
56. 00 05600 RADI 01 SOTOPE	0		0	0.00000		0	56. 00
57. 00 05700 CT SCAN	0		0	0.0000		0	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0		0	0. 00000		0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		0	0.00000		0	59. 00
60. 00 06000 LABORATORY	102, 959	1	2, 048, 911	0. 00854	5, 039, 305	43, 061	60. 00
60. 01 06001 BLOOD LABORATORY	0		0	0. 00000	00	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY							61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0. 00000	00	0	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0. 00000	00	0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0		0	0. 00000	00	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	41, 494		3, 901, 268	1		20, 743	
66. 00 06600 PHYSI CAL THERAPY	17, 643		479, 028			6, 191	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	i	. , , , , , ,	1		0, . , .	67. 00
68. 00 06800 SPEECH PATHOLOGY	0		0	0.00000		Ö	68. 00
69. 00 06900 ELECTROCARDI OLOGY	23, 036		1, 762, 148	1		9, 717	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	25,030	ŀ	1, 702, 140	0.0000		0,717	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 472		1 121 427	1		891	71.00
		ŀ	1, 131, 627				
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 310	ŀ	376, 611	0.00613		216	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	58, 646		9, 084, 326			29, 919	
74. 00 07400 RENAL DI ALYSI S	224		31, 320			115	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0		0	0.0000	00 0	0	75. 00
OUTPATIENT SERVICE COST CENTERS	_			T		_	
88.00 08800 RURAL HEALTH CLINIC	0		0			0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0.00000		0	89. 00
90. 00 09000 CLI NI C	0		0	0. 00000	00	0	90.00
90. 01 09001 PARTI AL HOSPI TALI ZATI ON	145, 200		0	0. 00000	00	0	90. 01
91. 00 09100 EMERGENCY	58, 367		2, 681, 678	0. 02176	55 414, 532	9, 022	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		293, 436	0. 00000	00	0	92. 00
OTHER REIMBURSABLE COST CENTERS							1
94.00 09400 HOME PROGRAM DIALYSIS	0		0	0.00000	00 0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	1	1					95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	1	0	0. 00000	00	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0		0	0. 00000		o o	97. 00
98. 00 05950 OTHER REIMBURSABLE COST CENTERS			0	0.00000		0	98. 00
200.00 Total (lines 50-199)	839, 910	1	1, 110, 909		15, 419, 901	·	
200.00 10tal (111103 00 177)	037, 910	1 7	1, 110, 707	I	15, 417, 701	212, 720	1200.00

Health Financial Systems	METHODIST HOSPITAL OF CHICA	√GO Ir	n Lieu of Form CMS-2552-10
ADDODEL ONMENT OF LADATIENT DOUTLAGE	CERVILOE OTHER PAGE THROUGH COCTE	1 00N 440407 D 1 1	W 1 1 1 D

Hearth Frhancial Systems	ETHUDIST HUSPI	TAL OF CHICAGO		III LI E	u or form cws-z	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provi der	1	Period: From 10/01/2011 Fo 09/30/2012		
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos-	t Amount (see	1 through 3,	
				instructions)	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	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	0)	l 0 ¹	31. 00
32. 00 03200 CORONARY CARE UNIT	0	0)	0	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0)	0	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0)	l o'	34.00
40. 00 04000 SUBPROVI DER - 1 PF	0	0		0	0	40. 00
41. 00 04100 SUBPROVI DER - RF	0	0		0	0	41. 00
42. 00 04200 SUBPROVI DER	0	0		0	0	42. 00
43. 00 04300 NURSERY	0			n o	0	43. 00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0))	0	44. 00
45. 00 04500 NURSI NG FACILITY] /	2	1	45. 00
]		0	1
200.00 Total (lines 30-199)	l 0	ıl O	1	기	1	200. 00

Health Financial Systems	METHODIST HOSPI	TAL OF CHICAGO		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA		rs Provi der	1	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part III Date/Time Pre 2/27/2013 1:0	pared:
			e XVIII	Hospi tal	PPS	
Cost Center Description	Total Patient	Per Diem (col.		Inpati ent		
	Days	5 ÷ col. 6)	Program Days			
				Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6. 00	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	24, 089	0.00	12, 30	0 0	I	30. 00
31.00 03100 INTENSIVE CARE UNIT	751	0.00	47	0 0	I	31. 00
32. 00 03200 CORONARY CARE UNIT	0	0.00		0 0		32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0.00		0 0		33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0.00		0 0	1	34.00
40. 00 04000 SUBPROVI DER - 1 PF	0	0.00		0 0		40. 00
41. 00 04100 SUBPROVI DER - I RF	0	0.00		0 0		41.00
42. 00 04200 SUBPROVI DER	0	0.00		0 0		42.00
43. 00 04300 NURSERY	0	0.00)	o		43.00
44.00 04400 SKILLED NURSING FACILITY	957	0.00	95	0	l	44. 00
45.00 04500 NURSING FACILITY	0	0.00		o lc		45. 00
200.00 Total (lines 30-199)	25, 797		13, 72	ol ol	I	200. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet D |
| From 10/01/2011 | Part IV |
| To 09/30/2012 | Date/Time Prepared: | 2/27/2013 1:01 pm | THROUGH COSTS

						'	0 077 007 2012	2/27/2013 1:0	1 pm
					e XVIII		Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi n	g School	Allied	Heal th	All Other	Total Cost	
		Anestheti st					Medi cal	(sum of col 1	
		Cost					Education Cost	through col.	
								4)	
		1.00	2	. 00	3.	00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS								
50. 00	05000 OPERATI NG ROOM	0		0		C		0	50. 00
51. 00	05100 RECOVERY ROOM	0		0		C	0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0)	0		C	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0)	0		C	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0)	0		C	0	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0)	0		C	0	0	55. 00
56.00	05600 RADI OI SOTOPE	0		0		C	0	0	56. 00
57. 00	05700 CT SCAN	0		0		C	0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0		C	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0		0		C	0	0	59. 00
60.00	06000 LABORATORY	0		0		C	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0		0		C	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY								61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0		C	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0		0		C	0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0		0		C	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0		0		C	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0		0		C	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0		0		C	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0		0		C	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0		0		C	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	ol .	0		C	0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	ol .	0		C	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	ol .	0		C	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	ol .	0		C	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	ol .	0		C	0	0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	ol .	0		C	0	0	75. 00
	OUTPATIENT SERVICE COST CENTERS		•						
88. 00	08800 RURAL HEALTH CLINIC	0		0		C	0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0)	0		C	0	0	89. 00
90.00	09000 CLI NI C	0	oj.	0		C	0	0	90.00
90. 01	09001 PARTI AL HOSPI TALI ZATI ON	0	ol .	0		C	0	0	90. 01
91.00	09100 EMERGENCY	0	ol .	0		C	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	ol .	0		C	0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS	•							
94.00	09400 HOME PROGRAM DIALYSIS	0		0		C	0	0	94. 00
	09500 AMBULANCE SERVICES								95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0)	0		C	0	0	96. 00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0		0		C	0	0	97. 00
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0		0		C	0	0	98. 00
200.00	Total (lines 50-199)	0		0		C	0	0	200. 00
		•					•		

Health Financial Systems	METHODIST HOSPITAL C	F CHI CAGO	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 140197		Worksheet D
THROUGH COSTS			From 10/01/2011	Part IV

THROUG	H COSTS					o 09/30/2012	Date/Time Pre 2/27/2013 1:0	pared:
				Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Total	Total	Charges	Ratio of Cost	Outpati ent	Inpati ent	
		Outpati ent	(from	Wkst. C,	to Charges	Ratio of Cost	Program	
		Cost (sum of	Part		(col. 5 ÷ col.	to Charges	Charges	
		col . 2, 3 and		8)	7)	(col. 6 ÷ col.		
		4)				7)		
	ANOULL ARV. CERVI OF COCT. CENTERS	6. 00		7. 00	8. 00	9. 00	10. 00	
EO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	1 0	ı	4 401 102	0.000000	0. 000000	752, 721	FO 00
50. 00 51. 00	05100 RECOVERY ROOM	0		4, 491, 103 0	0.000000		752, 721	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM			0	0.000000		0	52.00
53. 00	05300 ANESTHESI OLOGY	0		839, 550	0.000000	1	118, 061	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0		3, 989, 903	0.000000		1, 322, 383	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0		0, 707, 703	0.000000	1	1, 322, 303	1
56. 00	05600 RADI OI SOTOPE	0	l	0	0. 000000		0	56.00
57. 00	05700 CT SCAN	0		0	0. 000000		0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0		0	0. 000000		0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		0	0. 000000		0	59. 00
60.00	06000 LABORATORY	0	1	2, 048, 911	0. 000000		5, 039, 305	60.00
60. 01	06001 BLOOD LABORATORY	0	l	0	0.000000		0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		İ					61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0.000000	0. 000000	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0.000000	0. 000000	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0		0	0. 000000	0. 000000	0	64. 00
65.00	06500 RESPIRATORY THERAPY	0	ĺ	3, 901, 268	0.000000	0. 000000	1, 950, 247	65. 00
66.00	06600 PHYSI CAL THERAPY	0		479, 028	0.000000	0. 000000	168, 086	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0		0	0.000000	0. 000000	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0		0	0.000000		0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0		1, 762, 148		1	743, 294	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	0		0	0. 000000		0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		1, 131, 627	0. 000000		225, 551	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1	376, 611	0. 000000		35, 217	
73.00	07300 DRUGS CHARGED TO PATIENTS	0		9, 084, 326			4, 634, 370	
74.00	07400 RENAL DIALYSIS	0		31, 320			16, 134	
75. 00	07500 ASC (NON-DISTINCT PART)	0	1	0	0.000000	0.000000	0	75. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	1 0	ı	0	0.000000	0. 000000	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0			0	1
90.00	109000 CLINIC	0		0	0.000000		0	90.00
90. 00	09001 PARTIAL HOSPITALIZATION	0		0	0.000000		0	90.00
91. 00	09100 EMERGENCY			2, 681, 678			414, 532	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		293, 436			414, 552	1
72.00	OTHER REIMBURSABLE COST CENTERS			273, 430	0.00000	0.000000		72.00
94. 00	09400 HOME PROGRAM DIALYSIS	0		0	0.000000	0.000000	0	94. 00
95. 00	09500 AMBULANCE SERVI CES			_			_	95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0. 000000	0. 000000	0	
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD			0	0. 000000	1	0	97. 00
98. 00	05950 OTHER REIMBURSABLE COST CENTERS	0		0	0. 000000		0	
200.00		0	4	1, 110, 909			15, 419, 901	200. 00
		•			:			•

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | From 10/01/2011 | Part IV | To 09/30/2012 | Date/Time Prepared: | 2/27/2013 1:01 pm THROUGH COSTS

						2/27/2013 1:0	1 pm
			Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	I npati ent	Outpati ent	Outpati ent			
		Program	Program	Program			
		Pass-Through	Charges	Pass-Through	1		
		Costs (col. 8	Ŭ	Costs (col.	9		
		x col. 10)		x col. 12)			
		11.00	12. 00	13.00			
	ANCILLARY SERVICE COST CENTERS	11100	12.00	10.00			
50.00	05000 OPERATI NG ROOM	ام	1, 251, 249	ol	0		50.00
51. 00	05100 RECOVERY ROOM		143, 847	•	Ö		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	143, 647	1	0		52.00
		0	-		-		
53.00	05300 ANESTHESI OLOGY	0	211, 349		0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	817, 277		0		54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0)	0		55. 00
56. 00	05600 RADI OI SOTOPE	0	0)	0		56. 00
57.00	05700 CT SCAN	0	0)	0		57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	ol	0		0		59. 00
60.00	06000 LABORATORY	ol	344, 162		0		60.00
60. 01	06001 BLOOD LABORATORY	أم	0		0		60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	l	· ·	1			61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0		0		62.00
	l l	0	0	(0		
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	U	<u>'</u>	0		63.00
64.00	06400 I NTRAVENOUS THERAPY	0	(7.504	7	0		64. 00
65. 00	06500 RESPI RATORY THERAPY	0	67, 531		0		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0)	0		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0)	0		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0)	0		68. 00
69.00	06900 ELECTROCARDI OLOGY	0	272, 405	5	0		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	l ol	137, 377	·	0		71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	o	57, 393	1	0		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	أم	1, 788, 163	1	0		73. 00
74. 00	07400 RENAL DIALYSIS		0,700,700	1	o		74. 00
75. 00	07500 ASC (NON-DISTINCT PART)		Ö	1	Ö		75. 00
73.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>		′1	O _I		75.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	J	0		88. 00
		0	0	•			
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	U	<u>'</u>	0		89. 00
90.00	09000 CLI NI C	0	Ü)	0		90.00
90. 01	09001 PARTI AL HOSPI TALI ZATI ON	0	0)	0		90. 01
91. 00	09100 EMERGENCY	0	546, 281	1	0		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	117, 810)	0		92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0		0		94. 00
95.00	09500 AMBULANCE SERVICES						95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	l ol	0		0		96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	ا	n		o		97. 00
98. 00	05950 OTHER REIMBURSABLE COST CENTERS	١	0		Ö		98.00
200.00	l l		5, 754, 844		0		200.00
200.00	/ 10tui (111163 30-177)	١	5, 754, 044	1	Ο _I		1200.00

	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		CCN: 140197	Peri od: From 10/01/2011	Worksheet D Part V Date/Time Prepared: 2/27/2013 1:01 pm
-			Ti +I	e XVIII	Hospi tal	PPS
			11 (1	Charges	nospi tui	113
	Cost Center Description	Cost to Charge	DDS Doimbursod		Cost	
	cost center bescription		Services (see	Rei mbursed	Rei mbursed	
			inst.)	Servi ces	Servi ces Not	
		Worksheet C, Part I, col. 9		Subject To	Subject To	
		Part I, Cor. 9				
				Ded. & Coins		
		1 00	2.00	(see inst.)		
	ANGLILADY CEDVICE COCT CENTERS	1.00	2. 00	3. 00	4. 00	
F0 00	ANCI LLARY SERVI CE COST CENTERS	0.747045	4 054 040	1		F0.00
50.00	05000 OPERATI NG ROOM	0. 747345			0 0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	143, 847		0 0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 288780	211, 349		0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 480004	817, 277		0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	55. 00
56.00	05600 RADI OI SOTOPE	0. 000000	0		0 0	56.00
57.00	05700 CT SCAN	0. 000000	0		0 0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	59.00
60.00	06000 LABORATORY	0. 258132	344, 162		0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	01.7.02		0 0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			0 0	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0		0 0	62. 00
63.00	1	•	0	•		
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000		•		63.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0		9	64.00
65. 00	06500 RESPI RATORY THERAPY	0. 301346			0 0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 925378	0		0 0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	0		0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0		0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 303139	272, 405		0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 381072	137, 377		0 0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 806193	57, 393		0 0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 407359	1, 788, 163		0 650	73.00
74.00	07400 RENAL DIALYSIS	0. 917305	0	1	0 0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	75. 00
	OUTPATIENT SERVICE COST CENTERS					
88. 00	08800 RURAL HEALTH CLINIC	0. 000000				88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				89. 00
90.00	09000 CLINIC	0. 000000	0		0 0	90.00
90. 00	09001 PARTIAL HOSPITALIZATION	0. 000000	0	•	0 0	90.00
			·		-	
91.00	09100 EMERGENCY	0. 919572	546, 281	1		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	117, 810		0 0	92. 00
	OTHER REIMBURSABLE COST CENTERS					
94. 00	09400 HOME PROGRAM DI ALYSI S	0. 000000			0	94. 00
95. 00	09500 AMBULANCE SERVI CES	0. 000000			0	95. 00
96. 00	09600 DURABLE MEDI CAL EQUI P-RENTED	0. 000000	0	•	0 0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		0	97.00
98. 00	05950 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0	98. 00
200.00	Subtotal (see instructions)		5, 754, 844		0 650	200. 00
201.00	Less PBP Clinic Lab. Services-Program				0 0	201. 00
	Only Charges					
202.00	Net Charges (line 200 +/- line 201)		5, 754, 844		0 650	202. 00
		•				•

Cost Center Description	APPOR	FIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 140197	Peri od:	Worksheet D	
Cost Center Description						From 10/01/2011 To 09/30/2012	Part V	enared:
Cost Center Description						70 077 007 2012	2/27/2013 1:0)1 pm
Cost Center Description				Ti tl	le XVIII	Hospi tal	PPS	
See Inst. Services Servic								
NACT LARY SERVICE COST CENTERS Subject To Ded & Col ns. Subject To		Cost Center Description						
Subject To Ded & Coins Ded			(see inst.)					
Ded. & Coin Is. Gose Inst. See Inst.						τ		
See inst.) See inst.) See inst.) See inst. S				,				
ANCILLARY SERVICE COST CENTERS								
ANCI LLARY SERVICE COST CENTERS			5.00					
50.00 05000 0FERTING ROOM 935.115 0 0 51.00 51.00 05100 05200 0FELVERY ROOM 0 0 0 0 0 52.00 05200 0FELVERY ROOM 0 0 0 0 0 53.00 05300 0ARD 10CO 0 0 0 0 53.00 05300 0ARD 10CO 0 0 0 0 53.00 05300 0ARD 10CO 0 0 0 0 54.00 05400 RADI 0LOGY - 0 0 0 0 0 55.00 05500 0ARD 0LOGY - 10 AGNOSTI 0 0 0 0 0 55.00 05500 0ARD 0LOGY - 10 FRADEUTI 0 0 0 0 0 55.00 05500 0ARD 0LOGY - 10 FRADEUTI 0 0 0 0 0 55.00 05500 0ARD 0LOGY - 10 FRADEUTI 0 0 0 0 0 57.00 05700 05700 0T SCAN 0 0 0 0 0 57.00 05700 0T SCAN 0 0 0 0 0 0 58.00 05800 MADINETI 0.00 0 0 0 0 0 59.00 05900 CARDI 0.00 0 0 0 0 0 0 59.00 05900 CARDI 0.00 0 0 0 0 0 0 60.00 05900 CARDI 0.00 0 0 0 0 0 0 60.00 05900 CARDI 0.00 0 0 0 0 0 0 60.00 05900 HALD 1.00 0 0 0 0 0 0 0 60.00 05900 HALD 1.00 0 0 0 0 0 0 60.00 05900 HALD 1.00 0 0 0 0 0 0 60.00 05900 HALD 1.00 0 0 0 0 0 0 60.00 05900 0.00 0.00 0.00 0 0 0 0		ANCILLARY SERVICE COST CENTERS	0.00	0.00	7.00			
S2.00 05.200 05.200 05.200 05.200 05.300 05.300 05.300 05.300 05.300 05.300 05.300 05.300 05.300 05.300 05.300 05.300 05.300 05.300 05.300 05.300 05.300 05.300 05.300 05.00 05.500 05.00 05.00 05.00 05.500 05.	50.00		935, 115	(O	0		50.00
53.00 08300 ANESTHESI OLOGY	51.00	05100 RECOVERY ROOM	0		o	0		51.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C 392, 296 0 0 0 54. 00	52.00	05200 DELIVERY ROOM & LABOR ROOM	0	(0		52. 00
55. 00 05500 RADIO LOGY-THERAPEUTIC	53.00	05300 ANESTHESI OLOGY	61, 033	(o l	0		53.00
56. 00 05.	54.00	05400 RADI OLOGY-DI AGNOSTI C	392, 296	(0	0		54.00
57.00 05700 CT SCAN 0 0 0 0 0 58.00 58.00 05900 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 59.00 05900 05900 05900 05900 0 0 0 59.00 05900 05900 05900 05900 0 0 0 60.00 06000 06000 06000 0 0 0	55.00	05500 RADI OLOGY-THERAPEUTI C	0	(O	0		55.00
S8. 00 05900 MARNETIC RESONANCE IMAGING (MRI) 0 0 0 0 58. 00	56.00	05600 RADI OI SOTOPE	0	()	0		56. 00
59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 60.00	57. 00		0	(0	0		57. 00
60. 00 06000 LABORATORY 88,839 0 0 0 60. 01 61. 00 06100 BLOOD LABORATORY 0 0 0 0 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 0 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 63. 00 06300 BLOOD STORING, PROCESSI NG & TRANS. 0 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 65. 00 06500 RESPIR ATORY THERAPY 20,350 0 0 0 66. 00 06500 RESPIR ATORY THERAPY 0 0 0 0 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 68. 00 06600 SPECH PATHOLOGY 0 0 0 0 68. 00 06600 SPECH PATHOLOGY 82,577 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 82,577 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 82,577 0 0 0 67. 00 07000 ELECTROCARDI OLOGY 82,577 0 0 0 67. 00 07000 ELECTROCARDI OLOGY 82,577 0 0 0 67. 00 07000 ELECTROCARDI OLOGY 82,577 0 0 0 67. 00 07000 ELECTROCARDI OLOGY 82,577 0 0 0 67. 00 07000 ELECTROCARDI OLOGY 82,571 0 0 0 67. 00 07000 ELECTROCARDI OLOGY 82,571 0 0 0 67. 00 07000 ELECTROCARDI OLOGY 82,571 0 0 0 67. 00 07000 ELECTROCARDI OLOGY 82,571 0 0 0 67. 00 07000 ELECTROCARDI OLOGY 82,571 0 0 0 67. 00 07000 ELECTROCARDI OLOGRAPHY 0 0 0 67. 00 07000 ELECTROCARDI OLOGRAPHY 0 0 0 67. 00 07000 ELECTROCARDI OLOGRAPHY 0 0 0 67. 00 07000 ELECTROCARDI OLOGRAPHY 0 0 0 67. 00 07000 ELECTROCARDI OLOGRAPHY 0 0 0 67. 00 07000 ELECTROCARDI OLOGRAPHY 0 0 0 67. 00 07000 ELECTROCARDI OLOGRAPHY 0 0 0 67. 00 07000 ELECTROCARDI OLOGRAPHY 0 0 0 67. 00 07000 ELECTROCARDI OLOGRAPHY 0 0 0 67. 00 07000 ELECTROCARDI OLOGRAPHY 0 0 0 67. 00 07000 ELECTROCARDI OLOGRAPHY 0 0 0 67. 00 07000 ELECTROCARDI OLOGRAPHY 0 0 0 67. 00 07000 ELECTROCARDI OLOGRAPHY 0 0 67. 00 07000 ELECTROCARDI OLOGRAPH			0	(0	0		58. 00
60.01 06001 BLOOD LABORATORY 0 0 0 0 61.00 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 0 62.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 65.00 06500 RESPIRATORY THERAPY 20, 350 0 0 0 0 66.00 06600 PHYSICAL THERAPY 0 0 0 0 0 67.00 06600 PHYSICAL THERAPY 0 0 0 0 0 68.00 06600 PHYSICAL THERAPY 0 0 0 0 0 68.00 06600 PHYSICAL THERAPY 0 0 0 0 0 68.00 06600 PHYSICAL SUPPLIES CHARGED TO PATIENTS 20, 357 0 0 0 69.00 06900 ELECTROCROPIALOGRAPH 0 0 0 0 70.00 07000 CLUCTROCARDIOLOGY 82, 577 0 0 0 71.00 07100 MDICAL SUPPLIES CHARGED TO PATIENTS 52, 351 0 0 71.00 07100 MDICAL SUPPLIES CHARGED TO PATIENTS 52, 351 0 0 71.00 07300 IMPL. DEV. CHARGED TO PATIENTS 728, 424 0 265 73, 00 74.00 07400 RENAL DIALYSIS 0 0 0 0 75.00 07500 ASC (MON-DISTINCT PART) 0 0 0 0 75.00 07500 ASC (MON-DISTINCT PART) 0 0 0 76.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 90.01 09001 PARTI AL HOSPI TALIZATION 0 0 0 90.01 09001 09001 PARTI AL HOSPI TALIZATION 0 0 0 91.00 09000 CLINIC 0 0 0 92.00 09200 0SERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 91.00 09000 EMBERGENCY 0 0 0 92.00 09400 HOME PROGRAM DIALYSIS 0 0 0 94.00 09400 HOME PROGRAM DIALYSIS 0 0 95.00 09400 DURABLE MEDICAL EQUI P-RENTED 0 0 0 96.00 09400 DURABLE MEDICAL EQUI P-RENTED 0 0 97.00 09700	59. 00		1	(0	0		59. 00
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 0 0 0 0 0 0 0 0			88, 839	(0	0		60. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 0 0			0	(0	0		•
63. 00 06300 BLOOD STORI NG, PROCESSING & TRANS. 0 0 0 0 0 0 0 0 0				(0			•
64. 00 06400 NTRAVENOUS THERAPY			0	(O	O		
65. 00 06500 RESPIRATORY THERAPY 20,350 0 0 66. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 82,577 0 0 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 52,351 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 46,270 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 728,424 0 265 73. 00 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 88. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 90. 00 09900 CLINIC 0 0 0 90. 01 09900 DEBRYATIAL HOSPITALIZATION 0 0 0 91. 00 09900 DEBRYATIAL HOSPITALIZATION 0 0 0 92. 00 09500 DEBRYATION BEDS (NON-DISTINCT PART) 0 0 0 91. 00 09500 DEBRYATION BEDS (NON-DISTINCT PART) 0 0 0 92. 00 09500 DEBRYATION BEDS (NON-DISTINCT PART) 0 0 0 92. 00 09500 DEBRYATION BEDS (NON-DISTINCT PART) 0 0 0 92. 00 09500 DEBRYATION BEDS (NON-DISTINCT PART) 0 0 0 93. 00 09500 DEBRYATION BEDS (NON-DISTINCT PART) 0 0 0 94. 00 09500 DEBRYATION BEDS (NON-DISTINCT PART) 0 0 0 95. 00 09500 DEBRYATION BEDS (NON-DISTINCT PART) 0 0 0 96. 00 09500 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 97. 00 09500 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 98. 00 09500 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 99. 00 05950 OTHER REI MBURSABLE COST CENTERS 0 0 0 90. 01 05950 OTHER REI MBURSABLE COST CENTERS 0 0 0 90. 01 05950 OTHER REI MBURSABLE COST CENTERS 0 0 0 90. 01 05950 OTHER REI MBURSABLE COST CENTERS 0 0 0 90. 01 05950 OTHER REI MBURSABLE COST CENTERS 0 0 0 90. 01 05950 OTHER REI MBURSABLE COST CENTERS			_	()	-		1
66. 00 66			_	(0	9		1
67. 00 06700 OCCUPATIONAL THERAPY 0 0 0 0 0 0 0 0 0			1		0	0		
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 82,577 0 0 0 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 52,351 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 46,270 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 728,424 0 2655 73. 00 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 75. 00 0000 OND CONTROL OND CONTROL OND CONTROL 88. 00 08900 RURAL HEALTH CLINIC 0 0 0 0 89. 00 09000 CLINIC OND CONTROL OND CONTROL OND CONTROL 89. 00 09000 PEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 90. 01 09001 PARTI AL HOSPI TALI ZATI ON 0 0 0 91. 00 09000 PARTI AL HOSPI TALI ZATI ON 0 0 0 92. 00 09200 08SERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 97. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 97. 00 09400 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 98. 00 09500 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 99. 00 09500 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 99. 00 09500 DURABLE MEDI CAL EQUI P-SOLD 0 0 90. 00 09500 DURABLE MEDI CAL EQUI P-SOLD 0 0 90. 00 09500 DURABLE MEDI CAL EQUI P-SOLD 0 0 90. 00 09500 DURABLE MEDI CAL EQUI P-SOLD 0 0 90. 00 09500 DURABLE MEDI CAL EQUI P-SOLD 0 0 90. 00 09500 DURABLE MEDI CAL EQUI P-SOLD 0 0 90. 00 09500 DURABLE MEDI CAL EQUI P-SOLD 0 0 90. 00 09500 DURABLE MEDI CAL EQUI P-SOLD 0 0 90. 00 09500 DURABLE MEDI CAL EQUI P-SOLD 0 0 90. 00 09500			-	ł	2	0		
69. 00 06900 ELECTROCARDI OLOGY 82,577 0 0 0 69. 00 70. 00			0	9)	9		•
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0			0	9		9		
71.00			82,5//	9)	-		•
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 46, 270 0 0 0 0 0 0 0 0 0			52.251)	-		•
73. 00)	-		•
74. 00					2	-		•
75. 00					•			•
SERVICE COST CENTERS SERVICE COST CENTERS			1		-			
88. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 90. 00 90. 00 90. 00 90. 01	75.00		0		<u> </u>	U _I		75.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 90. 00 90. 00 90. 00 90. 01	88 00		1 0		nl n	0		88 00
90. 00 990.00 09000 09000 09000 000000)				
90. 01 09001 PARTI AL HOSPI TALI ZATI ON 0 0 0 0 0 0 0 0 0			_)	า	0		•
91. 00 09100 EMERGENCY 502, 345 0 0 0 0 92. 00			0			0		
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0			502 345	ì	Ď	0		
OTHER REI MBURSABLE COST CENTERS 94.00 94.00 95.00 95.00 95.00 95.00 96.00 96.00 96.00 96.00 97.00 9					Ď	-		•
94. 00 09400 HOME PROGRAM DIALYSIS 0 0 0 95.00 94.00 95.00 95.00 96.00 96.00 97.00 97.00 97.00 98.00 05950 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 98.00 05950 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	72.00			`	<u> </u>			72.00
95. 00 09500 AMBULANCE SERVICES 0 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 0 0 0 0 0	94. 00				ol	0		94.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 96. 00 97. 00 98. 00 05950 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 200. 00 201. 00 Uses PBP Clinic Lab. Services-Program 0 0 0 0 0 0 0 0 0					- 1			•
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 98. 00 05950 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 98. 00 200. 00 201. 00 Less PBP Clinic Lab. Services-Program 0 0 0 265 201. 00 0 0 0 0 0 0 0 0 0	96. 00	· ·	0		ol	0		96, 00
98. 00 05950 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 200. 00 201. 00 Uses PBP Clinic Lab. Services-Program			0		o			•
200.00 Subtotal (see instructions) 2,909,600 0 265 200.00 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 265 201.00		· ·	0		ol			•
201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges	200.00	1	2, 909, 600	(2	65		200.00
	201.00				o			201.00
202.00 Net Charges (line 200 +/- line 201) 2,909,600 0 265 202.00					1			
	202.00	Net Charges (line 200 +/- line 201)	2, 909, 600	(0 2	65		202. 00

Health Financial Systems	METHODIST HOSPITAL (OF CHI CAGO	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 140197 Component CCN: 145672		Worksheet D Part IV Date/Time Prepared: 2/27/2013 1:01 pm
		T' 11 \0.0111	CLILL LN I	DDC

						2/2//2013 1:0	ı pili
			Ti tl	e XVIII	Skilled Nursing	PPS	
					Facility		
	Cost Center Description	Non Physician	Nursing School	Allied Healt	h All Other	Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 0	0	50. 00
51.00	05100 RECOVERY ROOM	ol	0		0 0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55. 00
56. 00	05600 RADI OI SOTOPE		0			Ö	56. 00
57. 00	05700 CT SCAN	0	0			0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0	58. 00
59. 00		0	0		0	0	1
	05900 CARDI AC CATHETERI ZATI ON	0	0		0	-	59.00
60.00	06000 LABORATORY	0	0		0	0	60.00
60. 01	06001 BLOOD LABORATORY	U	Ü		0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		•			_	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63. 00
64. 00	06400 NTRAVENOUS THERAPY	0	0		0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
	07400 RENAL DI ALYSI S	0	0		0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0		0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	89. 00
90.00	09000 CLI NI C	0	0		0	0	90. 00
90. 01	09001 PARTI AL HOSPI TALI ZATI ON	0	0		0	0	90. 01
91.00	09100 EMERGENCY	0	0		0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0		0 0	0	94. 00
	09500 AMBULANCE SERVICES						95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	o	0		0 0	0	96. 00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	o	0		0 0	0	97. 00
	05950 OTHER REIMBURSABLE COST CENTERS	o	0		0 0	0	98. 00
200.00		l ol	0		0 0	0	200. 00
		1		•		•	•

Health Financial Systems	METHODIST HOSPI	ΓAL O	F CHI CAGO		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	3	Provi der		Peri od:	Worksheet D	
THROUGH COSTS			Component	CCN: 145672	From 10/01/2011 To 09/30/2012		
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description	Total	Tota	I Charges	Ratio of Cos	t Outpatient	I npati ent	
	Outpati ent	(fron	n Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of	Part	l, col.	(col. 5 ÷ col	. to Charges	Charges	
	col . 2, 3 and		8)	7)	(col. 6 ÷ col.		
	4)				7)		
	6.00		7.00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0		4, 491, 103	0.00000	0. 000000	40, 943	50. 00

Cost Center Description	lotal Outpatient		to Charges	Ratio of Cost	Inpatient Program	
	Cost (sum of		(col. 5 ÷ col.	to Charges	Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.	charges	
	4)		''	7)		
	6.00	7. 00	8.00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	4, 491, 103	0.000000	0.000000	40, 943	50. 00
51. 00 05100 RECOVERY ROOM	0	0	0.000000		0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	ļ	0.000000		0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	,			872	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	3, 989, 903			62, 726	54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0.000000	0. 000000	0	55. 00
56. 00 05600 RADI 0I SOTOPE	0	0	0.000000		0	56. 00
57. 00 05700 CT SCAN	0	0	0. 000000		0	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	_	0. 000000		0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	_	0.000000		0	59. 00
60. 00 06000 LABORATORY	0	12, 048, 911			205, 052	60.00
60. 01 06001 BL00D LABORATORY	0	0	0. 000000	0. 000000	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0. 000000	0. 000000	0	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0. 000000		0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	_	0. 000000		0	64. 00
65. 00 06500 RESPI RATORY THERAPY	0				290, 514	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	1,7,020	l .		161, 402	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	_	0.000000	0. 000000	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	_	0.000000	0. 000000	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 762, 148			16, 536	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000		0	70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	1, 131, 627			20, 267	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0				0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	7,001,020			460, 426	73. 00
74. 00 07400 RENAL DIALYSIS	0		l .		0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0. 000000	0	75. 00
OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	0	0	0. 000000	0. 000000	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER			0.000000		0	89. 00
90. 00 09000 CLINIC			0.000000		0	90.00
90. 01 09000 CETNIC 90. 01 09001 PARTI AL HOSPI TALI ZATI ON		_	0.000000		0	90.00
91. 00 09100 EMERGENCY		_	1		0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		,			0	91.00
OTHER REIMBURSABLE COST CENTERS		293, 430	ų 0. 000000	0.000000	0	92.00
94. 00 09400 HOME PROGRAM DIALYSIS			0.000000	0.000000	0	94. 00
95. 00 09500 AMBULANCE SERVI CES			0.00000	0.000000	٥	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0. 000000	0. 000000	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD			0.00000		0	97. 00
98. 00 05950 OTHER REIMBURSABLE COST CENTERS		0	0.000000		0	98.00
200.00 Total (lines 50-199)			1	0.00000	1, 258, 738	
1.000. (1	1,, ,0,	I .	1 I	., 200, 700	

Health Financial Systems	METHODIST HOSPITAL C	F CHI CAGO	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY SERVI CE OTHER PASS	Provider CCN: 140197 Component CCN: 145672	Peri od: From 10/01/2011 To 09/30/2012	
				2/27/2013 1:01 pm
		Title XVIII	Skilled Nursing	PPS

			11 11	e xviii	Skilled Nursing	PPS	
	Ct Ct Biti	1	0	0	Facility		
	Cost Center Description	Inpati ent	Outpati ent	Outpatient			
		Program	Program	Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8		Costs (col.	'		
		x col . 10)	40.00	x col. 12)	_		
	ANOLILIADY CERVICE COCT CENTERS	11. 00	12. 00	13. 00			
FO 00	ANCILLARY SERVICE COST CENTERS			1			
50.00	05000 OPERATI NG ROOM	0	0		0		50.00
51. 00	05100 RECOVERY ROOM	0	0		0		51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52. 00
53.00	05300 ANESTHESI OLOGY	0	0		0		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0		54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0		55. 00
56.00	05600 RADI 01 S0T0PE	0	0		0		56. 00
57. 00	05700 CT SCAN	0	0		0		57. 00
58.00	05800 MAGNETIC RESONANCE MAGING (MRI)	0	0		0		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0		59. 00
60.00	06000 LABORATORY	0	0		o		60.00
60. 01	06001 BLOOD LABORATORY	0	0		0		60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	o	0		o		62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	o	0		o		63.00
64.00	06400 I NTRAVENOUS THERAPY	o	0		o		64. 00
65.00	06500 RESPIRATORY THERAPY	o	0		o		65. 00
66. 00	06600 PHYSI CAL THERAPY	o	0		o		66, 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		ō		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		Ö		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		ō		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0		71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		ō		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		Ö		73. 00
74. 00	07400 RENAL DIALYSIS	0	0		o		74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		o		75. 00
73.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>			<u> </u>		73.00
88. 00	08800 RURAL HEALTH CLINIC	0	0		ol		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		Ö		89. 00
90.00	09000 CLINIC	0	0	•	o o		90.00
90. 01	09001 PARTI AL HOSPI TALI ZATI ON	0	0		o		90. 01
91. 00	09100 EMERGENCY		0		Ö		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0		Ö		92. 00
12.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>	0		<u></u>		/2.00
94. 00	09400 HOME PROGRAM DIALYSIS	0	0		ol		94. 00
95. 00	09500 AMBULANCE SERVICES		0				95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED		0		0		96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD		0	i .	0		97. 00
98. 00	05950 OTHER REIMBURSABLE COST CENTERS		0		0		98. 00
200.00	1		0		0		200.00
200.00	1 1000 (11103 30 177)	١	O	I	\sim_{I}		1200.00

Health Financial Systems	METHODIST HOS	PLIAL OF	F CHI CAGO	In Lie	u of Form CMS-2	2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COS	Τ	Provider CCN: 140197	Peri od: From 10/01/2011	Worksheet D Part V	
			Component CCN: 145672			
			Title XVIII	Skilled Nursing	PPS	
				Facility		
			Charges			

		Ti tl	e XVIII S	Skilled Nursing	PPS	
			Charges	Facility 1		
0 1 0 1 0 1 1		DC D : 1	Charges	0 1		
Cost Center Description	Cost to Charge P		Cost	Cost		
		Services (see	Reimbursed	Rei mbursed		
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
	1.00	0.00	(see inst.)	(see inst.)		
ANCLLIADY SERVICE COST CENTERS	1.00	2. 00	3. 00	4. 00		
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	0. 747345	0	C	0		50. 00
51. 00 05100 RECOVERY ROOM	0. 000000	0			I	51. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0. 000000	0		-		52. 00
l I	1 1	0	_	1	•	
	0. 288780	0	C	1	1	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 480004	0	C	1	•	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0.000000	0	C	1 1	•	55. 00
56. 00 05600 RADI 01 SOTOPE	0. 000000	0	C	0	•	56. 00
57. 00 05700 CT SCAN	0. 000000	0		0	•	57. 00
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	0. 000000	0	C	1	I	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0	C	1	I	59. 00
60. 00 06000 LABORATORY	0. 258132	0	383		•	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0	C			60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000		C	0	I	61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0	C	0	I	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0	C			63. 00
64.00 06400 I NTRAVENOUS THERAPY	0. 000000	0	C	-	I	64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 301346	0	C	1 1		65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 925378	0	C	0	l l	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0	C	-		67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0	C	0		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 303139	0	C	0	(69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	C	0	•	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 381072	0	C	0	'	71. 00
72.00 O7200 MPL. DEV. CHARGED TO PATIENTS	0. 806193	0	C	0	'	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 407359	0	C	0	'	73.00
74. 00 07400 RENAL DIALYSIS	0. 917305	0	C	0	'	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0	C	0		75. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000				•	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				1	89. 00
90. 00 09000 CLI NI C	0. 000000	0	C	ή	•	90. 00
90. 01 09001 PARTI AL HOSPI TALI ZATI ON	0. 000000	0	C	0	•	90. 01
91. 00 09100 EMERGENCY	0. 919572	0	C	0	•	91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0	C	0	(92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0. 000000		C			94. 00
95. 00 09500 AMBULANCE SERVICES	0. 000000		[C		'	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0	C	0		96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0	C	0		97. 00
98.00 05950 OTHER REIMBURSABLE COST CENTERS	0. 000000	0	C	1	I	98. 00
200.00 Subtotal (see instructions)		0	383	0		00.00
201.00 Less PBP Clinic Lab. Services-Program			C	0	20	01. 00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	1	0	383	B O	20	02. 00

Health Financial Systems	METHOL	DIST HOSPITAL C	OF CHI CAGO	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACO	CINE COST	Provider CCN: 140197	Peri od: From 10/01/2011	Worksheet D
			Component CCN: 145672	To 09/30/2012	
			Title XVIII	Skilled Nursing	PPS
				Facility	

				Ti tl	e XVIII	Skilled Nursing	PPS	
			Coot	_		Facility		
	Cost Conton Decemention	PPS Servi ces	Cost Cost		Cost			
	Cost Center Description	(see inst.)	Rei mbur		Reimbursed			
		(See Hist.)	Servi		Services Not			
			Subj ect		Subject To	•		
			Ded. & C		Ded. & Coins			
			(see in		(see inst.)			
		5. 00	6.00		7.00			
Α	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0		0		0		50.00
51.00	D5100 RECOVERY ROOM	0		0		0		51.00
52.00	D5200 DELIVERY ROOM & LABOR ROOM	0		0		0		52. 00
53.00	D5300 ANESTHESI OLOGY	0		0		0		53.00
54.00	D5400 RADI OLOGY-DI AGNOSTI C	0		0		0		54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0		0		0		55. 00
56.00	D5600 RADI OI SOTOPE	0		0		0		56. 00
57.00	D5700 CT SCAN	0		0		0		57. 00
58.00	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0		0		0		58. 00
	D5900 CARDI AC CATHETERI ZATI ON	0		0		0		59. 00
60.00	06000 LABORATORY	0		99		0		60.00
60. 01	06001 BLOOD LABORATORY	0		0		0		60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			0				61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0		0		62. 00
63.00	D6300 BLOOD STORING, PROCESSING & TRANS.	0		0		0		63.00
64.00	06400 INTRAVENOUS THERAPY	0		0		0		64. 00
65.00	06500 RESPI RATORY THERAPY	0		0		0		65. 00
66.00	06600 PHYSI CAL THERAPY	0		0		0		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0		0		0		67. 00
68.00	06800 SPEECH PATHOLOGY	0		0		0		68. 00
69.00	06900 ELECTROCARDI OLOGY	0		0		0		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0		0		70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0		0		71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0		0		72. 00
73.00	D7300 DRUGS CHARGED TO PATIENTS	0		0		0		73. 00
74.00	07400 RENAL DIALYSIS	0		0		0		74. 00
	D7500 ASC (NON-DISTINCT PART)	0		0		0		75. 00
	OUTPATIENT SERVICE COST CENTERS	,						
1	08800 RURAL HEALTH CLINIC	0		0		0		88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0		0		89. 00
1	09000 CLI NI C	0		0		0		90.00
	09001 PARTI AL HOSPI TALI ZATI ON	0		0		0		90. 01
1	09100 EMERGENCY	0		0		0		91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0		92. 00
	OTHER REIMBURSABLE COST CENTERS							
	09400 HOME PROGRAM DIALYSIS			0		0		94. 00
	09500 AMBULANCE SERVICES			0				95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0		0		0		96. 00
	09700 DURABLE MEDICAL EQUIP-SOLD	0		0		0		97. 00
	05950 OTHER REIMBURSABLE COST CENTERS	0		0		0		98. 00
200.00	Subtotal (see instructions)	0		99		0		200. 00
201. 00	Less PBP Clinic Lab. Services-Program			0				201. 00
000 00	Only Charges							000 00
202. 00	Net Charges (line 200 +/- line 201)	0	l	99	I	0		202. 00

Health Financial Systems	METHODIST HOSPITAL OF CHICAGO	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 14019	From 10/01/2011	Worksheet D-1
		To 09/30/2012	Date/Time Prepared: 2/27/2013 1:01 pm
	Title XVIII	Hospi tal	PPS

No. No.	-		Title XVIII	Hospi tal	2/27/2013 1: 0 PPS	1 pm
PART 1 - ALL PROVIDER COMPONENTS PART 1 - ALL PROVIDER COMPONENTS PART 1 - ALL PROVIDER COMPONENTS PART 1 - ALL PROVIDER COMPONENTS PART 1 - ALL PROVIDER COMPONENTS PART 1 - ALL PROVIDER COMPONENTS PART 2 - ALL P		Cost Center Description		nesp. ta.		
IMPATE INTERIT BAYS		DADT I ALL DOOVLDED COMPONENTS			1. 00	
Impatient days (including private room days, excluding safing-bed and nesborn days) 24,089 2,000 20,000 24,089 2,000 20,000 24,089 2,000 20,000 24,000						
do not complete this line. 4. 00 Semi-private room days (excluding swing-bed and observation bed days) 1. 00 Total swing-bed SW type Inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed W type Inpatient days (including private room days) brough becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed W type Inpatient days (including private room days) brough becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 8. 00 Total swing-bed W type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total swing-bed W type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10. 00 Swing-bed SW type inpatient days applicable to this line) 10. 00 Swing-bed SW type inpatient days applicable to the SW of the SW of the SW of the SW of the SW of the Cost reporting period (if calendar year, enter 0 on this line) 10. 00 Swing-bed SW type inpatient days applicable to title sW or XX only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 10. 00 Swing-bed SW type inpatient days applicable to title sW or XX only (including private room days) 11. 00 Swing-bed SW type inpatient days applicable to title sW or XX only (including private room days) 12. 00 Swing-bed NE type inpatient days applicable to title sW or XX only (including private room days) 13. 00 Swing-bed NE type inpatient days applicable to title sW or XX only (including private room days) 14. 00 Swing-bed NE type inpatient days applicable to title sW or XX only (including private room days) 15. 00 Total swing-bed NE type inpatient days applicable to service swing-bed swing-bed days) 16. 00 Narsery days (title V or XX only) 17. 00 Wedicare rate for swing	2.00	Inpatient days (including private room days, excluding swing-be	d and newborn days)		24, 089	2. 00
Total swing-bed SNF type inpatient days (including private room days) through becember 31 of the cost of proporting period (including private room days) after December 31 of the cost of reporting period (including private room days) through December 31 of the cost of reporting period (including private room days) through December 31 of the cost of reporting period (including private room days) through December 31 of the cost of period (including private room days) after December 31 of the cost of reporting period (including private room days) after December 31 of the cost o		do not complete this line.		vate room days,		
reporting period (if calendar year, enter 0 on this line) 7.00 Total sing-bed MF type inpatient days (including private room days) through December 31 of the cost 10 Total inpatient days including private room days after December 31 of the cost 10 Total inpatient days including private room days after December 31 of the cost 10 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10 total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 11 total inpatient days applicable to title XVIII only (including private room days) after 0 through December 31 of the cost reporting period (including private room days) 11 total Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 12 total Swing-bed SMF type inpatient days applicable to titles V or XX only (including private room days) 13 total type Inpatient days applicable to titles V or XX only (including private room days) 14 total Compatient days applicable to titles V or XX only (including private room days) 15 total nursery days (title V or XX only of (including private room days) 16 total nursery days (title V or XX only of (including private room days) 17 total nursery days (title V or XX only of (including private room days) 18 total proving private room days applicable to the Program (excluding swing-bed days) 19 total nursery days (title V or XX only of (including private room days) 19 total nursery days (title V or XX only of (including private room days) 10 total nursery days (title V or XX only of (including private room days) 11 total nursery days (title V or XX only of (including private room days) 12 total nursery days (title V or XX only of (including private room days) 13 total nursery days (title V or XX only of (including private room days) 14 total nursery days (title V or XX only of (including private room days) 15 total nursery days (title V or XX only of (including private room days) 16 tota		Total swing-bed SNF type inpatient days (including private room		r 31 of the cost		
reporting period 10.00 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) 10.00 Swing-bed Swit year inpatient days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed Swit year inpatient days applicable to title xVIII only (including private room days) 11.00 Swing-bed Swit 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) 12.00 Swing-bed Swit type inpatient days applicable to titles XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) of through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) of 13.00 after December 31 of the cost reporting period (if including private room days) of 14.00 swing-bed swing-bed SWF services applicable to services through December 31 of the cost reporting period (including period day) of 15.00 after December 31 of the cost reporting period (including period days) of 15.00 after December 31 of the cost reporting period (including period days) of 15.00 after December 31 of the cost reporting period (including period days) of 15.00 after December 31 of the cost reporting period (including period days) of 15.00 after December 31 of the cost reporting period (including after December 31 of the cost reporting period (including after December 31 of the cost reporting period (including after December 31 of the cost reporting period (including after December		reporting period (if calendar year, enter 0 on this line)	3 -			
reporting period (if calendar year, enter 0 on this line) 10.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Saing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 13.00 Swing-bed NF type inpatient days applicable to title V or XIX only (including private room days) after through December 31 of the cost reporting period (including private room days) after through December 31 of the cost reporting period (including private room days) after 20 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Nursery days (title V or XIX only) 17.00 Swing-Bed NF type inpatient days applicable to the Program (excluding swing-bed days) 18.00 Nursery days (title V or XIX only)		reporting period				
newborn days) 10.00 Simp-bed SNF type inpatient days applicable to fitte XVIII only (including private room days) 10.00 Simp-bed SNF type inpatient days applicable to titlet XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 11.00 Simp-bed SNF type inpatient days applicable to titlet XVIII only (including private room days) after through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Simp-bed NF type inpatient days applicable to titlet V or XIX only (including private room days) 13.00 Simp-bed NF type inpatient days applicable to titlet V or XIX only (including private room days) 14.00 Ided cally necessary private room daying period (if calendar year, enter 0 on this line) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 New Instance of the Cost (including SWIng-bed days) 18.00 New Instance of the Cost (including SWIng-bed days) 19.00 New Instance of the Cost (including SWIng-bed days) 19.00 New Instance of the Cost (including SWIng-bed days) 19.00 New Instance of the Cost (including SWIng-bed days) 19.00 New Instance of the Cost (including SWIng-bed days) 19.00 New Instance of the Cost (including SWIng-bed days) 19.00 New Instance of the Cost (including SWIng-bed days) 19.00 New Instance of the Cost (including SWIng-bed days) 19.00 New Instance of the Cost (including SWIng-bed days) 19.00 New Instance of the Cost (including SWIng-bed days) 19.00 New Instance of the Cost (including SWIng-bed days) 19.00 New Instance of the Cost (including SWIng-bed Cost (including SWIng-bed Cost applicable to SWI type services applicable to services after December 31 of the cost (including SWIng-bed Cost applicable to SWI type services after December 31 of the cost reporting period (line 6 (including SWIng-bed Cost applicable to SWI type services after December 31 of the cost reporting period (line 6 (including SWIng-bed Cost (including SWIng-bed Cost reportin		reporting period (if calendar year, enter 0 on this line)			_	
through December 31 of the cost reporting period (see instructions) 1.00 Sung-bed SNF type inpatient days applicable to title XVII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Sung-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Sung-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Sung-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Sung-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Sung-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 1.00 Sung-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 1.00 Sung-bed NF type sary (as the title V or XIX only) 1.00 Sung-y days (title V or XIX only) 1.00 Sung-y days (title V or XIX only) 1.00 Nedicare rate for swing-bed SNF services applicable to services through December 31 of the cost 1.00 Nedicare rate for swing-bed SNF services applicable to services after December 31 of the cost 1.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost 1.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost 1.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost 1.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost 1.00 Nedicard rate for swing-bed NF services applicable to services after December 31 of the cost 1.00 Nedicard rate for swing-bed NF services applicable to services after December 31 of the cost 1.00 Nedicard rate for swing-bed NF services after December 31 of the cost reporting period (line 8 x II ne 19) 1.01 Notal general inpatient routine service cost (see instructions) 1.01 Notal general inpatient routine service cost net of swing-bed cost reportin		newborn days)				
12.00 Swing-bed NF type inpatient days applicable to titles \(\tilde{V} \) or XIX only (including private room days) 0 12.00		through December 31 of the cost reporting period (see instructi Swing-bed SNF type inpatient days applicable to title XVIII onl	ons) y (including private r	,		
13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) and refree December 31 of the cost reporting period (if call endar year, enter 0 on this line) 14.00 15.00 16.00 1	12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 14.00 15.00 16.00 Nursery days (title V or XIX only) 0 15.00 16.00 Nursery days (title V or XIX only) 0 15.00 16.00 Nursery days (title V or XIX only) 0 16.00 Nursery days (title void only) 0 16.00 Nursery days (title void only	13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
16.00 Nursery days (title V or XIX only) New RED ADJUSTMENT 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting re		Medically necessary private room days applicable to the Program				
reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 19) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service cost net of swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average perivate room per diem charge (line 29 * line 3) 31.00 General inpatient routine service cost charges (excluding swing-bed charges) 32.00 Average perivate room per diem charge (line 30 * line 4) 33.00 Average perivate room per diem charge (line 30 * line 4) 34.00 Average perivate room cost differential (line 3 x line 35) 35.00 Average perivate room cost differential (line 3 x line 35) 36.00 Private room cost differential service cost net of swing-bed cost and private room cost differential (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3 x line 35) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00		Nursery days (title V or XIX only)				
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PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 681.68 38.00 8, 384, 664 9.00 40.00	31.00	27 minus line 36)	u private room cost di	THE CITTLE CLINE	10, 421, 030	37.00
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 839.00 Program general inpatient routine service cost (line 9 x line 38) 840.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 681.68 38.00 8, 384, 664 39.00 00 00 00 00 00 00 00 00 00 00 00 00			TMENTS			
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COMPUL	Financial Systems M ATION OF INPATIENT OPERATING COST	ETHODIST HOSPITAL		CCN: 140197	In Lie Period: From 10/01/2011	Worksheet D-1	
					To 09/30/2012	Date/Time Prep 2/27/2013 1:0	
				XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient CostIn	Total patient Days[Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	NURSERY (title V & XIX only)	0	0	0.0	00 0	0	42.0
	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	1, 217, 176	751	1, 620.	74 470	761, 748	43.0
	CORONARY CARE UNIT	0	731	0. (0	1
	BURN INTENSIVE CARE UNIT	0	0	0.0		0	45.0
	SURGICAL INTENSIVE CARE UNIT	0	0	0.0	00	0	46.0
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.0
	·					1. 00	
	Program inpatient ancillary service cost (Wks			_		5, 898, 941	48. 0
19. 00	Total Program inpatient costs (sum of lines A PASS THROUGH COST ADJUSTMENTS	41 through 48)(se	<u>e instructior</u>	ıs)		15, 045, 353	49.0
50. 00	Pass through costs applicable to Program inpa	atient routine se	rvices (from	Wkst. D. sun	n of Parts I and	366, 503	50. O
	III)		•				
51. 00	Pass through costs applicable to Program inpa	atient ancillary	services (fro	om Wkst. D, s	sum of Parts II	212, 928	51.0
52. 00	and IV) Total Program excludable cost (sum of lines!	50 and 51)				579, 431	52.0
	Total Program inpatient operating cost exclude		ted, non-phys	sician anesth	netist, and	14, 465, 922	
	medical education costs (line 49 minus line !	52)					
	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. C
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55)					0	
	Difference between adjusted inpatient operati	ng cost and targ	et amount (li	ne 56 minus	line 53)	0	
	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period en	dina 1996 ur	ndated and co	omnounded by the	0.00	58. 0 59. 0
7. 00	market basket	sor tring period en	arrig 1770, ap	dated and ec	simpounded by the	0.00	07.0
0.00	Lesser of lines 53/54 or 55 from prior year					0.00	
1. 00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					0	61.0
	amount (line 56), otherwise enter zero (see		(TTICS ST X C	00), 01 1% 01	the target		
	Relief payment (see instructions)	,				0	
3. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruct	i ons)			0	63.0
4. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decemb	er 31 of the	cost reporti	ng period (See	0	64. C
	instructions) (title XVIII only)	3		·	3 1		
5. 00	Medicare swing-bed SNF inpatient routine cos	ts after December	31 of the co	ost reportino	g period (See	0	65. C
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line 64	plus line 65	5)(title XVII	I only). For	0	66.0
	CAH (see instructions)						
7. 00	Title V or XIX swing-bed NF inpatient routine	e costs through D	ecember 31 of	the cost re	eporting period	0	67. C
8. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after Dec	ember 31 of t	he cost repo	ortina period	0	68. C
	(line 13 x line 20)			·	3 1		
9. 00	Total title V or XIX swing-bed NF inpatient I PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.0
0. 00	Skilled nursing facility/other nursing facili						70. C
	Adjusted general inpatient routine service co						71.0
	Program routine service cost (line 9 x line			0.5)			72.0
3. 00 4. 00	Medically necessary private room cost application Total Program general inpatient routine servi			ie 35)			73. C
	Capital -related cost allocated to inpatient	•	,	orksheet B, F	Part II, column		75. C
	26, line 45)						
	Per diem capital related costs (line 75 ÷ line	,					76.0
	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77. C
	Aggregate charges to beneficiaries for excess	,	vi der records	s)			79. C
	Total Program routine service costs for compa		t limitation	(line 78 mir	nus line 79)		80.0
	Inpatient routine service cost per diem limitation (li						81.0
	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (· · · · · · · · · · · · · · · · · · ·					82. 0 83. 0
	Program inpatient ancillary services (see ins						84.0
	Utilization review - physician compensation						85.0
6. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ugh 85)				86.0
	Total observation bed days (see instructions)					0	ı

0 87.00 0.00 88.00 0 89.00

87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)
89.00 Observation bed cost (line 87 x line 88) (see instructions)

Health Financial Systems M	ETHODIST HOSPI	TAL OF CHICAGO		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 10/01/2011 To 09/30/2012	Date/Time Pre 2/27/2013 1:0	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(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	675, 551	16, 421, 036	0. 04113	9 0	0	90. 00
91.00 Nursing School cost	0	16, 421, 036	0.00000	0	0	91.00
92.00 Allied health cost	0	16, 421, 036	0.00000	0	0	92. 00
93.00 All other Medical Education	0	16, 421, 036	0. 00000	0 0	0	93. 00

Health Financial Systems	METHODIST HOSPITAL OF CHICAGO	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 140197	Peri od: From 10/01/2011	Worksheet D-1
	Component CCN: 145672		
	Title XVIII	Skilled Nursing	PPS

		TI LIE AVIII	Facility	FF3	
	Cost Center Description		-	1. 00	
	PART I - ALL PROVIDER COMPONENTS		I	1.00	
1 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days,	avaludina nawhara)	T	957	1 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-bed			957 957	1. 00 2. 00
3.00	Private room days (excluding swing-bed and observation bed days)		vate room days,	0	3. 00
4 00	do not complete this line.			057	4 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation bed Total swing-bed SNF type inpatient days (including private room		31 of the cost	957 0	4. 00 5. 00
0.00	reporting period	days) thi odgir becomber	or or the cost	o .	0.00
6. 00	Total swing-bed SNF type inpatient days (including private room	days) after December 3	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room o	days) through December	31 of the cost	0	7. 00
7.00	reporting period	ayo, timough becomber			7.00
8.00	Total swing-bed NF type inpatient days (including private room of	days) after December 31	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to 1	the Program (excluding	swing-bed and	950	9. 00
	newborn days)	0			
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only through December 31 of the cost reporting period (see instruction		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter	er 0 on this line)	,		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX of through December 31 of the cost reporting period	only (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX of	only (including private	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar year				
14. 00 15. 00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding swing-bed of	days)	0	14. 00 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 reporting period	through December 31 of	f the cost	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of 1	the cost	0. 00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services treporting period	through December 31 of	the cost	0. 00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services a	after December 31 of th	ne cost	0. 00	20. 00
21 00	reporting period			1 010 400	21 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December	31 of the cost reporti	ng period (line	1, 019, 429 0	21. 00 22. 00
22.00	5 x line 17)	0. 0. 1.10 0001 report.	ng por rou (rino		22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31	of the cost reporting	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December 3	31 of the cost reportir	na period (line	0	24. 00
	7 x line 19)	'			
25. 00	Swing-bed cost applicable to NF type services after December 31 x line 20)	of the cost reporting	period (line 8	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 (li	ne 21 minus line 26)		1, 019, 429	27. 00
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed of	charges)	I	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	inal ges)		0	
30. 00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ l	ine 28)		0.000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
34. 00	Average per diem private room charge differential (line 32 minus	s line 33)(see instruct	tions)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x line	31)		0.00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and	d private room cost did	fferential (line	0 1, 019, 429	36. 00 37. 00
57.00	27 minus line 36)	. p. 1 va to 1 0011 0031 UI I	(Title	1, 517, 427	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	MENTO			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST Adjusted general inpatient routine service cost per diem (see in		T		38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38				39. 00
40. 00	Medically necessary private room cost applicable to the Program	(line 14 x line 35)			40. 00
41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)	ļ		41. 00

	Financial Systems M ATION OF INPATIENT OPERATING COST	ETHODIST HOSPI		er CCN: 140197	Peri od:	worksheet D-1	
			Compon	ent CCN: 145672	From 10/01/2011 To 09/30/2012		
			Ti	tle XVIII	Skilled Nursing	2/27/2013 1:0 PPS)ı pm
	Cost Center Description	Total	Total	Average Pe	Facility Program Days	Program Cost	
		Inpatient Cost	Inpatient Da	aysDiem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42. 00
43. 00	INTENSIVE CARE UNIT						43. 00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wks						48. 00
49. 00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	11 through 48)	(see instruc	tions)			49. 00
50.00	Pass through costs applicable to Program inpa	atient routine	services (f	rom Wkst. D, su	m of Parts I and		50. 00
51. 00	III) Pass through costs applicable to Program inpa	atient ancillar	y servi ces	(from Wkst. D,	sum of Parts II		51. 00
52. 00	and IV) Total Program excludable cost (sum of lines 5	50 and 51)					52. 00
53. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line 5		elated, non-	ohysician anest	hetist, and		53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	,					
54. 00 55. 00	Program discharges Target amount per discharge						54. 00 55. 00
56. 00	Target amount (line 54 x line 55)						56. 00
57. 00	Difference between adjusted inpatient operati	ng cost and ta	arget amount	(line 56 minus	line 53)		57. 00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost rep	norting period	endina 1996	undated and c	omnounded by the		58. 00 59. 00
	market basket	0 .	Ü	•			
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines						60. 00 61. 00
01.00	which operating costs (line 53) are less than	n expected cost					01.00
62. 00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructions)					62. 00
63. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	uctions)				63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cost instructions) (title XVIII only)	ts through Dece	ember 31 of	the cost report	ing period (See		64. 00
65. 00	Medicare swing-bed SNF inpatient routine cost	ts after Decemb	oer 31 of th	e cost reportin	g period (See		65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routir</pre>	ne costs (line	64 plus line	e 65)(title XVI	II only). For		66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	e costs through	n December 3	1 of the cost r	eporting period		67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	e costs after [December 31	of the cost ren	orting period		68. 00
	(line 13 x line 20)			·	or tring perrod		
69. 00	Total title V or XIX swing-bed NF inpatient r PART III - SKILLED NURSING FACILITY, OTHER NU						69. 00
70.00	Skilled nursing facility/other nursing facili					1, 019, 429	70. 00
71.00	Adjusted general inpatient routine service co	,	ine 70 ÷ li	ne 2)		1, 065. 23	
72. 00 73. 00	Program routine service cost (line 9 x line 7 Medically necessary private room cost applications)	,	n (line 14 x	line 35)		1, 011, 969 0	1
74.00	Total Program general inpatient routine servi	5	•	,		1, 011, 969	1
75. 00	Capital-related cost allocated to inpatient r	•			Part II, column	0	1
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lir	ne 2)				0.00	76. 00
77.00	Program capital -related costs (line 9 x line					0.00	1
78. 00	Inpatient routine service cost (line 74 minus	s line 77)				0	78. 00
79.00	Aggregate charges to beneficiaries for excess	s costs (from p	provi der rec			0	1
80.00	Total Program routine service costs for compa		cost limitat	ion (line 78 mi	nus line 79)	0	
	Total Program routine service costs for compa Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li	tati on		ion (line 78 mi	nus line 79)	0.00	

1, 011, 969 83. 00

0 1, 563, 057

84. 00 85. 00

86.00

0 87.00 0.00 88.00

0 89.00

551, 088

84.00

85.00

86.00

83.00 Reasonable inpatient routine service costs (see instructions)

89.00 Observation bed cost (line 87 x line 88) (see instructions)

Program inpatient ancillary services (see instructions)
Utilization review - physician compensation (see instructions)
Total Program inpatient operating costs (sum of lines 83 through 85)
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)

Health Financial Systems M	ETHODIST HOSPI	TAL OF CHICAGO		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component	CCN: 145672	From 10/01/2011 To 09/30/2012	Date/Time Prep 2/27/2013 1:0	
		Ti tl	e XVIII	Skilled Nursing	PPS	
				Facility		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	0	0	0.00000	0	0	90.00
91.00 Nursing School cost	0	0	0.00000	0	0	91.00
92.00 Allied health cost	0	0	0.00000	0	0	92.00
93.00 All other Medical Education	0	0	0. 00000	0 0	O	93. 00

Health Financial Systems METHODIST HOSPI	<u> FAL OF CHIC</u> AGO		In Lie	eu of Form CMS-:	<u> 2552-1</u> 0
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 140197	Peri od:	Worksheet D-3	
			From 10/01/2011		
			To 09/30/2012		
	T: +1	e XVIII	Hooni tal	2/27/2013 1: 0 PPS	Грііі
Cost Center Description	11 (1		Hospi tal	+'	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00		2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1		1	
30. 00 03000 ADULTS & PEDI ATRI CS			10, 099, 833		30.00
31. 00 03100 I NTENSI VE CARE UNI T			683, 850		31. 00
32. 00 03200 CORONARY CARE UNIT			0		32. 00
33.00 03300 BURN INTENSIVE CARE UNIT			0		33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT			0		34. 00
40. 00 04000 SUBPROVI DER - 1 PF			0		40. 00
41. 00 04100 SUBPROVI DER - I RF			0		41.00
42. 00 04200 SUBPROVI DER			0		42.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS			•	•	1
50. 00 05000 OPERATI NG ROOM		0. 74734	5 752, 721	562, 542	50.00
51. 00 05100 RECOVERY ROOM		0.00000		0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0.00000		l o	52. 00
53. 00 05300 ANESTHESI OLOGY		0. 28878		34, 094	1
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 48000			1
55. 00 05500 RADI OLOGY - THERAPEUTI C		0. 00000		034, 749	55.00
		1			1
56. 00 05600 RADI 0I SOTOPE		0.00000		0	56. 00
57. 00 05700 CT SCAN		0.00000		0	57. 00
58.00 05800 MAGNETI C RESONANCE I MAGING (MRI)		0.00000		0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.00000		0	59. 00
60. 00 06000 LABORATORY		0. 25813	5, 039, 305	1, 300, 806	60. 00
60. 01 06001 BL00D LABORATORY		0.00000	0 0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000	0 0	0	61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.00000	0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0.00000	0 0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY		0.00000	0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY		0. 30134	6 1, 950, 247	587, 699	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 92537			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0.00000		0	67. 00
68. 00 06800 SPEECH PATHOLOGY		0.00000		o o	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 30313		l .	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000		0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 38107		85, 951	
72. 00 07100 MEDICAL SUFFEILS CHARGED TO PATIENTS		0. 80619			71.00
		1		28, 392	1
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 40735			
74. 00 07400 RENAL DI ALYSI S		0. 91730			
75. 00 O7500 ASC (NON-DISTINCT PART)		0.00000	0	0	75. 00
OUTPATIENT SERVICE COST CENTERS		0.0000	.0		00.00
88. 00 08800 RURAL HEALTH CLINIC		0.00000		0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	
90. 00 09000 CLI NI C		0.00000		-	
90. 01 09001 PARTIAL HOSPITALIZATION		0.00000		0	90. 01
91. 00 09100 EMERGENCY		0. 91957			
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)		0.00000	0	0	92. 00
OTHER REIMBURSABLE COST CENTERS					
94.00 09400 HOME PROGRAM DIALYSIS		0.00000	0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES					95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0.00000	0 0	0	96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD		0.00000	0 0	0	97. 00
98.00 05950 OTHER REIMBURSABLE COST CENTERS		0.00000		0	98. 00
200.00 Total (sum of lines 50-94 and 96-98)			15, 419, 901	5, 898, 941	
201.00 Less PBP Clinic Laboratory Services-Program only charge	ges (line 61)		0		201. 00
202.00 Net Charges (line 200 minus line 201)	3 (1)		15, 419, 901		202. 00
		•		•	

Health Financial Systems	METHODIST HOSPITAL O	F CHI CAGO		In Lie	u of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der	CCN: 140197		Worksheet D-3
		Component	CCN: 145672	From 10/01/2011 To 09/30/2012	Date/Time Prepared:

2/27/2013 1:01 pm Title XVIII Skilled Nursing Facility Cost Center Description Ratio of Cost I npati ent Inpati ent To Charges Program Program Costs Charges (col. 1 x col. 2) 1.00 2.00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 0 0 0 0 31.00 03100 INTENSIVE CARE UNIT 31.00 32.00 03200 CORONARY CARE UNIT 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 33.00 03400 SURGICAL INTENSIVE CARE UNIT 34 00 34 00 40.00 04000 SUBPROVI DER - I PF 40.00 41.00 04100 SUBPROVIDER - IRF o 41.00 04200 SUBPROVI DER ol 42.00 42 00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.747345 40, 943 30, 599 50.00 05100 RECOVERY ROOM 0.000000 51 00 51 00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52.00 05300 ANESTHESI OLOGY 0.288780 872 53.00 252 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.480004 30, 109 62.726 54.00 05500 RADI OLOGY-THERAPEUTI C 55 00 0.000000 0 0 55 00 56.00 05600 RADI OI SOTOPE 0.000000 0 0 56.00 05700 CT SCAN 0.000000 0 57.00 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 0 58.00 0 58.00 05900 CARDIAC CATHETERIZATION 59 00 0.000000 0 0 59 00 205, 052 60.00 06000 LABORATORY 0.258132 52, 930 60.00 06001 BLOOD LABORATORY 0.000000 60.01 0 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 0.000000 0 61.00 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62 00 0.000000 0 0 62 00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 63.00 63.00 0 64.00 06400 I NTRAVENOUS THERAPY 0.000000 64.00 06500 RESPIRATORY THERAPY 0.301346 87, 545 65.00 290.514 65.00 66.00 06600 PHYSI CAL THERAPY 0.925378 161, 402 149, 358 66.00 06700 OCCUPATIONAL THERAPY 0.000000 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 06900 ELECTROCARDI OLOGY 5,013 69 00 0.303139 16, 536 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 Ω 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0.381072 20, 267 7,723 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.806193 72.00 0 187, 559 73.00 07300 DRUGS CHARGED TO PATIENTS 0.407359 460, 426 73.00 74.00 07400 RENAL DIALYSIS 0.917305 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 75.00 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 89.00 90.00 |09000| CLI NI C 0.000000 90.00 0 0 09001 PARTIAL HOSPITALIZATION 0 90.01 90.01 0.000000 0 91.00 09100 EMERGENCY 0.919572 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 0 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 0 Λ 94.00 09500 AMBULANCE SERVICES 95.00 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 96.00 0 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 97 00 0.000000 0 0 98.00 05950 OTHER REIMBURSABLE COST CENTERS 0.000000 0 98.00 551, 088 200. 00 200.00 Total (sum of lines 50-94 and 96-98) 1, 258, 738 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 201.00 Net Charges (line 200 minus line 201) 1, 258, 738 202.00 202.00

	ATION OF REIMBURSEMENT SETTLEMENT		Peri od: From 10/01/2011 To 09/30/2012	Worksheet E Part A	
		Title XVIII	Hospi tal	PPS	
			before 1/1 1.00	on/after 1/1 1.01	
	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1	DRG Amounts Other than Outlier Payments Outlier payments for discharges (see instructions)		11, 022, 426		1. 00 2. 00
	Outlier payments for discharges. (see instructions) Outlier reconciliation amount		84, 659		2. 00
1	Managed Care Simulated Payments		0		3. 00
	Bed days available divided by number of days in the cost reporti	ng period (see	170. 00		4. 00
	instructions) Indirect Medical Education Adjustment				
	FTE count for allopathic and osteopathic programs for the most ${\bf r}$	ecent cost reporting	0.00		5. 00
	period ending on or before 12/31/1996. (see instructions)		0.00		/ 00
6. 00	FTE count for allopathic and osteopathic programs which meet the add-on to the cap for new programs in accordance with 42 CFR 413		0.00		6. 00
7. 00	MMA Section 422 reduction amount to the IME cap as specified und		0.00		7. 00
7 01	§412. $105(f)(1)(iv)(B)(1)$	don 10 CED	0.00		7 01
7. 01	ACA Section 5503 reduction amount to the IME cap as specified un $\S412.105(f)(1)(iv)(B)(2)$ If the cost report straddles July 1, 20		0.00		7. 01
	instructions.				
8. 00	Adjustment (increase or decrease) to the FTE count for allopathi		0. 00		8. 00
	programs for affiliated programs in accordance with 42 CFR 413.7 and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol.				
	page 50069, August 1, 2002.	or rodoral magnetory			
8. 01	The amount of increase if the hospital was awarded FTE cap slots		0.00		8. 01
8. 02	the ACA. If the cost report straddles July 1, 2011, see instruct The amount of increase if the hospital was awarded FTE cap slots		0.00		8. 02
0.02	teaching hospital under section 5506 of ACA. (see instructions)		0.00		0.02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines	(8, 8,01 and 8,02)	0. 00		9. 00
10. 00	(see instructions) FTE count for allopathic and osteopathic programs in the current	vear from vour	0.00		10.00
	records	year rrom your	0.00		10.00
1	FTE count for residents in dental and podiatric programs.		0.00		11.00
1	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.		0. 00 0. 00		12. 00 13. 00
	Total allowable FTE count for the penultimate year if that year	ended on or after	0.00		14.00
	September 30, 1997, otherwise enter zero.				
	Sum of lines 12 through 14 divided by 3.		0. 00 0. 00		15.00
1	Adjustment for residents in initial years of the program Adjusment for residents displaced by program or hospital closure		0.00		16. 00 17. 00
1	Adjusted rolling average FTE count		0.00		18. 00
	Current year resident to bed ratio (line 18 divided by line 4).		0. 000000		19. 00
1	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)		0. 000000 0. 000000		20. 00 21. 00
	IME payment adjustment (see instructions)		0.00000		22.00
	Indirect Medical Education Adjustment for the Add-on for Section				
	Number of additional allopathic and osteopathic IME FTE resident	cap slots under 42	0.00		23. 00
	Sec. 412.105 (f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)		0.00		24. 00
1	If the amount on line 24 is greater than -O-, then enter the low	er of line 23 or line	0.00		25. 00
04 00	24 (see instructions)		0.00000		0, 00
	Resident to bed ratio (divide line 25 by line 4) IME payments adjustment. (see instructions)		0. 000000 0. 000000		26. 00 27. 00
	IME Adjustment (see instructions)		0.00000		28. 00
	Total IME payment (sum of lines 22 and 28)		0		29. 00
	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A pati	ont days (soo	14. 70		30.00
30.00	instructions)	ent days (see	14. 70		30.00
31. 00	Percentage of Medicaid patient days to total days reported on Wo	rksheet S-2, Part I,	46. 17		31. 00
00.00	line 24. (see instructions)		(0.07		00.00
	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions)		60. 87 39. 33		32. 00 33. 00
1	Disproportionate share adjustment (see instructions)		4, 335, 120		34.00
	Additional payment for high percentage of ESRD beneficiary disch				
40. 00	Total Medicare discharges on Worksheet S-3, Part I excluding dis 652, 682, 683, 684 and 685 (see instructions)	charges for MS-DRGs	0		40. 00
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683,	684 an 685. (see	0	0	41.00
	instructions)				
	Divide line 41 by line 40 (if less than 10%, you do not qualify Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682,		0.00		42. 00 43. 00
43.00	instructions)	003, 004 all 003. (See			43.00
	Ratio of average length of stay to one week (line 43 divided by	line 41 divided by 7	0. 000000		44. 00
1	days) Average weekly cost for dialysis treatments (see instructions)		0.00	0. 00	45. 00
1	Average weekly cost for dialysis treatments (see instructions) Total additional payment (line 45 times line 44 times line 41)		0.00	0.00	45.00
47. 00	Subtotal (see instructions)		15, 442, 205		47. 00
	Hospital specific payments (to be completed by SCH and MDH, smal	l rural hospitals	0		48. 00
	only. (see instructions)		1		l

Health Financial Systems	METHODIST HOSPITAL OF CHICAGO	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 140197	Peri od:	Worksheet E

From 10/01/2011 | Part A | To 09/30/2012 | Date/Time Prepared: 2/27/2013 1:01 pm Title XVIII Hospi tal PPS before 1/1 on/after 1/1 1.00 1.01 49.00 Total payment for inpatient operating costs SCH and MDH only (see instructions) 15, 442, 205 49 00 50.00 Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable) 1, 010, 859 50.00 Exception payment for inpatient program capital (Worksheet L, Part III, see 51.00 51.00 0 instructions) Direct graduate medical education payment (from Worksheet E-4, line 49 see 52 00 52 00 0 instructions) 53.00 Nursing and Allied Health Managed Care payment 53.00 54.00 Special add-on payments for new technologies 0 0 54.00 Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69) 55.00 55.00 56.00 Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20) 56.00 57.00 Routine service other pass through costs (from Wkst D, Part III, column 9, lines 0 57.00 30-35). Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200) 58.00 58.00 0 Total (sum of amounts on lines 49 through 58) 59.00 16, 453, 064 59.00 60.00 Primary payer payments 60.00 61.00 Total amount payable for program beneficiaries (line 59 minus line 60) 16, 453, 064 61.00 Deductibles billed to program beneficiaries 1, 281, 677 62 00 62 00 63.00 Coinsurance billed to program beneficiaries 192, 322 63.00 Allowable bad debts (see instructions) 1, 134, 510 64.00 64.00 Adjusted reimbursable bad debts (see instructions) 794, 157 65.00 65.00 66.00 1, 087, 818 Allowable bad debts for dual eligible beneficiaries (see instructions) 66.00 67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 15, 773, 222 67.00 Credits received from manufacturers for replaced devices applicable to MS-DRG (see 68.00 68.00 instructions) 69.00 Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see 69.00 instructions) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 70.00 70.00 Recovery of Accelerated Depreciation 0 70.95 70.95 70. 96 Low Volume Payment-1 70.96 Low Volume Payment-2 70 97 70 97 0 70. 98 Low Volume Payment-3 70. 98 Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70) 15, 773, 222 71.00 71.00 72.00 Interim payments 15, 771, 777 72.00 73.00 Tentative settlement (for contractor use only) 73.00 74.00 Balance due provider (Program) (line 71 minus the sum of lines 72 and 73) 1, 445 74.00 75.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, 75.00 section 115.2 TO BE COMPLETED BY CONTRACTOR 90.00 90.00 Operating outlier amount from Worksheet E, Part A line 2 (see instructions) 0 Capital outlier from Worksheet L, Part I, line 2 0 91.00 0 92.00 Operating outlier reconciliation adjustment amount (see instructions) 92.00 93.00 Capital outlier reconciliation adjustment amount (see instructions) 0 93.00 94.00 The rate used to calculate the Time Value of Money 0.00 94.00 95.00 Time Value of Money for operating expenses(see instructions) 95.00 96.00 Time Value of Money for capital related expenses (see instructions) 96.00

Health Financial Systems	METHODIST HOSPITAL O	OF CHI CAGO	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140197		Worksheet E Part B Date/Time Prepared: 2/27/2013 1:01 pm

PART 8 MEDICAL AND OTHER HEALTH SERVICES 1.00					2/27/2013 1:0	1 pm
DART B - MEDICAL AND OTHER HEALTH SERVICES 2.00 Modical and other services (see instructions) 2.65 1.00 Modical and other services (see instructions) 2.50 1.00 2.909,000 2.00 Modical and other services (reinbursed under OPPS (see instructions) 2.200,000 2.00 2.909,000 2.00 2.00 2.00 2.000			Title XVIII	Hospi tal		
DART B - MEDICAL AND OTHER HEALTH SERVICES 2.00 Modical and other services (see instructions) 2.65 1.00 Modical and other services (see instructions) 2.50 1.00 2.909,000 2.00 Modical and other services (reinbursed under OPPS (see instructions) 2.200,000 2.00 2.909,000 2.00 2.00 2.00 2.000				<u> </u>		
Medical and other services (see Instructions) 2,009, 600 2,000					1. 00	
Medical and other services (see Instructions) 2,009, 600 2,000		PART B - MEDICAL AND OTHER HEALTH SERVICES			•	
PPS payments 2,009,049 3,00					265	1. 00
11,420 4.00 0.00	2.00	Medical and other services reimbursed under OPPS (see instruction	ons)		2, 909, 600	2. 00
1,1,420 4.00 0.000 5.00 0.000 5.00 0.000 5.00 0.000 5.00 0.000 5.00 0.000 5.00 0.000 5.00 0.000 5.00 0.000 5.00 0.000 5.00 0.000 5.00 0.000 5.00 0.000 5.00 0.000 0.00	1	·	,		2, 009, 049	3. 00
Enter the hospital specific payment to cost ratio (see instructions)	1				1	4.00
Line 2 times line 5 0 6.00	1		ions)		l	5. 00
Sum of Time 3 plus line 4 divided by line 6 0.00 7.00 7.00 8.00 7.00 7.00 8.00 7.00 8.00 7.00 8.0	1		,		ł	
Transitional corridor payment (see instructions)	1					
0,00					l	
10.00 Organ acquisitions 265 11.00 COMPUTATION OF LESSER OF COST OR CHARGES 265 11.00 COMPUTATION OF LESSER OF COST OR CHARGES 265 11.00 265			rt IV column 13 line	200		
11.00 Total cost (sum of lines 1 and 10) (see instructions) 265 10.00			t i v, coramii ro, rine	200	· ·	
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges Cost or Charges	1	· ·			1	
Reasonable charges					203	11.00
12.00 Ancillary service charges 650 12.00 13.00 13.00 101 reasonable charges (Srum Worksheet D-4, Part III, line 69, col. 4) 650 13.00 13.00 101 reasonable charges (Sum of Lines 12 and 13) 650 14.00 650 18.00 15.00	+					
13.00 Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4) 13.00 13.00 14.00 15.00 15.00 Customary charges 15.00 Agregate amount actually collected from patients liable for payment for services on a charge basis 0 15.00 16.00 15.					650	12 00
14. 00 Total reasonable charges (sum of lines 12 and 13)			2 col 4)		l	
Customary_charges	1		9, (01. 4)		1	
15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.00					000	14.00
16.00 Amounts that would have been real ized from patients I able For payment for services on a chargebasis Nation of line 15 to I ine 16 (not to exceed 1.000000) 17.00 17.00 18.10 17.00 18.10 19.00						15 00
had such payment been made in accordance with 42 CFR 413.13(e)						
17.00	16.00	·	payment for services o	n a cnargebasis	0	16.00
18.00 Total customary charges (see Instructions) 650 18.00 20.00 2						47.00
19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 26.5 21.00 22.00 Interns and residents (see instructions) 26.5 21.00 22.00 Excess of cost or charges (line 11 minus line 20) (for CAH see instructions) 26.5 21.00 22.00 22.00 Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148) 0.22.00, 469 24.00 22	1				l	
Instructions 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20.00 1 20.00 1 20.00 1 20.00 1 20.00 1 20.00 1 20.00					i e	
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20.00	19. 00		if line 18 exceeds li	ne 11) (see	385	19. 00
Instructions 265 21.00		· · · · · · · · · · · · · · · · · · ·				
21.00 Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions) 2.65 21.00	20. 00		if line 11 exceeds li	ne 18) (see	0	20. 00
22.00 Interns and residents (see instructions) 0 22.00 Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148) 0 23.00 24.00 Total prospective payment (sum of lines 3, 4, 8 and 9) 2,000,469 24.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 0 25.00 Deductible sand coinsurance (for CAH, see instructions) 0 25.00 26.00 Deductible sand coinsurance (for CAH, see instructions) 0 25.00 Deductible sand coinsurance relating to amount on line 24 (for CAH, see instructions) 490,906 26.00 27.00 Subtotal ((lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23) (for CAH, see instructions) 0 28.00 29.00 ESRD direct medical education payments (from Worksheet E-4, line 36) 0 29.00 28.00 29.00 ESRD direct medical education costs (from Worksheet E-4, line 36) 0 29.00						
23.00 Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148) 0 23.00		5 · · · · · · · · · · · · · · · · · · ·	instructions)		265	
24.00					0	
COMPUTATION OF REIMBURSEMENT SETTLEMENT CAH, see instructions Cab	23. 00	Cost of teaching physicians (see instructions, 42 CFR 415.160 a	nd CMS Pub. 15-1, sect	ion 2148)	0	23. 00
25.00 Deductibles and coinsurance (for CAH, see instructions) 25.00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 490,906 26.00 27.00 Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions) 1,529,828 27.00 Subtotal {(sum of lines 27 through 29) 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 29.00 28.00 29.00 28.00 29.00 28.00 29.00 28.00 29.00 28.00 29.00 28.00 29.	24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			2, 020, 469	24. 00
26.00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 490,906 26.00 27.00 Subtotal ((lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23) (for CAH, see instructions) 1,529,828 27.00 28.00 Direct graduate medical education payments (from Worksheet E-4, line 50) 0 28.00 29.00 ESRD direct medical education costs (from Worksheet E-4, line 36) 0 29.00 29.		COMPUTATION OF REIMBURSEMENT SETTLEMENT				
27. 00 Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see Instructions) 28. 00 Direct graduate medical education payments (from Worksheet E-4, line 50) 29. 00 ESRD direct medical education costs (from Worksheet E-4, line 36) 30. 00 Subtotal (sum of lines 27 through 29) 31. 00 Primary payer payments 32. 00 Subtotal (line 30 minus line 31) 32. 00 Composite rate ESRD (from Worksheet I-5, line 11) 33. 00 Composite rate ESRD (from Worksheet I-5, line 11) 34. 00 Allowable bad debts (see instructions) 35. 00 Adj usted reimbursable bad debts (see instructions) 36. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 37. 00 Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only) 38. 00 MSP-LCC reconciliation amount from PS&R 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39. 90 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 40. 00 Subtotal (line 37 plus or minus lines 39 minus 38) 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 42. 00 Tentative settlement (for contractors use only) 42. 00 Tentative settlement (for contractors use only) 43. 00 Original outlier amount (see instructions) 44. 00 Original outlier amount (see instructions) 44. 00 Original outlier amount (see instructions) 44. 00 Original outlier amount (see instructions) 45. 00 Outlier reconciliation adjustment amount (see instructions) 46. 00 Time Value of Money (see instructions) 47. 00 Outlier amount (see instructions) 48. 00 Outlier amount (see instructions) 49. 00 Time Value of Money (see instructions) 50. 00 Outlier amount (see instructions) 50. 00 Outlier amount (see instructions) 50. 00 Outlier amount (see instructions) 50. 00 Outlier amount (see instructions) 50. 00 Outlier amount (see instructions) 50. 00 Outlier amount (see instructions) 50. 00 Outlier amount (see instructions) 50. 00 Outlier amount (see instructions) 50. 00 Outlier amount (see instructions) 50. 00 Outlier amount (see instructions) 50. 00 Outl	25. 00	Deductibles and coinsurance (for CAH, see instructions)			0	25. 00
See instructions See instructions See instructions Direct graduate medical education payments (from Worksheet E-4, line 50) 0 28.00 29.00 29.00 29.00 29.00 29.00 30.00	26. 00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions)		490, 906	26. 00
28. 00 Direct graduate medical education payments (from Worksheet E-4, line 50) 0 28. 00 29. 00 ESRD direct medical education costs (from Worksheet E-4, line 36) 0 29. 00 30. 00 Subtotal (sum of lines 27 through 29) 1, 529, 828 30. 00 31. 00 Primary payer payments 0 31. 00 32. 00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33. 00 Composite rate ESRD (from Worksheet I-5, line 11) 0 33. 00 34. 00 All lowable bad debts (see instructions) 221, 724 34. 00 35. 00 Adjusted reimbursable bad debts (see instructions) 155, 207 35. 00 36. 00 All lowable bad debts for dual eligible beneficiaries (see instructions) 218, 223 36. 00 37. 00 Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only) 1, 685, 035 37. 00 39. 00 MSP-LCC reconciliation amount from PS&R 0 39. 00 39. 00 THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 99 40. 00 PORCOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Interim payments 1, 685, 035 40. 00<	27. 00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the	ne sum of lines 22 and	23} (for CAH,	1, 529, 828	27. 00
29. 00 ESRD direct medical education costs (from Worksheet E-4, line 36) 0 29. 00 30. 00 Subtotal (sum of lines 27 through 29) 1,529,828 30. 00 31. 00 Primary payer payents 0 31. 00 32. 00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 32. 00 33. 00 Composite rate ESRD (from Worksheet I-5, line 11) 0 33. 00 34. 00 All lowable bad debts (see instructions) 221, 724 34. 00 35. 00 Adjusted reimbursable bad debts (see instructions) 155, 207 35. 00 36. 00 All lowable bad debts for dual eligible beneficiaries (see instructions) 218, 223 36. 00 37. 00 Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only) 1, 685, 035 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R 0 38. 00 39. 90 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 90 41. 00 Interim payments 1, 685, 035 40. 00 42. 00 Tentative settlement (for contractors use only) 0 42. 00 43. 00 Balance due provider/program (line 40 minus the sum of lines 41, and 42) -131	ļ	see instructions)				
30. 00 Subtotal (sum of lines 27 through 29) 31. 00 Primary payer payments 32. 00 Subtotal (line 30 minus line 31) 32. 00 Subtotal (line 30 minus line 31) 33. 00 Omposite rate ESRD (from Worksheet I-5, line 11) 34. 00 Allowable bad debts (see instructions) 35. 00 Adjusted reimbursable bad debts (see instructions) 36. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 37. 00 Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only) 38. 00 MSP-LCC reconciliation amount from PS&R 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 40. 00 Subtotal (line 37 plus or minus lines 39 minus 38) 41. 00 Subtotal (line 37 plus or minus lines 39 minus 38) 41. 00 Entaitive settlement (for contractors use only) 42. 00 Final ance due provider/program (line 40 minus the sum of lines 41, and 42) 44. 00 Original outlier amount (see instructions) 45. 00 Original outlier amount (see instructions) 46. 00 Outlier reconciliation adjustment amount (see instructions) 47. 00 Outlier reconciliation adjustment amount (see instructions) 48. 00 Outlier reconciliation adjustment amount (see instructions) 49. 00 Outlier reconciliation adjustment amount (see instructions) 40. 00 Outlier reconciliation adjustment amount (see instructions) 40. 00 Outlier reconciliation adjustment amount (see instructions) 40. 00 Outlier reconciliation adjustment amount (see instructions) 40. 00 Outlier reconciliation adjustment amount (see instructions) 41. 00 Outlier reconciliation adjustment amount (see instructions) 42. 00 Outlier reconciliation adjustment amount (see instructions) 43. 00 Outlier reconciliation adjustment amount (see instructions) 44. 00 Outlier reconciliation adjustment amount (see instructions) 45. 00 Outlier reconciliation adjustment amount (see instructions) 46. 00 Outlier reconciliation adjustment amount (see instructions) 47. 00 Outlier reconciliation adjustment amount (see instructions) 48. 00 Outlier reconciliation adjustment amount	28. 00	Direct graduate medical education payments (from Worksheet E-4,	line 50)		0	28. 00
31.00 Subtotal (line 30 minus line 31) 1,529,828 32.00	29. 00	ESRD direct medical education costs (from Worksheet E-4, line 3	6)		0	29. 00
32.00 Subtotal (line 30 minus line 31) 1,529,828 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 33.00 Composite rate ESRD (from Worksheet I-5, line 11) 0 33.00 34.00 Allowable bad debts (see instructions) 221,724 34.00 35.00 Allowable bad debts (see instructions) 155,207 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 218,223 36.00 37.00 Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only) 1,685,035 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.90 RECOVERY OF ACCELERATED DEPRECIATION 0 39.90 40.00 Subtotal (line 37 plus or minus lines 39 minus 38) 1,685,035 40.00 1nterim payments 1,816,719 41.00 42.00 Tentative settlement (for contractors use only) 42.00 Tentative settlement (for contractors use only) 42.00 Balance due provider/program (line 40 minus the sum of lines 41, and 42) -131,684 43.00 44.00 To BE COMPLETED BY CONTRACTOR 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 90.00 92.00 The rate used to calculate the Time Value of Money (see instructions) 0 93.00 93.00 1 me Value of Money (see instructions) 0 93.00 93.00 1 me Value of Money (see instructions) 0 93.00 93.00 1 me Value of Money (see instructions) 0 93.00 93.00 1 me Value of Money (see instructions) 0 93.00 93.00 1 me Value of Money (see instructions) 0 93.00 93.00 1 me Value of Money (see instructions) 0 93.00 93.00 1 me Value of Money (see instructions) 0 93.00 93.00 1 me Value of Money (see instructions) 0 93.00 93.00 1 me Value of Money (see instructions) 0 93.00	30.00	Subtotal (sum of lines 27 through 29)			1, 529, 828	30.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Worksheet I-5, line 11) 34.00 Allowable bad debts (see instructions) 35.00 Adjusted reimbursable bad debts (see instructions) 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 37.00 Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only) 38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.90 Subtotal (line 37 plus or minus lines 39 minus 38) 40.00 Subtotal (line 37 plus or minus lines 39 minus 38) 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (line 40 minus the sum of lines 41, and 42) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2 90.00 To BE COMPLETED BY CONTRACTOR 90.00 To ginal outlier amount (see instructions) 91.00 The rate used to calculate the Time Value of Money 92.00 The rate used for calculate the Time Value of Money 10 33.00 33.00 33.00 33.00 33.00 34.00 251, 724 34.00 271, 724 34.00 34.00 38.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 30.00 39.00	31.00	Primary payer payments			0	31. 00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Worksheet I-5, line 11) 34.00 Allowable bad debts (see instructions) 35.00 Adjusted reimbursable bad debts (see instructions) 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 37.00 Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only) 38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.90 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (line 37 plus or minus lines 39 minus 38) 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (line 40 minus the sum of lines 41, and 42) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2 90.00 To BE COMPLETED BY CONTRACTOR 90.00 To ginal outlier amount (see instructions) 0 13.00 To me Value of Money (see instructions) 0 93.00 Time Value of Money (see instructions) 0 93.00 Time Value of Money (see instructions)					1, 529, 828	32. 00
34.00			5)			
34.00	33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0	33. 00
35.00 Adjusted reimbursable bad debts (see instructions) 155, 207 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 218, 223 36.00 37.00 Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only) 1, 685, 035 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 0 0 0 0 0 0 0 0 0					221, 724	
36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 37.00 Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only) 38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (line 37 plus or minus lines 39 minus 38) 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (line 40 minus the sum of lines 41, and 42) 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-II, section 115.2 Original outlier amount (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions) 91.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions)						
37. 00 Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only) 38. 00 MSP-LCC reconciliation amount from PS&R 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (line 37 plus or minus lines 39 minus 38) 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (line 40 minus the sum of lines 41, and 42) 44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-II, section 115. 2 90. 00 To giginal outlier amount (see instructions) 91. 00 Utilier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 93. 00 Time Value of Money (see instructions)			ctions)			
38. 00 MSP-LCC reconciliation amount from PS&R 0 38. 00 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 00 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (line 37 plus or minus lines 39 minus 38) 1, 685, 035 40. 00 1nterim payments 1, 816, 719 41. 00 42. 00 Tentative settlement (for contractors use only) 0 42. 00 43. 00 Balance due provider/program (line 40 minus the sum of lines 41, and 42) -131, 684 43. 00 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115. 2 0 44. 00 TO BE COMPLETED BY CONTRACTOR 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (line 37 plus or minus lines 39 minus 38) 1,685,035 40.00 41.00 Interim payments 1,816,719 41.00 Tentative settlement (for contractors use only) 0 42.00 Balance due provider/program (line 40 minus the sum of lines 41, and 42) -131,684 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2 0 44.00 Original outlier amount (see instructions) 0 90.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 The rate used to calculate the Time Value of Money (see instructions) 0 93.00 Time Value of Money (see instructions) 0 93.00			and Subprovider only)			
39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (line 37 plus or minus lines 39 minus 38) 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (line 40 minus the sum of lines 41, and 42) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115. 2 70 BE COMPLETED BY CONTRACTOR 90. 00 Outlier reconciliation adjustment amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 93. 00 Time Value of Money (see instructions) 94. 00 Outlier reconciliation adjustment amount (see instructions) 94. 00 Outlier reconciliation adjustment amount (see instructions) 95. 00 Outlier reconciliation adjustment amount (see instructions) 96. 00 Outlier reconciliation adjustment amount (see instructions) 97. 00 Outlier reconciliation adjustment amount (see instructions) 98. 00 Outlier reconciliation adjustment amount (see instructions) 99. 00 Outlier reconciliation adjustment amount (see instructions) 90. 00 Outlier reconciliation adjustment amount (see instructions) 90. 00 Outlier reconciliation adjustment amount (see instructions) 90. 00 Outlier reconciliation adjustment amount (see instructions) 90. 00 Outlier reconciliation adjustment amount (see instructions) 90. 00 Outlier reconciliation adjustment amount (see instructions) 90. 00 Outlier reconciliation adjustment amount (see instructions) 90. 00 Outlier reconciliation adjustment amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions)						
40.00 Subtotal (line 37 plus or minus lines 39 minus 38) 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (line 40 minus the sum of lines 41, and 42) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2 70 BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions)					1	
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43.00 Balance due provider/program (line 40 minus the sum of lines 41, and 42) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2 90.00 TO BE COMPLETED BY CONTRACTOR 90.00 Outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)		1 3				
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TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 90.00 93.00	1		,			
90.00 Original outlier amount (see instructions) 0 10.00 Outlier reconciliation adjustment amount (see instructions) 0 10.00 Outlier reconciliation adjustment amount (see instructions) 0 10.00 Outlier reconciliation adjustment amount (see instructions) 0 10.00 Outlier reconciliation adjustment amount (see instructions) 0 10.00 Outlier reconciliation adjustment amount (see instructions) 0 10.00 Outlier reconciliation adjustment amount (see instructions) 0 10.00 Outlier reconciliation adjustment amount (see instructions) 0 10.00 Outlier reconciliation adjustment amount (see instructions) 0 10.00 Outlier reconciliation adjustment amount (see instructions) 0 10.00 Outlier reconciliation adjustment amount (see instructions) 0 10.00 Outlier reconciliation adjustment amount (see instructions) 0 10.00 Outlier reconciliation adjustment amount (see instructions) 0 10.00 Outlier reconciliation adjustment amount (see instructions) 0 10.00 Outlier reconciliation adjustment amount (see instructions) 0 10.00 Outlier reconciliation adjustment amount (see instructions) 0 10.00 Outlier reconciliation adjustment amount (see instructions) 0 10.00 Outlier reconciliation adjustment amount (see instructions)		· · · · · · · · · · · · · · · · · · ·	e with CMS Pub. 15-II,	section 115.2	0	44.00
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.00 92.00 93.00						
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00	1	· · · · · · · · · · · · · · · · · · ·			1	
93.00 Time Value of Money (see instructions) 0 93.00	1	· · · · · · · · · · · · · · · · · · ·				
					ł	
	1	, · · · · · · · · · · · · · · · · · · ·				
94.00 Total (sum of lines 91 and 93) 0 94.00	94. 00	Total (sum of lines 91 and 93)			0	94. 00

Health Financial Systems	METHODIST HOSPITAL OF CHICAGO	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 140197		Worksheet E
		From 10/01/2011	
	Component CCN: 145672	To 09/30/2012	Date/Time Prepared:
	·		2/27/2013 1:01 pm
	Title XVIII	Skilled Nursing	PPS

	Title XVIII	Skilled Nursing Facility	PPS	
	<u>'</u>	-	1. 00	
PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
Medical and other services (see instructions)			99	
Medical and other services reimbursed under OPPS (see instr	ructions)		0	
00 PPS payments 00 Outlier payment (see instructions)				3.
OO Outlier payment (see instructions) OO Enter the hospital specific payment to cost ratio (see inst	ructions)			5.
Une 2 times line 5	i deti olis)		0	6
O Sum of line 3 plus line 4 divided by line 6			0.00	
Transitional corridor payment (see instructions)			0	8
O Ancillary service other pass through costs from Worksheet D), Part IV, column 13, line	200	0	
00 Organ acquisitions			0	10
00 Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			99	11
Reasonable charges				1
00 Ancillary service charges			383	1 12
00 Organ acquisition charges (from Worksheet D-4, Part III, Ii	ne 69, col. 4)		0	1
00 Total reasonable charges (sum of lines 12 and 13)	•		383	14
Customary charges				
OO Aggregate amount actually collected from patients liable fo			0	
00 Amounts that would have been realized from patients liable		n a chargebasis	0	16
had such payment been made in accordance with 42 CFR 413.13 00 Ratio of line 15 to line 16 (not to exceed 1.000000)	s(e)		0. 000000	17
00 Total customary charges (see instructions)			383	
00 Excess of customary charges over reasonable cost (complete	only if line 18 exceeds li	ne 11) (see	284	1
instructions)	, , , , , , , , , , , , , , , , , , , ,	, (***		
00 Excess of reasonable cost over customary charges (complete	only if line 11 exceeds li	ne 18) (see	0	20
instructions)				
00 Lesser of cost or charges (line 11 minus line 20) (for CAH	see instructions)		99	
00 Interns and residents (see instructions) 00 Cost of teaching physicians (see instructions, 42 CFR 415.1	60 and CMS Dub 15 1 soct	i on 2149)	0	22
00 Total prospective payment (sum of lines 3, 4, 8 and 9)	TOO and CWS Fub. 15-1, Sect	1011 2140)	0	
COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	-
OD Deductibles and coinsurance (for CAH, see instructions)			77	25
00 Deductibles and Coinsurance relating to amount on line 24 ((for CAH, see instructions)			26
00 Subtotal ((lines 21 and 24 - the sum of lines 25 and 26) pl	us the sum of lines 22 and	23} (for CAH,	22	2
see instructions)	F 4 1: mg FO)		0	١,
00 Direct graduate medical education payments (from Worksheet 00 ESRD direct medical education costs (from Worksheet E-4, li			0	
OD Subtotal (sum of lines 27 through 29)	Tie 30)		22	
00 Primary payer payments			0	1
00 Subtotal (line 30 minus line 31)			22	
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SER	VI CES)			
OO Composite rate ESRD (from Worksheet I-5, line 11)			0	
00 Allowable bad debts (see instructions)			0	
00 Adjusted reimbursable bad debts (see instructions)	octructions)		0	3!
00 Allowable bad debts for dual eligible beneficiaries (see in 00 Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospi	*		22	3
00 MSP-LCC reconciliation amount from PS&R	tai and subprovider only)		22	38
OO OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
99 RECOVERY OF ACCELERATED DEPRECIATION				39
00 Subtotal (line 37 plus or minus lines 39 minus 38)			22	40
00 Interim payments			306	
OD Tentative settlement (for contractors use only)			0	
00 Balance due provider/program (line 40 minus the sum of line	· · · · · · · · · · · · · · · · · · ·		-284	
OD Protested amounts (nonallowable cost report items) in accor	raance with CMS Pub. 15-II,	section 115.2	0	44
TO BE COMPLETED BY CONTRACTOR On ignal outlier amount (see instructions)				90
00 Outlier reconciliation adjustment amount (see instructions	:)			91
00 The rate used to calculate the Time Value of Money	·/			92
00 Time Value of Money (see instructions)				93
00 Total (sum of lines 91 and 93)				94

In Lieu of Form CMS-2552-10 ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 140197 Peri od: Worksheet E-1

From 10/01/2011 Part I 09/30/2012 Date/Time Prepared: 2/27/2013 1:01 pm Title XVIII Hospi tal PPS Inpatient Part A Part B mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 14, 945, 195 1, 529, 880 1. 00 2.00 Interim payments payable on individual bills, either 891, 369 269, 479 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 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) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 05/04/2012 17, 360 3.01 1, 347, 740 3.02 05/11/2012 0 3.02 3.03 3.03 C 0 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 05/04/2012 1, 412, 527 0 3.50 3.51 0 3.51 0 0 3.52 3.52 3.53 0 3.53 0 3.54 \cap Λ 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines -64, 787 17, 360 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 15, 771, 777 1, 816, 719 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 0 0 5.01 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00

1, 445

Contractor

Number

1 00

15, 773, 222

0

0

131, 684

1, 685, 035

Date (Mo/Day/Yr)

2 00

6.01

6.02

7.00

8.00

the cost report. (1) SETTLEMENT TO PROVIDER

SETTLEMENT TO PROGRAM

8.00 Name of Contractor

Total Medicare program liability (see instructions)

6.01

6 02

7.00

Health Financial Systems METHOD ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		11 (1	e XVIII	Facility	PPS	
		Innation	t Part A		t 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		317, 380		306	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3. 00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3.02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provider to Program	T	_		_	
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52 3. 53			0		0	3. 52 3. 53
			0		0	
3. 54 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 54 3. 99
3. 99	3. 50-3. 98)		0		U	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		317, 380		306	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		317, 300		300	4.00
	appropri ate)					
	TO BE COMPLÉTED BY CONTRACTOR	<u>'</u>				
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	1				
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5. 03	Dravi dan ta Dragnam		0		0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		0		0	5. 50
5. 50	TENTATIVE TO PROGRAM		0		0	5. 50
5. 52			0		ő	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
0. ,,	5. 50-5. 98)		Ĭ		ŭ	0. ,,
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		53, 475		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		284	6. 02
7.00	Total Medicare program liability (see instructions)		370, 855		22	7. 00
				Contractor	Date	
			2	Number	(Mo/Day/Yr)	
8. 00	Name of Contractor)	1. 00	2. 00	9.00
0.00	Name of Contractor	I		I	l	8. 00

Hool +b	Financial Systems METHODIST HOSPITAL C	NE CHICACO	In Lio	u of Form CMS-2	DEE2 10
	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 140197	Peri od:	Worksheet E-3	
CALCUL	ATTOM OF RETWINDORSEMENT SETTLEMENT	110VIdel CCN. 140197	From 10/01/2011		
		Component CCN: 145672	To 09/30/2012	Date/Time Pre 2/27/2013 1:0	
		Title XVIII	Skilled Nursing Facility	PPS	
				1. 00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER	HEALTH SERVICES FOR T	ITLE XVIII PART A	PPS SNF	
	SERVI CES SERVI CES				
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)			347, 844	1. 00
2.00	Routine service other pass through costs			0	2. 00
3.00	Ancillary service other pass through costs			0	3. 00
4.00	Subtotal (sum of lines 1 through 3)			347, 844	4. 00
	COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine cos	ts are included in lin	e 1 of W/S E,		5. 00
	Part B. This line is now shaded.)				
6.00	Deducti bl e			0	6. 00
7. 00	Coi nsurance			30, 464	
	Allowable bad debts (see instructions)			54, 465	
9.00	Reimbursable bad debts for dual eligible beneficiaries (see ins	tructi ons)		51, 165	
	Allowable reimbursable bad debts (see instructions)			53, 475	
	Utilization review			0	
	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see In	structions)		370, 855	
	Inpatient primary payer payments			0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Recovery of Accelerated Depreciation			0	
	Subtotal (line 12 minus 13 ± lines 14			370, 855	
	Interim payments			317, 380	
	Tentative settlement (for contractor use only)	1 17)		0	
	Balance due provider/program (line 15 minus the sum of lines 16		0	53, 475	
19.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS 19 Pub. 15-	2, section [15.2]	0	19. 00

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

Provider CCN: 140197

Peri od: Worksheet G From 10/01/2011 To 09/30/2012 Date/Time Prepared:

			1	0 09/30/2012	2/27/2013 1:0	
	<u> </u>	General Fund	Speci fi c	Endowment Fund		
		1.00	Purpose Fund	2.00	4.00	
	CURRENT ASSETS	1.00	2. 00	3. 00	4. 00	
1.00	Cash on hand in banks	185, 666	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2. 00
3.00	Notes receivable	306, 900	0	0	0	3. 00
4.00	Accounts receivable	9, 648, 501	0	0	0	4. 00
5.00	Other recei vable	0	0	0	0	5. 00
6. 00	Allowances for uncollectible notes and accounts receivable	-1, 258, 942	1	0	0	6. 00
7.00	Inventory	448, 910	1	0	0	7. 00
8.00	Prepai d expenses	3, 660, 017		0	0	8.00
9. 00 10. 00	Other current assets Due from other funds	727, 502		0	0	9. 00 10. 00
11. 00	Total current assets (sum of lines 1-10)	13, 718, 554			0	11.00
11.00	FIXED ASSETS	13, 710, 334	·		0	11.00
12. 00	Land	6, 072, 657	' O	0	0	12. 00
13. 00	Land improvements	4, 025, 600	1	0	0	13. 00
14.00	Accumulated depreciation	0	0	0	0	14. 00
15.00	Bui I di ngs	106, 058, 456	0	0	0	15. 00
16. 00	Accumul ated depreciation	-78, 560, 076	0	0	0	16. 00
17. 00	Leasehold improvements	0	0	0	0	17. 00
18. 00	Accumul ated depreciation	0	0	_	0	18. 00
19. 00	Fixed equipment	17, 205, 854	0	0	0	19.00
20. 00	Accumulated depreciation	0		0	0	20.00
21. 00 22. 00	Automobiles and trucks			0	0	21. 00 22. 00
23. 00	Accumulated depreciation Major movable equipment			0	0	23. 00
24. 00	Accumulated depreciation			0	0	24.00
25. 00	Mi nor equi pment depreci abl e			0	0	25. 00
26. 00	Accumulated depreciation		ol o	_	0	26.00
27. 00	HIT designated Assets	Ö	ol o	0	0	27. 00
28.00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	O	0	0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	54, 802, 491	0	0	0	30. 00
	OTHER ASSETS			_	_	
31. 00	Investments	10, 562, 318	1		0	31.00
32. 00	Deposits on Leases	0	0	_	0	32.00
33. 00	Due from owners/officers	F 401 1//	0		0	33.00
34. 00 35. 00	Other assets Total other assets (sum of lines 31-34)	5, 481, 166 16, 043, 484		_	0	34. 00 35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	84, 564, 529	1		0	36.00
30.00	CURRENT LIABILITIES	04, 304, 327	`L		<u> </u>	30.00
37.00	Accounts payable	5, 224, 236	0	0	0	37. 00
38.00	Salaries, wages, and fees payable	4, 653, 289	0	0	0	38. 00
39.00	Payroll taxes payable	0	0	0	0	39. 00
40.00	Notes and Loans payable (short term)	639, 175	5 0	0	0	40. 00
41.00	Deferred income	0	0	0	0	41. 00
42. 00	Accel erated payments	0				42. 00
43. 00	Due to other funds	0 700 077	0	0	0	43.00
44. 00	Other current liabilities	8, 723, 277		_	0	
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	19, 239, 977	' 0	U	0	45. 00
46. 00	Mortgage payable			0	0	46. 00
47. 00	Notes payable		ol o	_	0	47. 00
48. 00	Unsecured Loans		ol o		Ö	48. 00
49.00	Other long term liabilities	61, 123, 846	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	61, 123, 846	1	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	80, 363, 823	0	0	0	51.00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	4, 200, 706				52. 00
53. 00	Specific purpose fund		0			53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			O		56.00
57. 00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	4, 200, 706		0	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	84, 564, 529	•	0	0	60.00
	59)					
		•	•			

Deductions (debit adjustments) (specify)

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

12.00

13.00

14.00

15.00

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18. 00

19.00

0

12.00

13.00

14.00

15.00

16.00

17.00

18.00

19.00

STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 140197 Peri od: Worksheet G-1 From 10/01/2011 To 09/30/2012 Date/Time Prepared: 2/27/2013 1:01 pm General Fund Special Purpose Fund 1.00 2.00 3.00 4. 00 1. 00 1.00 Fund balances at beginning of period 9, 268, 353 0 2.00 Net income (loss) (from Wkst. G-3, line 29) -5, 067, 647 2.00 3.00 Total (sum of line 1 and line 2) 4, 200, 706 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 0 0 0 0 0 0 0 0 0 0 5.00 5.00 6.00 6.00 7.00 7. 00 8.00 8.00 9.00 9. 00 10.00 Total additions (sum of line 4-9) 0 10.00 Subtotal (line 3 plus line 10) 4, 200, 706 11.00 11.00 0

4, 200, 706

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Peri od: From 10/01/2011 To 09/30/2012 Date/Ti me Prepared: 2/27/2013 1:01 pm Provider CCN: 140197

						2/2//2013 1.0	ı pili
		Endowme	nt Fund	PI ant	Fund		
		5. 00	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		o		3.00
4.00	Additions (credit adjustments) (specify)	0		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)		0		o		10.00
11. 00	Subtotal (line 3 plus line 10)		0		o		11. 00
12.00	Deductions (debit adjustments) (specify)	0		0			12.00
13.00	, , , , , , , , , , , , , , , , , , , ,	0		0			13.00
14.00		0		0			14.00
15.00		0		0			15.00
16.00		0		0			16.00
17. 00		0		0			17. 00
18. 00	Total deductions (sum of lines 12-17)		0		0		18. 00
19. 00	Fund balance at end of period per balance		0		0		19. 00
	sheet (line 11 minus line 18)					l	00

Health Financial Systems MET STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES METHODIST HOSPITAL OF CHICAGO In Lieu of Form CMS-2552-10 Worksheet G-2 Parts I & II Date/Time Prepared: 2/27/2013 1:01 pm Provi der CCN: 140197 Peri od: From 10/01/2011 To 09/30/2012 Cost Center Description Outpati ent Inpatient Total 1.00 2.00 3.00 PART I - PATIENT REVENUES

	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	19, 684, 565		19, 684, 565	1.00
2.00	SUBPROVI DER - I PF	0		0	2.00
3.00	SUBPROVI DER - I RF	0		0	3. 00
4. 00	SUBPROVI DER	0		ő	4. 00
5. 00	Swing bed - SNF	ő		ő	5. 00
6. 00	Swing bed - NF	0		0	6. 00
7. 00	SKILLED NURSING FACILITY	472, 500		472, 500	7. 00
		472, 300			
8.00	NURSI NG FACILITY	0		0	8. 00
9.00	OTHER LONG TERM CARE	0		0	9.00
10. 00	Total general inpatient care services (sum of lines 1-9)	20, 157, 065		20, 157, 065	10. 00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	1, 184, 741		1, 184, 741	11. 00
12.00	CORONARY CARE UNIT	0		0	12.00
13.00	BURN INTENSIVE CARE UNIT	0		0	13.00
14. 00	SURGICAL INTENSIVE CARE UNIT	0		0	14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines	1, 184, 741		1, 184, 741	16.00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	21, 341, 806		21, 341, 806	17.00
18.00	Ancillary services	28, 452, 966	9, 525, 722	37, 978, 688	18.00
19. 00	Outpati ent servi ces	1, 316, 453	1, 658, 661	2, 975, 114	19.00
20. 00	RURAL HEALTH CLINIC	0	0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	ő	21. 00
22. 00	HOME HEALTH AGENCY	Ŭ		ő	22. 00
23. 00	AMBULANCE SERVICES	0	0	o l	23. 00
24. 00	CMHC	U	0	0	24. 00
	CORF	0	0	0	
24. 10		0	U	0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P.)	0	U	- 1	25. 00
26. 00	HOSPI CE	0	0	0	26. 00
27. 00		0	0	0	27. 00
27. 01		0	0	0	27. 01
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	51, 111, 225	11, 184, 383	62, 295, 608	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES	,			
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		39, 062, 626		29. 00
30. 00	PROVISION FOR DOUBTFUL ACCOUNTS	1, 646, 751			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36, 00	Total additions (sum of lines 30-35)		1, 646, 751		36.00
37. 00	DEDUCT (SPECIFY)	0	., ,		37. 00
38. 00	SESSOT (SEESITT)	ő			38. 00
39. 00		0			39. 00
40. 00		0			40. 00
41. 00					41. 00
	Total deductions (sum of lines 27 41)				
42.00	Total deductions (sum of lines 37-41)		40 700 077		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		40, 709, 377		43. 00
	to Wkst. G-3, line 4)	I I	I	I	

	Financial Systems METHODIST HOSPITAL 0 ENT OF REVENUES AND EXPENSES	Provider CCN: 140197	Peri od:	Worksheet G-3	
			From 10/01/2011	Data/Time Drag	norod.
			To 09/30/2012	Date/Time Pre 2/27/2013 1:0	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 2	28)		62, 295, 608	1. 00
2.00	Less contractual allowances and discounts on patients' accounts			28, 661, 781	2. 00
3.00	Net patient revenues (line 1 minus line 2)			33, 633, 827	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43))		40, 709, 377	4.00
5.00	Net income from service to patients (line 3 minus line 4)			-7, 075, 550	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			5, 771	6. 00
7.00	Income from investments			328, 443	7. 00
8.00	Revenues from telephone and telegraph service			0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			1, 349	10. 00
11.00	Rebates and refunds of expenses			744	11. 00
12.00	Parking lot receipts			0	12. 00
13.00	Revenue from Laundry and Linen service			0	13. 00
14.00	Revenue from meals sold to employees and guests			112, 684	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	n 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			7, 290	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			5, 932	21.00
22.00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	HIT INCENTIVE PAYMENT			2, 994, 327	24. 00
24.01	MAINTENANCE INCOME			144	24. 01
24. 02	GAIN FROM ASSET DISPOSAL			25, 000	24. 02
24. 03	UNREALI ZED GAI N			79, 915	24. 03
24.04	NON-HOSPI TAL REVENUES			27, 632, 540	24. 04
25.00	Total other income (sum of lines 6-24)			31, 194, 139	25. 00
26.00	Total (line 5 plus line 25)			24, 118, 589	26. 00
27 00	NET PENSION AD HISTMENT			351 538	27 00

351, 538

108, 488

208, 650

31, 063

28, 486, 497 29, 186, 236 -5, 067, 647 29, 00

27.00

27.01

27. 02

27. 03

NET PENSION ADJUSTMENT

27. 02 | INTEREST RATE SWAP AGREEMENTS

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

27. 01 LOSS ON DEBT DEFEASANCE

27. 03 FUNDRAI SI NG EXPENSES

27. 04 NON-HOSPI TAL EXPENSES

27.00

Heal th	Financial Systems	METHODIST HOSPITAL	OF CHI CAGO	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSABLE BAD DEBTS - TITLE XVII	I - PART B	Provider CCN: 140197	Peri od:	Worksheet I-5	
				From 10/01/2011 To 09/30/2012	Date/Time Pre 2/27/2013 1:0	
					1. 00	
1.00	Total expenses related to care of program b	eneficiaries (see in	nstructions)		0	1. 00
2.00	Total payment (from Worksheet I-4, column 6	, line 11)			0	2. 00
3.00	Deductibles billed to Medicare (Part B) pat	ients			0	3.00
4.00	Coinsurance billed to Medicare (Part B) pat	i ents			0	4. 00
5.00	Bad debts for deductibles and coinsurance,	net of bad debt reco	overi es		0	5.00
6.00						6.00
7.00	Reimbursable bad debts for dual eligible be	neficiaries (see ins	structions)		0	7. 00
8.00	Net deductibles and coinsurance billed to M 5)	edicare (Part B) pa	tients (sum of lines 3	and 4 less line	0	8. 00
9.00	Program payment (line 2 less line 3, times	80 percent)			0	9. 00
10. 00	Unrecovered from Medicare (Part B) patients enter zero and do not complete line 11.)	(Line 1 minus the s	sum of lines 8 and 9. I	f negative,	0	10. 00
11. 00	Reimbursable bad debts (lesser of line 10 c	r line 5) (transfer	to Worksheet E, Part B	, line 33)	0	11. 00

	<i></i>	TAL OF CHI CAGO		u of Form CMS-2	2552-10
CALCUL	ATION OF CAPITAL PAYMENT	Provi der CCN: 140197	Peri od: From 10/01/2011 To 09/30/2012	Worksheet L Parts I-III Date/Time Pre 2/27/2013 1:0	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				1
1.00	Capital DRG other than outlier			891, 370	1.00
2.00	Capital DRG outlier payments			2, 541	2.00
3.00	Total inpatient days divided by number of days in the cost	reporting period (see inst	ructi ons)	67. 87	3.00
4. 00	Number of interns & residents (see instructions)			0.00	4.00
5.00	Indirect medical education percentage (see instructions)			0.00	
6. 00	Indirect medical education adjustment (line 1 times line 5			0	
7. 00	Percentage of SSI recipient patient days to Medicare Part	A patient days (Worksheet E	, part A line	14. 70	7.00
0 00	30) (see instructions)	l Wardishaat C 2 Davit I (4/ 17	0.00
8. 00	Percentage of Medicaid patient days to total days reported instructions)	on worksneet 5-3, Part I (see	46. 17	8.00
9. 00	Sum of lines 7 and 8			60. 87	9.00
10. 00		ons)			10.00
11. 00		0113)		116, 948	
	Total prospective capital payments (sum of lines 1-2, 6, a	nd 11)		1, 010, 859	
				.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1. 00	Program inpatient routine capital cost (see instructions)			0	
2.00	Program inpatient ancillary capital cost (see instructions	5)		0	
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	
4. 00 5. 00	Capital cost payment factor (see instructions)			0	1
3.00	Total inpatient program capital cost (line 3 x line 4)			0	3.00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1. 00	Program inpatient capital costs (see instructions)			0	1
2. 00	Program inpatient capital costs for extraordinary circumst	ances (see instructions)		0	
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	
4.00	Applicable exception percentage (see instructions)			0.00	
5. 00 6. 00	Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see	instructions)		0 0. 00	
6. 00 7. 00	Adjustment to capital minimum payment level for extraordin		lino 4)	0.00	
7. 00 3. 00	Capital minimum payment level (line 5 plus line 7)	lary cricumstances (rine 2 x	Title 0)	0	
9. 00	Current year capital payments (from Part I, line 12, as ap	ınl i cahl e)		0	
10.00	Current year comparison of capital minimum payment level t		less line 9)	0	
11. 00	Carryover of accumulated capital minimum payment level ove Worksheet L, Part III, line 14)			0	
12. 00		payments (line 10 plus lin	e 11)	0	12.00
13. 00	Current year exception payment (if line 12 is positive, en	1 3 1	,	0	
14. 00	Carryover of accumulated capital minimum payment level ove			0	
45.00	(if line 12 is negative, enter the amount on this line)			-	45.00
15. 00					15.00
	Current year operating and capital costs (see instructions	()		0	16.00
16.00	Current year exception offset amount (see instructions)	,		^	17. 00