This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140124	Period: From 12/01/2014 To 11/30/2015	Worksheet S Parts I-III Date/Time Prepared: 4/29/2016 10:04 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 4/29/2016 Time: 10:04 am
2. [ ] Manually submitted cost report
3. [0] 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
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by JOHN H. STROGER JR. HOSP OF COOK CTY (140124) for the cost reporting period beginning 12/01/2014 and ending 11/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

CHIEF FINANCIAL OFFICER
Title

04/29/2016
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	682,343	201,818	97,028	66,593	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	682,343	201,818	97,028	66,593	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 4/29/2016 10:03 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1901 WEST HARRISON STREET	PO Box:			1.00
2.00	City: CHICAGO	State: IL	Zip Code: 60612-3714	County: COOK	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	JOHN H. STROGER JR. HOSP OF COOK CTY	140124	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis	JOHN H. STROGER JR. HOSP DIALYSIS	142313	16794		07/01/1973				18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	12/01/2014	11/30/2015	20.00
21.00	Type of Control (see instructions)	9		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	1	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	25,456	8,405	0	0	6,356	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 4/29/2016 10:03 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	Y	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	Y			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 4/29/2016 10:03 am

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	

	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 4/29/2016 10:03 am

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	264.14	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	FAMILY MED INTERNAL MED, INTERNAL ME	1350	0.00	27.39	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 4/29/2016 10:03 am

		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00

			1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.		N	110.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	410,456	7,510,740	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 4/29/2016 10:03 am

		1.00	2.00	
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: COOK COUNTY	Contractor's Name:	Contractor's Number: 00131	141.00
142.00	Street: 118 NORTH CLARK STREET	PO Box:		142.00
143.00	City: CHICAGO	State: IL	Zip Code: 60602	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.25	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	12/01/2014	11/30/2015	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140124	Period: From 12/01/2014 To 11/30/2015	Worksheet S-2 Part I Date/Time Prepared: 4/29/2016 10:03 am

			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 4/29/2016 10:03 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	06/15/2015	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	Y		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	Y		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	04/05/2016	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 4/29/2016 10:03 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				Y	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				Y	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LEO	JANCILA	41.00
42.00	Enter the employer/company name of the cost report preparer.	COOK COUNTY HEALTH & HOSPITAL SYSTEM		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	312-864-4778	LJANCILA@COOKCOUNTYHHS.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 4/29/2016 10:03 am

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	04/05/2016			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		ADMINISTRATIVE CORRDINATOR III		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

VOLUNTARY CONTACT INFORMATION | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet S-2 Part V | Date/Time Prepared: 4/29/2016 10:03 am

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

HFS Supplemental Information | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet S-2 Part IX Date/Time Prepared: 4/29/2016 10:03 am

		Title V	Title XIX	
		1.00	2.00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE			
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient	Outpatient	
		1.00	2.00	
	CRITICAL ACCESS HOSPITALS			
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
	RCE DISALLOWANCE			
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
	PASS THROUGH COST			
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "O") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00
	RHC			
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 4/29/2016 10:03 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	310	111,456	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		310	111,456	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	32	11,680	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT	33.00	8	2,920	0.00	0	10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34.00	14	5,110	0.00	0	11.00
11.01	PEDIATRIC INTENSIVE CARE UNIT	34.01	10	3,650	0.00	0	11.01
11.02	TRAUMA INTENSIVE CARE UNIT	34.02	12	4,380	0.00	0	11.02
11.03	NEURO INTENSIVE CARE	34.03	10	3,650	0.00	0	11.03
11.04	NEONATAL INTENSIVE CARE UNIT	34.04	52	18,980	0.00	0	11.04
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		448	161,826	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		448				27.00
28.00	Observation Bed Days					5,488	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		9	3,285			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 4/29/2016 10:03 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	9,315	20,993	70,473			1.00
2.00	HMO and other (see instructions)	3,115	14,761				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	9,315	20,993	70,473			7.00
8.00	INTENSIVE CARE UNIT	1,415	2,057	7,440			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT	184	397	1,423			10.00
11.00	SURGICAL INTENSIVE CARE UNIT	412	569	2,649			11.00
11.01	PEDIATRIC INTENSIVE CARE UNIT	0	582	868			11.01
11.02	TRAUMA INTENSIVE CARE UNIT	366	1,338	2,489			11.02
11.03	NEURO INTENSIVE CARE	244	793	2,480			11.03
11.04	NEONATAL INTENSIVE CARE UNIT	0	6,035	9,096			11.04
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		1,232	1,845			13.00
14.00	Total (see instructions)	11,936	33,996	98,763	473.60	4,938.97	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				473.60	4,938.97	27.00
28.00	Observation Bed Days		7,780	13,268			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	1,136	1,964			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 4/29/2016 10:03 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,494	6,450	21,577	1.00
2.00	HMO and other (see instructions)			676	2,219		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
11.01	PEDIATRIC INTENSIVE CARE UNIT						11.01
11.02	TRAUMA INTENSIVE CARE UNIT						11.02
11.03	NEURO INTENSIVE CARE						11.03
11.04	NEONATAL INTENSIVE CARE UNIT						11.04
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	2,494	6,450	21,577	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet S-3 Part II Date/Time Prepared: 4/29/2016 10:03 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	414,573,746	0	414,573,746	9,819,555.00	42.22	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		1,901,145	0	1,901,145	25,719.00	73.92	3.00
4.00	Physician-Part A - Administrative		27,829,348	0	27,829,348	234,290.00	118.78	4.00
4.01	Physicians - Part A - Teaching		15,523,443	0	15,523,443	133,319.00	116.44	4.01
5.00	Physician-Part B		67,808,892	0	67,808,892	607,390.00	111.64	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	22,970,843	-2,220,761	20,750,082	899,891.00	23.06	7.00
7.01	Contracted interns and residents (in an approved programs)		6,345,462	0	6,345,462	339,058.00	18.71	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		3,747,599	1,086,811	4,834,410	104,376.00	46.32	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		12,856,960	0	12,856,960	413,225.00	31.11	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		20,943,871	0	20,943,871	567,092.00	36.93	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		7,623,252	0	7,623,252			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		982,162	0	982,162			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		491,589	0	491,589			21.00
22.00	Physician Part A - Administrative		9,474,664	0	9,474,664			22.00
22.01	Physician Part A - Teaching		5,285,690	0	5,285,690			22.01
23.00	Physician Part B		23,094,862	0	23,094,862			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		15,527,803	0	15,527,803			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	480,868	0	480,868	35,675.00	13.48	26.00
27.00	Administrative & General	5.00	23,666,019	293,467	23,959,486	660,429.00	36.28	27.00
28.00	Administrative & General under contract (see inst.)		14,044,659	0	14,044,659	569,161.00	24.68	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	17,116,614	0	17,116,614	442,785.00	38.66	30.00
31.00	Laundry & Linen Service	8.00	173,698	0	173,698	6,373.00	27.26	31.00
32.00	Housekeeping	9.00	8,931,609	0	8,931,609	431,133.00	20.72	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	3,419,724	-9,377	3,410,347	150,116.00	22.72	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	677,804	0	677,804	35,882.00	18.89	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	3,083,537	0	3,083,537	73,358.00	42.03	38.00
39.00	Central Services and Supply	14.00	2,890,526	0	2,890,526	128,703.00	22.46	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet S-3 Part II Date/Time Prepared: 4/29/2016 10:03 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	3,545,533	0	3,545,533	142,500.00	24.88	41.00
42.00	Social Service	17.00	549,538	-80,642	468,896	6,661.00	70.39	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet S-3 Part III Date/Time Prepared: 4/29/2016 10:03 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		314,068,620	2,220,761	316,289,381	8,383,339.00	37.73	1.00
2.00	Excluded area salaries (see instructions)		3,747,599	1,086,811	4,834,410	104,376.00	46.32	2.00
3.00	Subtotal salaries (line 1 minus line 2)		310,321,021	1,133,950	311,454,971	8,278,963.00	37.62	3.00
4.00	Subtotal other wages & related costs (see inst.)		33,800,831	0	33,800,831	980,317.00	34.48	4.00
5.00	Subtotal wage-related costs (see inst.)		17,097,916	0	17,097,916	0.00	5.49	5.00
6.00	Total (sum of lines 3 thru 5)		361,219,768	1,133,950	362,353,718	9,259,280.00	39.13	6.00
7.00	Total overhead cost (see instructions)		78,580,129	203,448	78,783,577	2,682,776.00	29.37	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet S-3 Part IV Date/Time Prepared: 4/29/2016 10:03 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	40,300,232	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	56,969,864	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	2,242,342	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	711,346	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	2,288,961	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	0	17.00
18.00	Medicare Taxes - Employers Portion Only	5,556,688	18.00
19.00	Unemployment Insurance	148,985	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	9,789	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	108,228,207	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED - MALPRACTICE EXP	19,251,811	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet S-3 Part V Date/Time Prepared: 4/29/2016 10:03 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	15,372,732	105,599,603	1.00
2.00	Hospital	15,372,732	104,770,472	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	829,131	17.00
18.00	Other	0	0	18.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet S-5 | Date/Time Prepared: 4/29/2016 10:03 am

		Outpatient		Training		Home		
		Regular	High Flux	Hemodialysis	CAPD / CCPD	Hemodialysis	CAPD / CCPD	
		1.00	2.00	3.00	4.00	5.00	6.00	
1.00	Number of patients in program at end of cost reporting period	29	0	0	0	0	0	1.00
2.00	Number of times per week patient receives dialysis	3.50	0.00	0.00	0.00	0.00	0.00	2.00
3.00	Average patient dialysis time including setup	5.00	0.00	0.00	0.00			3.00
4.00	CAPD exchanges per day				0.00		0.00	4.00
5.00	Number of days in year dialysis furnished	312	0					5.00
6.00	Number of stations	8	0	0	0			6.00
7.00	Treatment capacity per day per station	4	0					7.00
8.00	Utilization (see instructions)	0.00	0.00					8.00
9.00	Average times dialyzers re-used	0.00	0.00					9.00
10.00	Percentage of patients re-using dialyzers	0.00	0.00					10.00

		Y/N	
		1.00	
	ESRD PPS		
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter "Y" for yes or "N" for no. (see instructions)	N	10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter "Y" for yes or "N" for no. (See instructions for "new" providers.)	Y	10.02

		Prior to 1/1	After 12/31	
		1.00	2.00	
10.03	If you responded "N" to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)	0	0	10.03
	TRANSPLANT INFORMATION			
11.00	Number of patients on transplant list	0		11.00
12.00	Number of patients transplanted during the cost reporting period	0		12.00
	EPOETIN			
13.00	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider.			13.00
14.00	Epoetin amount from Worksheet A for Home Dialysis program			14.00
15.00	Number of EPO units furnished relating to the renal dialysis department			15.00
16.00	Number of EPO units furnished relating to the home dialysis department			16.00
	ARANESP			
17.00	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider.			17.00
18.00	ARANESP amount from Worksheet A for Home Dialysis program			18.00
19.00	Number of ARANESP units furnished relating to the renal dialysis department			19.00
20.00	Number of ARANESP units furnished relating to the home dialysis department			20.00

		MCP	INITIAL METHOD	
		1.00	2.00	
	PHYSICIAN PAYMENT METHOD			
21.00	Enter "X" if method(s) is applicable		X	21.00

		ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.	
		1.00	2.00	3.00	4.00	5.00	
	ESAs						
22.00	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)		0	0	0	0	22.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet S-10 | Date/Time Prepared: 4/29/2016 10:03 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.600714	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	129,416,565	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	412,413,628	6.00
7.00	Medicaid cost (line 1 times line 6)	247,742,640	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	118,326,075	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	4,670,514	9.00
10.00	Stand-alone SCHIP charges	5,583,397	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	3,354,025	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	94,566,392	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	72,650,471	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	43,642,155	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	118,326,075	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	346,198,932	0	346,198,932	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	207,966,545	0	207,966,545	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	207,966,545	0	207,966,545	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	172,692,948	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	956,418	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	171,736,530	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	103,164,538	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	311,131,083	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	429,457,158	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet A | Date/Time Prepared: 4/29/2016 10:03 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		14,810,192	14,810,192	308,525	15,118,717	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		5,922,645	5,922,645	0	5,922,645	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	480,868	103,449,905	103,930,773	2,288,961	106,219,734	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	23,666,019	62,574,688	86,240,707	-533,571	85,707,136	5.00
7.00	00700	OPERATION OF PLANT	17,116,614	15,852,545	32,969,159	0	32,969,159	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	173,698	1,293,988	1,467,686	0	1,467,686	8.00
9.00	00900	HOUSEKEEPING	8,931,609	1,055,895	9,987,504	590,067	10,577,571	9.00
10.00	01000	DIETARY	3,419,724	7,198,533	10,618,257	-705,065	9,913,192	10.00
11.00	01100	CAFETERIA	677,804	0	677,804	0	677,804	11.00
13.00	01300	NURSING ADMINISTRATION	3,083,537	20,491	3,104,028	0	3,104,028	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,890,526	19,160,797	22,051,323	-17,368,056	4,683,267	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,545,533	664,462	4,209,995	0	4,209,995	16.00
17.00	01700	SOCIAL SERVICE	549,538	80	549,618	-80,642	468,976	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	22,970,843	14,049,323	37,020,166	-2,220,761	34,799,405	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	763,585	538,739	1,302,324	26,308,965	27,611,289	22.00
23.00	02300	ALLIED HEALTH	0	0	0	266,755	266,755	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	67,561,065	7,174,720	74,735,785	-9,884,768	64,851,017	30.00
31.00	03100	INTENSIVE CARE UNIT	8,450,982	72,557	8,523,539	198,913	8,722,452	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	2,782,085	27,254	2,809,339	-27,686	2,781,653	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	3,859,190	18,675	3,877,865	10,937	3,888,802	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	2,504,670	66,361	2,571,031	-16,850	2,554,181	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	5,877,711	380,210	6,257,921	52,887	6,310,808	34.02
34.03	02400	NEURO INTENSIVE CARE	4,117,530	14,816	4,132,346	-452,299	3,680,047	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	10,516,880	133,386	10,650,266	-427,365	10,222,901	34.04
43.00	04300	NURSERY	1,977,042	11,321	1,988,363	0	1,988,363	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,040,166	15,504,891	46,545,057	-9,127,368	37,417,689	50.00
51.00	05100	RECOVERY ROOM	2,456,935	2,532	2,459,467	-36,144	2,423,323	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,533,602	27,741	3,561,343	12,443	3,573,786	52.00
53.00	05300	ANESTHESIOLOGY	9,662,448	135,410	9,797,858	-2,625,427	7,172,431	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,804,810	11,913,473	29,718,283	-764,744	28,953,539	54.00
60.00	06000	LABORATORY	15,884,471	15,895,859	31,780,330	-578,376	31,201,954	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,130,824	2,978,658	4,109,482	0	4,109,482	62.00
65.00	06500	RESPIRATORY THERAPY	6,949,868	549,197	7,499,065	-243,881	7,255,184	65.00
66.00	06600	PHYSICAL THERAPY	1,659,177	118,625	1,777,802	0	1,777,802	66.00
67.00	06700	OCCUPATIONAL THERAPY	522,129	0	522,129	0	522,129	67.00
68.00	06800	SPEECH PATHOLOGY	528,608	258,952	787,560	0	787,560	68.00
69.00	06900	ELECTROCARDIOLOGY	5,323,545	1,968,744	7,292,289	-183,953	7,108,336	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	15,046,056	15,046,056	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,483,172	6,483,172	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,328,586	22,924,659	43,253,245	28,699,633	71,952,878	73.00
74.00	07400	RENAL DIALYSIS	3,506,936	9,111	3,516,047	0	3,516,047	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	64,037,258	35,129,976	99,167,234	-31,964,142	67,203,092	90.00
91.00	09100	EMERGENCY	30,539,731	233,865	30,773,596	-3,846,272	26,927,324	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	410,826,147	362,143,276	772,969,423	-820,056	772,149,367	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	DENTISTRY	2,121,313	266,495	2,387,808	168,498	2,556,306	190.01
190.02	19002	ACHN SATELITTE CLINICS	0	0	0	0	0	190.02
190.03	19003	SPECIAL FUNDS	0	0	0	651,558	651,558	190.03
190.04	19004	SENGSTACKE CLINIC	0	3,211,874	3,211,874	0	3,211,874	190.04
194.00	07950	COUNTYCARE	1,626,286	651,124,836	652,751,122	0	652,751,122	194.00
200.00		TOTAL (SUM OF LINES 118-199)	414,573,746	1,016,746,481	1,431,320,227	0	1,431,320,227	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet A | Date/Time Prepared: 4/29/2016 10:03 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	41,834,009	56,952,726		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	12,583,623	18,506,268		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,421,775	113,641,509		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	122,534,922	208,242,058		5.00
7.00	00700	OPERATION OF PLANT	-3,208,809	29,760,350		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,467,686		8.00
9.00	00900	HOUSEKEEPING	0	10,577,571		9.00
10.00	01000	DIETARY	0	9,913,192		10.00
11.00	01100	CAFETERIA	0	677,804		11.00
13.00	01300	NURSING ADMINISTRATION	0	3,104,028		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,683,267		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-149,173	4,060,822		16.00
17.00	01700	SOCIAL SERVICE	-1,821	467,155		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	34,799,405		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	-6,671,145	20,940,144		22.00
23.00	02300	ALLIED HEALTH	0	266,755		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-32,395,477	32,455,540		30.00
31.00	03100	INTENSIVE CARE UNIT	-311,920	8,410,532		31.00
33.00	03300	BURN INTENSIVE CARE UNIT	-1,290,128	1,491,525		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	-389,085	3,499,717		34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	-851,256	1,702,925		34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	-2,348,190	3,962,618		34.02
34.03	02400	NEURO INTENSIVE CARE	-1,013,378	2,666,669		34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	-3,947,472	6,275,429		34.04
43.00	04300	NURSERY	0	1,988,363		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-15,303,366	22,114,323		50.00
51.00	05100	RECOVERY ROOM	-502,357	1,920,966		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,573,786		52.00
53.00	05300	ANESTHESIOLOGY	-6,087,420	1,085,011		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-8,379,633	20,573,906		54.00
60.00	06000	LABORATORY	-4,570,103	26,631,851		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	4,109,482		62.00
65.00	06500	RESPIRATORY THERAPY	-2,224,780	5,030,404		65.00
66.00	06600	PHYSICAL THERAPY	0	1,777,802		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	522,129		67.00
68.00	06800	SPEECH PATHOLOGY	0	787,560		68.00
69.00	06900	ELECTROCARDIOLOGY	-2,401,425	4,706,911		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	15,046,056		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,483,172		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,283,932	76,236,810		73.00
74.00	07400	RENAL DIALYSIS	0	3,516,047		74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-23,522,753	43,680,339		90.00
91.00	09100	EMERGENCY	-4,086,182	22,841,142		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	69,002,388	841,151,755		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	DENTISTRY	0	2,556,306		190.01
190.02	19002	ACHN SATELITTE CLINICS	0	0		190.02
190.03	19003	SPECIAL FUNDS	0	651,558		190.03
190.04	19004	SENGSTACKE CLINIC	-3,211,874	0		190.04
194.00	07950	COUNTYCARE	-639,641,420	13,109,702		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-573,850,906	857,469,321		200.00

COST CENTERS USED IN COST REPORT | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet Non-CMS W | Date/Time Prepared: 4/29/2016 10:03 am

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
21.00	I&R SERVICES-SALARY & FRINGES APPRV	02100		21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	02200		22.00
23.00	ALLIED HEALTH	02300		23.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
33.00	BURN INTENSIVE CARE UNIT	03300		33.00
34.00	SURGICAL INTENSIVE CARE UNIT	03400		34.00
34.01	PEDIATRIC INTENSIVE CARE UNIT	02080	PEDIATRIC INTENSIVE CARE UNIT	34.01
34.02	TRAUMA INTENSIVE CARE UNIT	02180	TRAUMA INTENSIVE CARE UNIT	34.02
34.03	NEURO INTENSIVE CARE	02400		34.03
34.04	NEONATAL INTENSIVE CARE UNIT	02060	NEONATAL INTENSIVE CARE UNIT	34.04
43.00	NURSERY	04300		43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELL	06200		62.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
74.00	RENAL DIALYSIS	07400		74.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
	SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
190.01	DENTISTRY	19001		190.01
190.02	ACHN SATELITTE CLINICS	19002		190.02
190.03	SPECIAL FUNDS	19003		190.03
190.04	SENGSTACKE CLINIC	19004		190.04
194.00	COUNTYCARE	07950		194.00
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet A-6 | Date/Time Prepared: 4/29/2016 10:03 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - TO RECLASS FRINGE BENEFITS TO EHW				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,288,961	1.00
	TOTALS		0	2,288,961	
	B - SERVICE CONTRACTS				
1.00	HOUSEKEEPING	9.00	0	590,067	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	105,621	2.00
	TOTALS		0	695,688	
	C - SAL OF NON RESIDENTS MOVED TO OTHER				
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	805,910	0	1.00
	TOTALS		805,910	0	
	D - TRANSFER MOONLIGHTING TO ER				
1.00	EMERGENCY	91.00	1,414,851	0	1.00
	TOTALS		1,414,851	0	
	E - TO RECLASSIFY I/R OTHER COST				
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	5,061,712	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	5,061,712	
	F - TO ALLOCATE PEDS ALGY & PSYCH TO INP				
1.00	ADULTS & PEDIATRICS	30.00	187,021	207	1.00
	TOTALS		187,021	207	
	G - TO TRANSFER DIETARY SAL TO CLINIC				
1.00	CLINIC	90.00	9,377	0	1.00
	TOTALS		9,377	0	
	H - TO ALLOCATE REGSTRY AND IN-HOUSE NSG				
1.00	INTENSIVE CARE UNIT	31.00	63,801	235,661	1.00
2.00	BURN INTENSIVE CARE UNIT	33.00	5,035	38,274	2.00
3.00	SURGICAL INTENSIVE CARE UNIT	34.00	4,028	75,888	3.00
4.00	PEDIATRIC INTENSIVE CARE UNIT	34.01	0	12,163	4.00
5.00	TRAUMA INTENSIVE CARE UNIT	34.02	51,919	283,653	5.00
6.00	NEURO INTENSIVE CARE	34.03	3,061	64,253	6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	4,511	7,932	7.00
8.00	EMERGENCY	91.00	27,953	278,563	8.00
9.00	CLINIC	90.00	0	1,058	9.00
10.00	NEURO INTENSIVE CARE	34.03	0	26,111	10.00
	TOTALS		160,308	1,023,556	
	J - TO RECLASS HEKTOEN COST TO RESRCH.				
1.00	SPECIAL FUNDS	190.03	651,558	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	TOTALS		651,558	0	
	K - TO RECLASS COST OF IMPLANTS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	6,483,172	1.00
	TOTALS		0	6,483,172	
	M - TO RECLASS HBP TEACHING TIME				
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	20,770,503	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
	TOTALS		20,770,503	0	

RECLASSIFICATIONS | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet A-6 | Date/Time Prepared: 4/29/2016 10:03 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	Q - INSURANCE RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,885,287	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	308,525	2.00
	TOTALS		0	3,193,812	
	R - PHARMACY SCHOOL				
1.00	ALLIED HEALTH	23.00	266,755	0	1.00
	TOTALS		266,755	0	
	S - MEDICAL DIRECTOR				
1.00	ADMINISTRATIVE & GENERAL	5.00	329,160	0	1.00
2.00	DENTISTRY	190.01	168,498	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		497,658	0	
	T - SUPPLY COST				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	15,046,056	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	28,971,876	2.00
	TOTALS		0	44,017,932	
500.00	Grand Total: Increases		24,763,941	62,765,040	500.00

RECLASSIFICATIONS | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet A-6 | Date/Time Prepared: 4/29/2016 10:03 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - TO RECLASS FRINGE BENEFITS TO EHW					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,288,961	0	1.00
	TOTALS		0	2,288,961		
	B - SERVICE CONTRACTS					
1.00	DIETARY	10.00	0	695,688	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	695,688		
	C - SAL OF NON RESIDENTS MOVED TO OTHER					
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	805,910	0	0	1.00
	TOTALS		805,910	0		
	D - TRANSFER MOONLIGHTING TO ER					
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	1,414,851	0	0	1.00
	TOTALS		1,414,851	0		
	E - TO RECLASSIFY I/R OTHER COST					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,528,985	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	3,382,259	0	2.00
3.00	LABORATORY	60.00	0	150,468	0	3.00
	TOTALS		0	5,061,712		
	F - TO ALLOCATE PEDS ALGY & PSYCH TO INP					
1.00	CLINIC	90.00	187,021	207	0	1.00
	TOTALS		187,021	207		
	G - TO TRANSFER DIETARY SAL TO CLINIC					
1.00	DIETARY	10.00	9,377	0	0	1.00
	TOTALS		9,377	0		
	H - TO ALLOCATE REGSTRY AND IN-HOUSE NSG					
1.00	ADULTS & PEDIATRICS	30.00	160,308	1,023,556	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
	TOTALS		160,308	1,023,556		
	J - TO RECLASS HEKTOEN COST TO RESRCH.					
1.00	ADMINISTRATIVE & GENERAL	5.00	35,693	0	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	563,485	0	0	2.00
3.00	ANESTHESIOLOGY	53.00	16,200	0	0	3.00
4.00	CLINIC	90.00	30,692	0	0	4.00
5.00	DRUGS CHARGED TO PATIENTS	73.00	5,488	0	0	5.00
	TOTALS		651,558	0		
	K - TO RECLASS COST OF IMPLANTS					
1.00	OPERATING ROOM	50.00	0	6,483,172	0	1.00
	TOTALS		0	6,483,172		
	M - TO RECLASS HBP TEACHING TIME					
1.00	ADULTS & PEDIATRICS	30.00	4,942,388	0	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	100,549	0	0	2.00
3.00	BURN INTENSIVE CARE UNIT	33.00	70,995	0	0	3.00
4.00	PEDIATRIC INTENSIVE CARE UNIT	34.01	29,013	0	0	4.00
5.00	TRAUMA INTENSIVE CARE UNIT	34.02	282,685	0	0	5.00
6.00	NEURO INTENSIVE CARE	34.03	545,724	0	0	6.00
7.00	NEONATAL INTENSIVE CARE UNIT	34.04	427,365	0	0	7.00
8.00	OPERATING ROOM	50.00	2,644,196	0	0	8.00
9.00	ANESTHESIOLOGY	53.00	2,609,227	0	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	764,744	0	0	10.00
11.00	LABORATORY	60.00	427,908	0	0	11.00
12.00	RESPIRATORY THERAPY	65.00	243,881	0	0	12.00
13.00	ELECTROCARDIOLOGY	69.00	183,953	0	0	13.00
14.00	CLINIC	90.00	1,744,471	0	0	14.00
15.00	EMERGENCY	91.00	5,567,639	0	0	15.00
16.00	SOCIAL SERVICE	17.00	80,642	0	0	16.00
17.00	SURGICAL INTENSIVE CARE UNIT	34.00	68,979	0	0	17.00
18.00	RECOVERY ROOM	51.00	36,144	0	0	18.00
	TOTALS		20,770,503	0		
	Q - INSURANCE RECLASS					
1.00	CLINIC	90.00	0	3,193,812	0	1.00
2.00		0.00	0	0	12	2.00
	TOTALS		0	3,193,812		

RECLASSIFICATIONS | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet A-6 | Date/Time Prepared: 4/29/2016 10:03 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	R - PHARMACY SCHOOL						
1.00	DRUGS CHARGED TO PATIENTS	73.00	266,755	0	0		1.00
	TOTALS		266,755	0			
	S - MEDICAL DIRECTOR						
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	329,160	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00	CLINIC	90.00	168,498	0	0		3.00
	TOTALS		497,658	0			
	T - SUPPLY COST						
1.00	CLINIC	90.00	0	26,649,876	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	17,368,056	0		2.00
	TOTALS		0	44,017,932			
500.00	Grand Total: Decreases		24,763,941	62,765,040			500.00

RECLASSIFICATIONS | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 4/29/2016 10:03 am

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	A - TO RECLASS FRINGE BENEFITS TO EHW								
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,288,961	ADMINISTRATIVE & GENERAL	5.00	0	2,288,961	1.00
	TOTALS		0	2,288,961	TOTALS		0	2,288,961	
	B - SERVICE CONTRACTS								
1.00	HOUSEKEEPING	9.00	0	590,067	DIETARY	10.00	0	695,688	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	105,621		0.00	0	0	2.00
	TOTALS		0	695,688	TOTALS		0	695,688	
	C - SAL OF NON RESIDENTS MOVED TO OTHER								
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	805,910	0	I&R SERVICES-SALARY & FRINGES APPRV	21.00	805,910	0	1.00
	TOTALS		805,910	0	TOTALS		805,910	0	
	D - TRANSFER MOONLIGHTING TO ER								
1.00	EMERGENCY	91.00	1,414,851	0	I&R SERVICES-SALARY & FRINGES APPRV	21.00	1,414,851	0	1.00
	TOTALS		1,414,851	0	TOTALS		1,414,851	0	
	E - TO RECLASSIFY I/R OTHER COST								
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	5,061,712	ADMINISTRATIVE & GENERAL	5.00	0	1,528,985	1.00
2.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	3,382,259	2.00
3.00		0.00	0	0	LABORATORY	60.00	0	150,468	3.00
	TOTALS		0	5,061,712	TOTALS		0	5,061,712	
	F - TO ALLOCATE PEDS ALGY & PSYCH TO INP								
1.00	ADULTS & PEDIATRICS	30.00	187,021	207	CLINIC	90.00	187,021	207	1.00
	TOTALS		187,021	207	TOTALS		187,021	207	
	G - TO TRANSFER DIETARY SAL TO CLINIC								
1.00	CLINIC	90.00	9,377	0	DIETARY	10.00	9,377	0	1.00
	TOTALS		9,377	0	TOTALS		9,377	0	
	H - TO ALLOCATE REGSTRY AND IN-HOUSE NSG								
1.00	INTENSIVE CARE UNIT	31.00	63,801	235,661	ADULTS & PEDIATRICS	30.00	160,308	1,023,556	1.00
2.00	BURN INTENSIVE CARE UNIT	33.00	5,035	38,274		0.00	0	0	2.00
3.00	SURGICAL INTENSIVE CARE UNIT	34.00	4,028	75,888		0.00	0	0	3.00
4.00	PEDIATRIC INTENSIVE CARE UNIT	34.01	0	12,163		0.00	0	0	4.00
5.00	TRAUMA INTENSIVE CARE UNIT	34.02	51,919	283,653		0.00	0	0	5.00
6.00	NEURO INTENSIVE CARE	34.03	3,061	64,253		0.00	0	0	6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	4,511	7,932		0.00	0	0	7.00
8.00	EMERGENCY	91.00	27,953	278,563		0.00	0	0	8.00
9.00	CLINIC	90.00	0	1,058		0.00	0	0	9.00
10.00	NEURO INTENSIVE CARE	34.03	0	26,111		0.00	0	0	10.00
	TOTALS		160,308	1,023,556	TOTALS		160,308	1,023,556	
	J - TO RECLASS HEKTOEN COST TO RESRCH.								
1.00	SPECIAL FUNDS	190.03	651,558	0	ADMINISTRATIVE & GENERAL	5.00	35,693	0	1.00
2.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	563,485	0	2.00
3.00		0.00	0	0	ANESTHESIOLOGY	53.00	16,200	0	3.00
4.00		0.00	0	0	CLINIC	90.00	30,692	0	4.00
5.00		0.00	0	0	DRUGS CHARGED TO PATIENTS	73.00	5,488	0	5.00
	TOTALS		651,558	0	TOTALS		651,558	0	
	K - TO RECLASS COST OF IMPLANTS								
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	6,483,172	OPERATING ROOM	50.00	0	6,483,172	1.00
	TOTALS		0	6,483,172	TOTALS		0	6,483,172	
	M - TO RECLASS HBP TEACHING TIME								
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	20,770,503	0	ADULTS & PEDIATRICS	30.00	4,942,388	0	1.00
2.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	100,549	0	2.00
3.00		0.00	0	0	BURN INTENSIVE CARE UNIT	33.00	70,995	0	3.00
4.00		0.00	0	0	PEDIATRIC INTENSIVE CARE UNIT	34.01	29,013	0	4.00
5.00		0.00	0	0	TRAUMA INTENSIVE CARE UNIT	34.02	282,685	0	5.00
6.00		0.00	0	0	NEURO INTENSIVE CARE	34.03	545,724	0	6.00
7.00		0.00	0	0	NEONATAL INTENSIVE CARE UNIT	34.04	427,365	0	7.00
8.00		0.00	0	0	OPERATING ROOM	50.00	2,644,196	0	8.00
9.00		0.00	0	0	ANESTHESIOLOGY	53.00	2,609,227	0	9.00
10.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	764,744	0	10.00

RECLASSIFICATIONS | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 4/29/2016 10:03 am

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
11.00		0.00	0	0	LABORATORY	60.00	427,908	0	11.00
12.00		0.00	0	0	RESPIRATORY THERAPY	65.00	243,881	0	12.00
13.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	183,953	0	13.00
14.00		0.00	0	0	CLINIC	90.00	1,744,471	0	14.00
15.00		0.00	0	0	EMERGENCY	91.00	5,567,639	0	15.00
16.00		0.00	0	0	SOCIAL SERVICE	17.00	80,642	0	16.00
17.00		0.00	0	0	SURGICAL INTENSIVE CARE UNIT	34.00	68,979	0	17.00
18.00		0.00	0	0	RECOVERY ROOM	51.00	36,144	0	18.00
	TOTALS		20,770,503	0	TOTALS		20,770,503	0	
	Q - INSURANCE RECLASS								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,885,287	CLINIC	90.00	0	3,193,812	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	308,525		0.00	0	0	2.00
	TOTALS		0	3,193,812	TOTALS		0	3,193,812	
	R - PHARMACY SCHOOL								
1.00	ALLIED HEALTH	23.00	266,755	0	DRUGS CHARGED TO PATIENTS	73.00	266,755	0	1.00
	TOTALS		266,755	0	TOTALS		266,755	0	
	S - MEDICAL DIRECTOR								
1.00	ADMINISTRATIVE & GENERAL	5.00	329,160	0	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	329,160	0	1.00
2.00	DENTISTRY	190.01	168,498	0		0.00	0	0	2.00
3.00		0.00	0	0	CLINIC	90.00	168,498	0	3.00
	TOTALS		497,658	0	TOTALS		497,658	0	
	T - SUPPLY COST								
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	15,046,056	CLINIC	90.00	0	26,649,876	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	28,971,876	CENTRAL SERVICES & SUPPLY	14.00	0	17,368,056	2.00
	TOTALS		0	44,017,932	TOTALS		0	44,017,932	
500.00	Grand Total: Increases		24,763,941	62,765,040	Grand Total: Decreases		24,763,941	62,765,040	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 4/29/2016 10:03 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	2,717,512	0	0	0	0	2.00
3.00	Buildings and Fixtures	523,013,795	122,407	0	122,407	0	3.00
4.00	Building Improvements	93,874,543	1,541,623	0	1,541,623	0	4.00
5.00	Fixed Equipment	161,828,485	14,415,340	0	14,415,340	0	5.00
6.00	Movable Equipment	6,332,236	47,292	0	47,292	0	6.00
7.00	HIT designated Assets	10,632,409	8,710	0	8,710	0	7.00
8.00	Subtotal (sum of lines 1-7)	798,398,980	16,135,372	0	16,135,372	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	798,398,980	16,135,372	0	16,135,372	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	2,717,512	0	2.00
3.00	Buildings and Fixtures	523,136,202	0	3.00
4.00	Building Improvements	95,416,166	0	4.00
5.00	Fixed Equipment	176,243,825	0	5.00
6.00	Movable Equipment	6,379,528	0	6.00
7.00	HIT designated Assets	10,641,119	0	7.00
8.00	Subtotal (sum of lines 1-7)	814,534,352	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	814,534,352	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet A-7 Part II | Date/Time Prepared: 4/29/2016 10:03 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	14,810,192	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,922,645	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	20,732,837	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	14,810,192	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,922,645	2.00
3.00	Total (sum of lines 1-2)	0	20,732,837	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 4/29/2016 10:03 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	797,513,704	0	797,513,704	0.979104	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	17,020,648	0	17,020,648	0.020896	0	2.00
3.00	Total (sum of lines 1-2)	814,534,352	0	814,534,352	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	13,716,732	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	6,293,806	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	20,010,538	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	42,927,469	308,525	0	0	56,952,726	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	12,212,462	0	0	0	18,506,268	2.00
3.00	Total (sum of lines 1-2)	55,139,931	308,525	0	0	75,458,994	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet A-8 | Date/Time Prepared: 4/29/2016 10:03 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)	B	-3,208,809	OPERATION OF PLANT	7.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-103,680,112			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	15,588,619			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-451,297	LABORATORY	60.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-149,173	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-477,663	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	371,161	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet A-8 | Date/Time Prepared: 4/29/2016 10:03 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISCELLANEOUS INCOME	B	-83,447	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02			0		0.00	0	33.02
33.03	COUNTY ADJ. FOR HOSPITAL BOND INT.	A	12,212,462	CAP REL COSTS-MVBLE EQUIP	2.00	11	33.03
33.04	COUNTY ADJ. FOR HOSPITAL BOND INT.	A	42,927,469	CAP REL COSTS-BLDG & FIXT	1.00	11	33.04
33.05	COUNTY ADJ. FOR HOSPITAL BOND INT.	A	9,758,205	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	SYSTEM HEALTH & HOSPITAL ADMINSTN.	A	95,654,317	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	SYSTEM HEALTH & HOSPITAL PHARMCY.	A	4,283,932	DRUGS CHARGED TO PATIENTS	73.00	0	33.07
33.08	SYSTEM HEALTH & HOSPITAL BENEFITS	A	6,236,474	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	SYSTEM HEALTH & HOSPITAL WAIVER COST	A	1,511,408	COUNTYCARE	194.00	0	33.09
33.10	RESIDENCY PROGRAM REIMBURSEMNT.	B	-653,740	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	33.10
33.11	MISCELLANEOUS INCOME	B	-3,490	CLINIC	90.00	0	33.11
33.12	TO OFFSET PHYSICIAN PART C TIME	A	-346,924	NEONATAL INTENSIVE CARE UNIT	34.04	0	33.12
33.13	TO OFFSET PHYSICIAN PART C TIME	A	-934,795	ADULTS & PEDIATRICS	30.00	0	33.13
33.14	TO OFFSET PHYSICIAN PART C TIME	A	-23,270	INTENSIVE CARE UNIT	31.00	0	33.14
33.15	TO OFFSET PHYSICIAN PART C TIME	A	-28,127	PEDIATRIC INTENSIVE CARE UNIT	34.01	0	33.15
33.16	TO OFFSET PHYSICIAN PART C TIME	A	-1,624	TRAUMA INTENSIVE CARE UNIT	34.02	0	33.16
33.17	TO OFFSET PHYSICIAN PART C TIME	A	-297,480	OPERATING ROOM	50.00	0	33.17
33.18	TO OFFSET PHYSICIAN PART C TIME	A	-32,601	ANESTHESIOLOGY	53.00	0	33.18
33.19	TO OFFSET PHYSICIAN PART C TIME	A	-170,221	RADIOLOGY-DIAGNOSTIC	54.00	0	33.19
33.20	TO OFFSET PHYSICIAN PART C TIME	A	-16,066	LABORATORY	60.00	0	33.20
33.21	TO OFFSET PHYSICIAN PART C TIME	A	-7,780	RESPIRATORY THERAPY	65.00	0	33.21
33.22	TO OFFSET PHYSICIAN PART C TIME	A	-7,770	ELECTROCARDIOLOGY	69.00	0	33.22
33.23	TO OFFSET PHYSICIAN PART C TIME	A	-174,417	CLINIC	90.00	0	33.23
33.24	TO OFFSET PHYSICIAN PART C TIME	A	-127,331	EMERGENCY	91.00	0	33.24
33.25	PHYSICIAN PART C TIME	A	-1,821	SOCIAL SERVICE	17.00	0	33.25
33.26			0		0.00	0	33.26
33.27			0		0.00	0	33.27
33.28	CRNA	A	-1,901,145	ANESTHESIOLOGY	53.00	0	33.28
33.29			0		0.00	0	33.29
33.30	TO REMOVE SENGSTACKE CLINIC FROM C/R	A	-3,211,874	SENGSTACKE CLINIC	190.04	0	33.30
33.31	IHA LOBBYING	A	-47,192	ADMINISTRATIVE & GENERAL	5.00	0	33.31
33.32			0		0.00	0	33.32
33.33	NURSE PRACTITIONER AND PHYS ASST.	A	-1,801,060	ADULTS & PEDIATRICS	30.00	0	33.33
33.34	NURSE PRACTITIONER AND PHYS ASST.	A	-207,520	SURGICAL INTENSIVE CARE UNIT	34.00	0	33.34
33.35			0		0.00	0	33.35
33.36	NURSE PRACTITIONER AND PHYS ASST.	A	-344,246	NEURO INTENSIVE CARE	34.03	0	33.36
33.37	NURSE PRACTITIONER AND PHYS ASST.	A	-248,737	NEONATAL INTENSIVE CARE UNIT	34.04	0	33.37
33.38	NURSE PRACTITIONER AND PHYS ASST.	A	-757,780	OPERATING ROOM	50.00	0	33.38
33.39			0		0.00	0	33.39
33.40	NURSE PRACTITIONER AND PHYS ASST.	A	-234,273	ELECTROCARDIOLOGY	69.00	0	33.40
33.41			0		0.00	0	33.41
33.42	NURSE PRACTITIONER AND PHYS ASST.	A	-2,941,136	CLINIC	90.00	0	33.42

ADJUSTMENTS TO EXPENSES | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet A-8 | Date/Time Prepared: 4/29/2016 10:03 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.43	NURSE PRACTITIONER AND PHYS ASST.	A	-903,128	EMERGENCY	91.00	0	33.43
33.44	OAK FOREST VACANT SPACE ADJUSTMENT	A	-615,797	CAP REL COSTS-BLDG & FIXT	1.00	9	33.44
33.45	WAIVER COSTS	A	-641,344,600	COUNTYCARE	194.00	0	33.45
33.46	3 YR PENSION AVG	A	1,185,301	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.46
33.47			0		0.00	0	33.47
33.48			0		0.00	0	33.48
33.49			0		0.00	0	33.49
33.50			0		0.00	0	33.50
33.51			0		0.00	0	33.51
33.52			0		0.00	0	33.52
33.53			0		0.00	0	33.53
33.54	WAIVER INSURANCE COSTS	A	-203,129	COUNTYCARE	194.00	0	33.54
33.55	HOSPITAL INSURANCES	A	2,059,321	ADMINISTRATIVE & GENERAL	5.00	0	33.55
33.56	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.56
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-573,850,906				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet A-8-1 | Date/Time Prepared: 4/29/2016 10:03 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	STORE ROOM	2,062,851	2,062,851	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	PAYROLL	230,261	232,345	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	GENERAL ACCOUNTING	280,575	281,979	3.00
3.01	194.00	COUNTYCARE	COUNTY COSTS ALLOCATED TO CC	394,901	0	3.01
4.00	5.00	ADMINISTRATIVE & GENERAL	COUNTY COSTS ALLOCATED TO CC	28,960,616	13,763,410	4.00
4.01	0.00			0	0	4.01
4.02	0.00			0	0	4.02
5.00	0		0	31,929,204	16,340,585	5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 140124	Period: From 12/01/2014 To 11/30/2015	Worksheet A-8-1 Date/Time Prepared: 4/29/2016 10:03 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	0		1.00
2.00	-2,084	0		2.00
3.00	-1,404	0		3.00
3.01	394,901	0		3.01
4.00	15,197,206	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
5.00	15,588,619			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 4/29/2016 10:03 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22,129,454	248,810	21,880,644	211,500	144,724	1.00
2.00	30.00	ADULTS & PEDIATRICS	37,923,438	25,055,910	12,867,528	179,000	86,486	2.00
3.00	31.00	INTENSIVE CARE UNIT	526,125	208,273	317,852	211,500	2,136	3.00
4.00	33.00	BURN INTENSIVE CARE UNIT	1,452,721	1,145,114	307,607	211,500	1,406	4.00
5.00	34.00	SURGICAL INTENSIVE CARE UNIT	239,921	161,972	77,949	211,500	525	5.00
6.00	34.01	PEDIATRIC INTENSIVE CARE UNIT	898,437	805,025	93,412	211,500	682	6.00
7.00	34.02	TRAUMA INTENSIVE CARE UNIT	2,648,730	2,117,040	531,690	211,500	2,638	7.00
8.00	34.03	NEURO INTENSIVE CARE	758,049	615,488	142,561	211,500	785	8.00
9.00	34.04	NEONATAL INTENSIVE CARE UNIT	4,234,517	3,072,799	1,161,718	211,500	7,952	9.00
10.00	50.00	OPERATING ROOM	16,556,416	12,828,907	3,727,509	246,400	17,478	10.00
11.00	53.00	ANESTHESIOLOGY	6,244,278	3,172,392	3,071,886	239,400	16,461	11.00
12.00	54.00	RADIOLOGY-DIAGNOSTIC	9,444,750	7,602,593	1,842,157	271,900	8,551	12.00
13.00	60.00	LABORATORY	5,212,610	4,052,056	1,160,554	260,300	8,277	13.00
14.00	65.00	RESPIRATORY THERAPY	2,738,809	1,983,576	755,233	197,500	4,988	14.00
15.00	67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	15.00
16.00	69.00	ELECTROCARDIOLOGY	2,558,161	1,956,090	602,071	211,500	3,544	16.00
17.00	90.00	CLINIC	23,039,539	19,231,211	3,808,328	179,000	27,805	17.00
18.00	91.00	EMERGENCY	7,119,941	1,809,503	5,310,438	246,400	31,448	18.00
20.00	51.00	RECOVERY ROOM	553,587	469,404	84,183	211,500	451	20.00
200.00			144,279,483	86,536,163	57,743,320		366,337	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	14,715,926	735,796	0	0	1,411,999	1.00
2.00	30.00	ADULTS & PEDIATRICS	7,442,786	372,139	0	0	2,419,755	2.00
3.00	31.00	INTENSIVE CARE UNIT	217,194	10,860	0	0	33,570	3.00
4.00	33.00	BURN INTENSIVE CARE UNIT	142,966	7,148	0	0	92,693	4.00
5.00	34.00	SURGICAL INTENSIVE CARE UNIT	53,383	2,669	0	0	15,308	5.00
6.00	34.01	PEDIATRIC INTENSIVE CARE UNIT	69,348	3,467	0	0	57,326	6.00
7.00	34.02	TRAUMA INTENSIVE CARE UNIT	268,239	13,412	0	0	169,006	7.00
8.00	34.03	NEURO INTENSIVE CARE	79,821	3,991	0	0	48,368	8.00
9.00	34.04	NEONATAL INTENSIVE CARE UNIT	808,581	40,429	0	0	270,189	9.00
10.00	50.00	OPERATING ROOM	2,070,471	103,524	0	0	1,056,404	10.00
11.00	53.00	ANESTHESIOLOGY	1,894,598	94,730	0	0	398,424	11.00
12.00	54.00	RADIOLOGY-DIAGNOSTIC	1,117,797	55,890	0	0	602,635	12.00
13.00	60.00	LABORATORY	1,035,819	51,791	0	0	332,597	13.00
14.00	65.00	RESPIRATORY THERAPY	473,620	23,681	0	0	174,753	14.00
15.00	67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	15.00
16.00	69.00	ELECTROCARDIOLOGY	360,363	18,018	0	0	163,227	16.00
17.00	90.00	CLINIC	2,392,834	119,642	0	0	1,470,068	17.00
18.00	91.00	EMERGENCY	3,725,379	186,269	0	0	454,297	18.00
20.00	51.00	RECOVERY ROOM	45,859	2,293	0	0	35,322	20.00
200.00			36,914,984	1,845,749	0	0	9,205,941	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	1,396,123	16,112,049	5,768,595	6,017,405		1.00
2.00	30.00	ADULTS & PEDIATRICS	821,030	8,263,816	4,603,712	29,659,622		2.00
3.00	31.00	INTENSIVE CARE UNIT	20,281	237,475	80,377	288,650		3.00
4.00	33.00	BURN INTENSIVE CARE UNIT	19,627	162,593	145,014	1,290,128		4.00
5.00	34.00	SURGICAL INTENSIVE CARE UNIT	4,973	58,356	19,593	181,565		5.00
6.00	34.01	PEDIATRIC INTENSIVE CARE UNIT	5,960	75,308	18,104	823,129		6.00
7.00	34.02	TRAUMA INTENSIVE CARE UNIT	33,925	302,164	229,526	2,346,566		7.00
8.00	34.03	NEURO INTENSIVE CARE	9,096	88,917	53,644	669,132		8.00
9.00	34.04	NEONATAL INTENSIVE CARE UNIT	74,125	882,706	279,012	3,351,811		9.00
10.00	50.00	OPERATING ROOM	237,839	2,308,310	1,419,199	14,248,106		10.00
11.00	53.00	ANESTHESIOLOGY	196,006	2,090,604	981,282	4,153,674		11.00
12.00	54.00	RADIOLOGY-DIAGNOSTIC	117,541	1,235,338	606,819	8,209,412		12.00
13.00	60.00	LABORATORY	74,051	1,109,870	50,684	4,102,740		13.00
14.00	65.00	RESPIRATORY THERAPY	48,189	521,809	233,424	2,217,000		14.00
15.00	67.00	OCCUPATIONAL THERAPY	0	0	0	0		15.00
16.00	69.00	ELECTROCARDIOLOGY	38,416	398,779	203,292	2,159,382		16.00
17.00	90.00	CLINIC	242,995	2,635,829	1,172,499	20,403,710		17.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 4/29/2016 10:03 am

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
18.00	91.00	EMERGENCY	338,839	4,064,218	1,246,220	3,055,723		18.00
20.00	51.00	RECOVERY ROOM	5,371	51,230	32,953	502,357		20.00
200.00			3,684,387	40,599,371	17,143,949	103,680,112		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet B Part I Date/Time Prepared: 4/29/2016 10:03 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	56,952,726	56,952,726				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	18,506,268		18,506,268			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	113,641,509	445,817	161,110	114,248,436		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	208,242,058	8,407,719	2,756,436	6,610,446	226,016,659	5.00
7.00	00700	OPERATION OF PLANT	29,760,350	20,376,321	128,916	4,722,491	54,988,078	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,467,686	405,962	447	47,923	1,922,018	8.00
9.00	00900	HOUSEKEEPING	10,577,571	469,137	7,916	2,464,240	13,518,864	9.00
10.00	01000	DIETARY	9,913,192	23,320	1,182	940,918	10,878,612	10.00
11.00	01100	CAFETERIA	677,804	974,355	45,608	187,007	1,884,774	11.00
13.00	01300	NURSING ADMINISTRATION	3,104,028	284,312	280,472	850,751	4,519,563	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,683,267	1,805,894	503,657	797,499	7,790,317	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,060,822	725,706	2,097	978,216	5,766,841	16.00
17.00	01700	SOCIAL SERVICE	467,155	83,786	438	129,369	680,748	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	34,799,405	24,061	4,175	5,724,968	40,552,609	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	20,940,144	0	0	6,072,812	27,012,956	22.00
23.00	02300	ALLIED HEALTH	266,755	2,895	0	73,598	343,248	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	32,455,540	6,240,049	5,560,382	17,128,257	61,384,228	30.00
31.00	03100	INTENSIVE CARE UNIT	8,410,532	649,609	0	2,321,496	11,381,637	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	1,491,525	138,671	3,146	749,382	2,382,724	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	3,499,717	218,497	0	1,046,834	4,765,048	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	1,702,925	153,932	2,832	683,036	2,542,725	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	3,962,618	525,319	266,235	1,557,998	6,312,170	34.02
34.03	02400	NEURO INTENSIVE CARE	2,666,669	109,770	0	986,309	3,762,748	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	6,275,429	279,912	40,001	2,783,707	9,379,049	34.04
43.00	04300	NURSERY	1,988,363	200,248	0	545,468	2,734,079	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	22,114,323	1,602,797	3,324,738	7,834,477	34,876,335	50.00
51.00	05100	RECOVERY ROOM	1,920,966	309,277	2,499	667,899	2,900,641	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,573,786	306,428	0	976,169	4,856,383	52.00
53.00	05300	ANESTHESIOLOGY	1,085,011	106,875	564,644	1,941,521	3,698,051	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,573,906	2,273,109	219,674	4,701,371	27,768,060	54.00
60.00	06000	LABORATORY	26,631,851	1,781,902	1,012,942	4,264,481	33,691,176	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	4,109,482	63,870	9,418	311,995	4,494,765	62.00
65.00	06500	RESPIRATORY THERAPY	5,030,404	127,555	733,305	1,850,189	7,741,453	65.00
66.00	06600	PHYSICAL THERAPY	1,777,802	108,218	5,263	457,769	2,349,052	66.00
67.00	06700	OCCUPATIONAL THERAPY	522,129	102,683	0	144,056	768,868	67.00
68.00	06800	SPEECH PATHOLOGY	787,560	55,579	14,587	145,843	1,003,569	68.00
69.00	06900	ELECTROCARDIOLOGY	4,706,911	495,746	1,355,054	1,418,019	7,975,730	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	15,046,056	0	0	0	15,046,056	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,483,172	0	0	0	6,483,172	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,236,810	265,925	53,562	5,533,565	82,089,862	73.00
74.00	07400	RENAL DIALYSIS	3,516,047	53,866	43,359	967,567	4,580,839	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	43,680,339	4,338,165	1,067,998	17,082,673	66,169,175	90.00
91.00	09100	EMERGENCY	22,841,142	1,764,047	330,894	7,287,896	32,223,979	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	841,151,755	56,301,334	18,502,987	112,988,215	839,236,861	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	DENTISTRY	2,556,306	105,231	3,281	631,761	3,296,579	190.01
190.02	19002	ACHN SATELITTE CLINICS	0	0	0	0	0	190.02
190.03	19003	SPECIAL FUNDS	651,558	486,552	0	179,766	1,317,876	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	13,109,702	59,609	0	448,694	13,618,005	194.00
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)	857,469,321	56,952,726	18,506,268	114,248,436	857,469,321	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet B Part I | Date/Time Prepared: 4/29/2016 10:03 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	226,016,659					5.00
7.00	00700	OPERATION OF PLANT	19,681,938	74,670,016				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	687,950	1,093,436	3,703,404			8.00
9.00	00900	HOUSEKEEPING	4,838,821	1,263,595	0	19,621,280		9.00
10.00	01000	DIETARY	3,893,792	62,812	0	17,043	14,852,259	10.00
11.00	01100	CAFETERIA	674,619	2,624,371	0	712,092	8,908,323	11.00
13.00	01300	NURSING ADMINISTRATION	1,617,692	765,779	0	207,785	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,788,396	4,864,075	0	1,319,810	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,064,131	1,954,649	0	530,371	0	16.00
17.00	01700	SOCIAL SERVICE	243,661	225,673	0	61,234	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	14,515,036	64,808	0	17,585	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	9,668,774	0	0	0	0	22.00
23.00	02300	ALLIED HEALTH	122,859	7,797	0	2,116	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,971,318	16,807,231	978,203	4,560,447	4,275,574	30.00
31.00	03100	INTENSIVE CARE UNIT	4,073,841	1,749,685	149,545	474,756	252,870	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	852,851	373,502	113,381	101,345	52,952	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,705,558	588,509	153,178	159,685	82,341	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	910,120	414,607	36,876	112,499	34,048	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	2,259,321	1,414,917	169,409	383,921	69,260	34.02
34.03	02400	NEURO INTENSIVE CARE	1,346,804	295,658	14,133	80,223	96,416	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	3,357,052	753,928	134,507	204,570	0	34.04
43.00	04300	NURSERY	978,612	539,358	47,225	146,348	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,483,321	4,317,045	515,325	1,171,380	0	50.00
51.00	05100	RECOVERY ROOM	1,038,229	833,020	164,046	226,030	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,738,250	825,348	202,594	223,948	0	52.00
53.00	05300	ANESTHESIOLOGY	1,323,647	287,861	26,172	78,108	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,939,049	6,122,493	378,434	1,661,267	0	54.00
60.00	06000	LABORATORY	12,059,116	4,799,454	0	1,302,276	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,608,816	172,031	0	46,678	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,770,906	343,562	0	93,222	0	65.00
66.00	06600	PHYSICAL THERAPY	840,799	291,479	29,773	79,089	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	275,202	276,571	0	75,044	0	67.00
68.00	06800	SPEECH PATHOLOGY	359,208	149,700	0	40,619	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,854,761	1,335,264	41,033	362,308	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,385,450	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,320,528	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,382,684	716,254	0	194,347	0	73.00
74.00	07400	RENAL DIALYSIS	1,639,624	145,085	0	39,367	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	23,683,999	11,684,608	24,435	3,170,481	329,799	90.00
91.00	09100	EMERGENCY	11,533,961	4,751,363	525,135	1,289,227	750,676	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	219,490,696	72,915,528	3,703,404	19,145,221	14,852,259	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	DENTISTRY	1,179,948	283,433	0	76,906	0	190.01
190.02	19002	ACHN SATELITTE CLINICS	0	0	0	0	0	190.02
190.03	19003	SPECIAL FUNDS	471,709	1,310,501	0	355,589	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	4,874,306	160,554	0	43,564	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	226,016,659	74,670,016	3,703,404	19,621,280	14,852,259	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet B Part I Date/Time Prepared: 4/29/2016 10:03 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	14.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	14,804,179					11.00
13.00	01300	NURSING ADMINISTRATION	163,443	7,274,262				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	286,754	0	17,049,352			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	317,494	0	0	10,633,486		16.00
17.00	01700	SOCIAL SERVICE	14,841	0	0	0	1,226,157	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,823,496	0	4,836	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	386,558	0	12,695	0	0	22.00
23.00	02300	ALLIED HEALTH	20,242	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,720,980	1,207,291	56,682	1,617,094	371,035	30.00
31.00	03100	INTENSIVE CARE UNIT	413,677	226,035	0	188,411	30,261	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	98,784	45,420	674	37,762	15,065	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	187,054	102,693	1,326	66,824	22,707	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	109,969	52,802	0	21,956	15,065	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	242,269	117,729	23	89,735	22,707	34.02
34.03	02400	NEURO INTENSIVE CARE	164,923	87,654	0	63,148	22,707	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	407,847	185,981	7,159	238,282	22,707	34.04
43.00	04300	NURSERY	117,256	65,717	0	15,468	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,341,030	643,661	6,114,463	1,547,494	0	50.00
51.00	05100	RECOVERY ROOM	111,170	58,852	0	148,708	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	171,785	96,139	0	34,149	0	52.00
53.00	05300	ANESTHESIOLOGY	126,091	62,291	37,868	500,875	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	792,961	364,600	817,934	1,399,634	0	54.00
60.00	06000	LABORATORY	935,742	474,067	0	1,250,337	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	74,371	41,682	0	79,659	0	62.00
65.00	06500	RESPIRATORY THERAPY	351,763	172,574	66,205	55,410	0	65.00
66.00	06600	PHYSICAL THERAPY	95,667	53,617	68,966	29,516	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	30,716	17,215	0	13,981	0	67.00
68.00	06800	SPEECH PATHOLOGY	31,818	17,833	291	10,595	0	68.00
69.00	06900	ELECTROCARDIOLOGY	274,528	135,793	712,037	239,228	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	8,747,407	91,291	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	164,225	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,122,720	614,867	32,691	1,152,172	0	73.00
74.00	07400	RENAL DIALYSIS	143,418	20,916	5,279	75,904	45,413	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	318,833	1,721,388	184,964	971,086	431,424	90.00
91.00	09100	EMERGENCY	1,315,156	651,241	27,390	530,542	227,066	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,713,356	7,238,058	16,898,890	10,633,486	1,226,157	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	DENTISTRY	0	36,204	150,462	0	0	190.01
190.02	19002	ACHN SATELITTE CLINICS	0	0	0	0	0	190.02
190.03	19003	SPECIAL FUNDS	0	0	0	0	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	90,823	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	14,804,179	7,274,262	17,049,352	10,633,486	1,226,157	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet B Part I | Date/Time Prepared: 4/29/2016 10:03 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	ALLIED HEALTH	Subtotal	
			19.00	21.00	22.00	23.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		56,978,370				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			37,080,983			22.00
23.00	02300	ALLIED HEALTH				496,262		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	13,069,549	8,505,538	0	137,525,170	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,029,485	1,320,770	0	22,290,973	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	381,356	248,183	0	4,703,999	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	630,380	410,245	0	8,875,548	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	243,009	158,148	0	4,651,824	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	0	0	0	11,081,461	34.02
34.03	02400	NEURO INTENSIVE CARE	0	102,256	66,547	0	6,103,217	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	0	1,086,322	706,968	0	16,484,372	34.04
43.00	04300	NURSERY	0	348,874	227,044	0	5,219,981	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	9,403,963	6,120,010	0	78,534,027	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	5,480,696	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	846,922	551,169	0	9,546,687	52.00
53.00	05300	ANESTHESIOLOGY	0	3,861,676	2,513,142	0	12,515,782	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,451,743	1,595,571	0	53,291,746	54.00
60.00	06000	LABORATORY	0	988,878	643,552	0	56,144,598	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	6,518,002	62.00
65.00	06500	RESPIRATORY THERAPY	0	1,212,638	789,174	0	13,596,907	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	3,837,958	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	1,457,597	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	1,613,633	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,423,166	926,183	0	16,280,031	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	29,270,204	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	8,967,925	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	120,301	78,291	496,262	116,000,451	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	6,695,845	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	7,735,382	5,034,114	0	121,459,688	90.00
91.00	09100	EMERGENCY	0	9,749,229	6,344,705	0	69,919,670	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	55,685,129	36,239,354	496,262	828,067,992	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	DENTISTRY	0	1,061,059	690,527	0	6,775,118	190.01
190.02	19002	ACHN SATELITTE CLINICS	0	0	0	0	0	190.02
190.03	19003	SPECIAL FUNDS	0	232,182	151,102	0	3,838,959	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	0	0	0	0	18,787,252	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	56,978,370	37,080,983	496,262	857,469,321	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet B Part I | Date/Time Prepared: 4/29/2016 10:03 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
23.00	02300	ALLIED HEALTH				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-21,575,087	115,950,083		30.00
31.00	03100	INTENSIVE CARE UNIT	-3,350,255	18,940,718		31.00
33.00	03300	BURN INTENSIVE CARE UNIT	-629,539	4,074,460		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	-1,040,625	7,834,923		34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	-401,157	4,250,667		34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	11,081,461		34.02
34.03	02400	NEURO INTENSIVE CARE	-168,803	5,934,414		34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	-1,793,290	14,691,082		34.04
43.00	04300	NURSERY	-575,918	4,644,063		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-15,523,973	63,010,054		50.00
51.00	05100	RECOVERY ROOM	0	5,480,696		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-1,398,091	8,148,596		52.00
53.00	05300	ANESTHESIOLOGY	-6,374,818	6,140,964		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-4,047,314	49,244,432		54.00
60.00	06000	LABORATORY	-1,632,430	54,512,168		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	6,518,002		62.00
65.00	06500	RESPIRATORY THERAPY	-2,001,812	11,595,095		65.00
66.00	06600	PHYSICAL THERAPY	0	3,837,958		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,457,597		67.00
68.00	06800	SPEECH PATHOLOGY	0	1,613,633		68.00
69.00	06900	ELECTROCARDIOLOGY	-2,349,349	13,930,682		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	29,270,204		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,967,925		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-198,592	115,801,859		73.00
74.00	07400	RENAL DIALYSIS	0	6,695,845		74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-12,769,496	108,690,192		90.00
91.00	09100	EMERGENCY	-16,093,934	53,825,736		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-91,924,483	736,143,509		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	DENTISTRY	-1,751,586	5,023,532		190.01
190.02	19002	ACHN SATELITTE CLINICS	0	0		190.02
190.03	19003	SPECIAL FUNDS	-383,284	3,455,675		190.03
190.04	19004	SENGSTACKE CLINIC	0	0		190.04
194.00	07950	COUNTYCARE	0	18,787,252		194.00
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	-94,059,353	763,409,968		202.00

COST ALLOCATION STATISTICS | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet Non-CMS W | Date/Time Prepared: 4/29/2016 10:03 am

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

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet B Part II | Date/Time Prepared: 4/29/2016 10:03 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	445,817	161,110	606,927	606,927	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,526,145	8,407,719	2,756,436	20,690,300	35,125	5.00
7.00	00700	OPERATION OF PLANT	0	20,376,321	128,916	20,505,237	25,093	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	405,962	447	406,409	255	8.00
9.00	00900	HOUSEKEEPING	0	469,137	7,916	477,053	13,094	9.00
10.00	01000	DIETARY	0	23,320	1,182	24,502	5,000	10.00
11.00	01100	CAFETERIA	0	974,355	45,608	1,019,963	994	11.00
13.00	01300	NURSING ADMINISTRATION	0	284,312	280,472	564,784	4,520	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	448,342	1,805,894	503,657	2,757,893	4,238	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	725,706	2,097	727,803	5,198	16.00
17.00	01700	SOCIAL SERVICE	0	83,786	438	84,224	687	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	24,061	4,175	28,236	30,420	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	32,268	22.00
23.00	02300	ALLIED HEALTH	0	2,895	0	2,895	391	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	6,240,049	5,560,382	11,800,431	90,879	30.00
31.00	03100	INTENSIVE CARE UNIT	0	649,609	0	649,609	12,335	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	138,671	3,146	141,817	3,982	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	218,497	0	218,497	5,562	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	153,932	2,832	156,764	3,629	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	525,319	266,235	791,554	8,278	34.02
34.03	02400	NEURO INTENSIVE CARE	0	109,770	0	109,770	5,241	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	0	279,912	40,001	319,913	14,791	34.04
43.00	04300	NURSERY	0	200,248	0	200,248	2,898	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,602,797	3,324,738	4,927,535	41,628	50.00
51.00	05100	RECOVERY ROOM	0	309,277	2,499	311,776	3,549	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	306,428	0	306,428	5,187	52.00
53.00	05300	ANESTHESIOLOGY	0	106,875	564,644	671,519	10,316	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,273,109	219,674	2,492,783	24,981	54.00
60.00	06000	LABORATORY	0	1,781,902	1,012,942	2,794,844	22,659	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	63,870	9,418	73,288	1,658	62.00
65.00	06500	RESPIRATORY THERAPY	433,334	127,555	733,305	1,294,194	9,831	65.00
66.00	06600	PHYSICAL THERAPY	0	108,218	5,263	113,481	2,432	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	102,683	0	102,683	765	67.00
68.00	06800	SPEECH PATHOLOGY	0	55,579	14,587	70,166	775	68.00
69.00	06900	ELECTROCARDIOLOGY	0	495,746	1,355,054	1,850,800	7,535	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	265,925	53,562	319,487	29,403	73.00
74.00	07400	RENAL DIALYSIS	0	53,866	43,359	97,225	5,141	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	684,024	4,338,165	1,067,998	6,090,187	90,769	90.00
91.00	09100	EMERGENCY	0	1,764,047	330,894	2,094,941	38,724	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,091,845	56,301,334	18,502,987	85,896,166	600,231	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	DENTISTRY	0	105,231	3,281	108,512	3,357	190.01
190.02	19002	ACHN SATELITTE CLINICS	0	0	0	0	0	190.02
190.03	19003	SPECIAL FUNDS	0	486,552	0	486,552	955	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	376,232	59,609	0	435,841	2,384	194.00
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)	11,468,077	56,952,726	18,506,268	86,927,071	606,927	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet B Part II | Date/Time Prepared: 4/29/2016 10:03 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,725,425					5.00
7.00	00700	OPERATION OF PLANT	1,804,819	22,335,149				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	63,084	327,066	796,814			8.00
9.00	00900	HOUSEKEEPING	443,716	377,964	0	1,311,827		9.00
10.00	01000	DIETARY	357,058	18,788	0	1,139	406,487	10.00
11.00	01100	CAFETERIA	61,862	784,997	0	47,609	243,808	11.00
13.00	01300	NURSING ADMINISTRATION	148,341	229,058	0	13,892	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	255,694	1,454,933	0	88,239	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	189,279	584,671	0	35,459	0	16.00
17.00	01700	SOCIAL SERVICE	22,344	67,503	0	4,094	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,331,018	19,385	0	1,176	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	886,619	0	0	0	0	22.00
23.00	02300	ALLIED HEALTH	11,266	2,332	0	141	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,014,753	5,027,348	210,466	304,897	117,017	30.00
31.00	03100	INTENSIVE CARE UNIT	373,568	523,362	32,176	31,741	6,921	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	78,206	111,721	24,395	6,776	1,449	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	156,398	176,034	32,957	10,676	2,254	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	83,457	124,017	7,934	7,521	932	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	207,178	423,227	36,450	25,668	1,896	34.02
34.03	02400	NEURO INTENSIVE CARE	123,501	88,437	3,041	5,364	2,639	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	307,839	225,514	28,940	13,677	0	34.04
43.00	04300	NURSERY	89,738	161,332	10,161	9,784	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,144,711	1,291,306	110,876	78,315	0	50.00
51.00	05100	RECOVERY ROOM	95,205	249,171	35,296	15,112	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	159,396	246,876	43,590	14,973	0	52.00
53.00	05300	ANESTHESIOLOGY	121,377	86,104	5,631	5,222	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	911,403	1,831,348	81,423	111,068	0	54.00
60.00	06000	LABORATORY	1,105,812	1,435,603	0	87,067	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	147,527	51,457	0	3,121	0	62.00
65.00	06500	RESPIRATORY THERAPY	254,090	102,766	0	6,233	0	65.00
66.00	06600	PHYSICAL THERAPY	77,101	87,187	6,406	5,288	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	25,236	82,727	0	5,017	0	67.00
68.00	06800	SPEECH PATHOLOGY	32,939	44,778	0	2,716	0	68.00
69.00	06900	ELECTROCARDIOLOGY	261,779	399,402	8,828	24,223	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	493,842	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	212,791	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,694,241	214,244	0	12,994	0	73.00
74.00	07400	RENAL DIALYSIS	150,352	43,397	0	2,632	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,171,805	3,495,077	5,257	211,970	9,026	90.00
91.00	09100	EMERGENCY	1,057,655	1,421,218	112,987	86,194	20,545	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,127,000	21,810,350	796,814	1,279,998	406,487	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	DENTISTRY	108,200	84,780	0	5,142	0	190.01
190.02	19002	ACHN SATELITTE CLINICS	0	0	0	0	0	190.02
190.03	19003	SPECIAL FUNDS	43,255	391,995	0	23,774	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	446,970	48,024	0	2,913	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	20,725,425	22,335,149	796,814	1,311,827	406,487	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet B Part II | Date/Time Prepared: 4/29/2016 10:03 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	14.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	2,159,233					11.00
13.00	01300	NURSING ADMINISTRATION	23,839	984,434				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	41,824	0	4,602,821			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	46,307	0	0	1,588,717		16.00
17.00	01700	SOCIAL SERVICE	2,165	0	0	0	181,017	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	265,962	0	1,306	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	56,381	0	3,427	0	0	22.00
23.00	02300	ALLIED HEALTH	2,952	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	396,863	163,384	15,302	242,025	54,776	30.00
31.00	03100	INTENSIVE CARE UNIT	60,336	30,590	0	28,141	4,467	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	14,408	6,147	182	5,640	2,224	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	27,282	13,898	358	9,981	3,352	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	16,039	7,146	0	3,279	2,224	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	35,336	15,932	6	13,403	3,352	34.02
34.03	02400	NEURO INTENSIVE CARE	24,054	11,862	0	9,432	3,352	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	59,486	25,169	1,933	35,590	3,352	34.04
43.00	04300	NURSERY	17,102	8,894	0	2,310	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	195,593	87,107	1,650,721	231,134	0	50.00
51.00	05100	RECOVERY ROOM	16,214	7,964	0	22,211	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	25,055	13,011	0	5,100	0	52.00
53.00	05300	ANESTHESIOLOGY	18,391	8,430	10,223	74,811	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	115,656	49,342	220,818	209,050	0	54.00
60.00	06000	LABORATORY	136,481	64,156	0	186,751	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	10,847	5,641	0	11,898	0	62.00
65.00	06500	RESPIRATORY THERAPY	51,306	23,355	17,873	8,276	0	65.00
66.00	06600	PHYSICAL THERAPY	13,953	7,256	18,619	4,409	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,480	2,330	0	2,088	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,641	2,413	78	1,583	0	68.00
69.00	06900	ELECTROCARDIOLOGY	40,041	18,377	192,228	35,731	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	2,361,547	13,635	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	24,529	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	163,752	83,211	8,826	172,089	0	73.00
74.00	07400	RENAL DIALYSIS	20,918	2,831	1,425	11,337	6,704	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	46,503	232,955	49,935	145,042	63,692	90.00
91.00	09100	EMERGENCY	191,819	88,133	7,394	79,242	33,522	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,145,986	979,534	4,562,201	1,588,717	181,017	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	DENTISTRY	0	4,900	40,620	0	0	190.01
190.02	19002	ACHN SATELITTE CLINICS	0	0	0	0	0	190.02
190.03	19003	SPECIAL FUNDS	0	0	0	0	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	13,247	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,159,233	984,434	4,602,821	1,588,717	181,017	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet B Part II Date/Time Prepared: 4/29/2016 10:03 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	ALLIED HEALTH	Subtotal	
			19.00	21.00	22.00	23.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		1,677,503				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			978,695			22.00
23.00	02300	ALLIED HEALTH				19,977		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS					20,438,141	30.00
31.00	03100	INTENSIVE CARE UNIT					1,753,246	31.00
33.00	03300	BURN INTENSIVE CARE UNIT					396,947	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT					657,249	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT					412,942	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT					1,562,280	34.02
34.03	02400	NEURO INTENSIVE CARE					386,693	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT					1,036,204	34.04
43.00	04300	NURSERY					502,467	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM					9,758,926	50.00
51.00	05100	RECOVERY ROOM					756,498	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM					819,616	52.00
53.00	05300	ANESTHESIOLOGY					1,012,024	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC					6,047,872	54.00
60.00	06000	LABORATORY					5,833,373	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL					305,437	62.00
65.00	06500	RESPIRATORY THERAPY					1,767,924	65.00
66.00	06600	PHYSICAL THERAPY					336,132	66.00
67.00	06700	OCCUPATIONAL THERAPY					225,326	67.00
68.00	06800	SPEECH PATHOLOGY					160,089	68.00
69.00	06900	ELECTROCARDIOLOGY					2,838,944	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT					2,869,024	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS					237,320	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS					3,698,247	73.00
74.00	07400	RENAL DIALYSIS					341,962	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC					12,612,218	90.00
91.00	09100	EMERGENCY					5,232,374	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	0	0	81,999,475	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN					0	190.00
190.01	19001	DENTISTRY					355,511	190.01
190.02	19002	ACHN SATELITTE CLINICS					0	190.02
190.03	19003	SPECIAL FUNDS					946,531	190.03
190.04	19004	SENGSTACKE CLINIC					0	190.04
194.00	07950	COUNTYCARE					949,379	194.00
200.00		Cross Foot Adjustments	0	1,677,503	978,695	19,977	2,676,175	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,677,503	978,695	19,977	86,927,071	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet B Part II | Date/Time Prepared: 4/29/2016 10:03 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
23.00	02300	ALLIED HEALTH				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	20,438,141		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,753,246		31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	396,947		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	657,249		34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	412,942		34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	1,562,280		34.02
34.03	02400	NEURO INTENSIVE CARE	0	386,693		34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	0	1,036,204		34.04
43.00	04300	NURSERY	0	502,467		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	9,758,926		50.00
51.00	05100	RECOVERY ROOM	0	756,498		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	819,616		52.00
53.00	05300	ANESTHESIOLOGY	0	1,012,024		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,047,872		54.00
60.00	06000	LABORATORY	0	5,833,373		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	305,437		62.00
65.00	06500	RESPIRATORY THERAPY	0	1,767,924		65.00
66.00	06600	PHYSICAL THERAPY	0	336,132		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	225,326		67.00
68.00	06800	SPEECH PATHOLOGY	0	160,089		68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,838,944		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,869,024		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	237,320		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,698,247		73.00
74.00	07400	RENAL DIALYSIS	0	341,962		74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	12,612,218		90.00
91.00	09100	EMERGENCY	0	5,232,374		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	81,999,475		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	DENTISTRY	0	355,511		190.01
190.02	19002	ACHN SATELITTE CLINICS	0	0		190.02
190.03	19003	SPECIAL FUNDS	0	946,531		190.03
190.04	19004	SENGSTACKE CLINIC	0	0		190.04
194.00	07950	COUNTYCARE	0	949,379		194.00
200.00		Cross Foot Adjustments	0	2,676,175		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	86,927,071		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet B-1 | Date/Time Prepared: 4/29/2016 10:03 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,459,298					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		6,293,807				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	19,251	54,792	414,092,878			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	363,057	937,438	23,959,486	-226,016,659	631,452,662	5.00
7.00	00700	OPERATION OF PLANT	879,878	43,843	17,116,614	0	54,988,078	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,530	152	173,698	0	1,922,018	8.00
9.00	00900	HOUSEKEEPING	20,258	2,692	8,931,609	0	13,518,864	9.00
10.00	01000	DIETARY	1,007	402	3,410,347	0	10,878,612	10.00
11.00	01100	CAFETERIA	42,074	15,511	677,804	0	1,884,774	11.00
13.00	01300	NURSING ADMINISTRATION	12,277	95,386	3,083,537	0	4,519,563	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	77,981	171,289	2,890,526	0	7,790,317	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	31,337	713	3,545,533	0	5,766,841	16.00
17.00	01700	SOCIAL SERVICE	3,618	149	468,896	0	680,748	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,039	1,420	20,750,082	0	40,552,609	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22,010,838	0	27,012,956	22.00
23.00	02300	ALLIED HEALTH	125	0	266,755	0	343,248	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	269,454	1,891,033	62,081,905	0	61,384,228	30.00
31.00	03100	INTENSIVE CARE UNIT	28,051	0	8,414,234	0	11,381,637	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	5,988	1,070	2,716,125	0	2,382,724	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	9,435	0	3,794,239	0	4,765,048	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	6,647	963	2,475,657	0	2,542,725	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	22,684	90,544	5,646,945	0	6,312,170	34.02
34.03	02400	NEURO INTENSIVE CARE	4,740	0	3,574,867	0	3,762,748	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	12,087	13,604	10,089,515	0	9,379,049	34.04
43.00	04300	NURSERY	8,647	0	1,977,042	0	2,734,079	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	69,211	1,130,712	28,395,970	0	34,876,335	50.00
51.00	05100	RECOVERY ROOM	13,355	850	2,420,791	0	2,900,641	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,232	0	3,538,113	0	4,856,383	52.00
53.00	05300	ANESTHESIOLOGY	4,615	192,030	7,037,021	0	3,698,051	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	98,156	74,709	17,040,066	0	27,768,060	54.00
60.00	06000	LABORATORY	76,945	344,492	15,456,563	0	33,691,176	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,758	3,203	1,130,824	0	4,494,765	62.00
65.00	06500	RESPIRATORY THERAPY	5,508	249,390	6,705,987	0	7,741,453	65.00
66.00	06600	PHYSICAL THERAPY	4,673	1,790	1,659,177	0	2,349,052	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,434	0	522,129	0	768,868	67.00
68.00	06800	SPEECH PATHOLOGY	2,400	4,961	528,608	0	1,003,569	68.00
69.00	06900	ELECTROCARDIOLOGY	21,407	460,841	5,139,592	0	7,975,730	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	15,046,056	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	6,483,172	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,483	18,216	20,056,343	0	82,089,862	73.00
74.00	07400	RENAL DIALYSIS	2,326	14,746	3,506,936	0	4,580,839	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	187,328	363,216	61,915,953	0	66,169,175	90.00
91.00	09100	EMERGENCY	76,174	112,534	26,414,896	0	32,223,979	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,431,170	6,292,691	409,525,223	-226,016,659	613,220,202	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	DENTISTRY	4,544	1,116	2,289,811	0	3,296,579	190.01
190.02	19002	ACHN SATELITTE CLINICS	0	0	0	0	0	190.02
190.03	19003	SPECIAL FUNDS	21,010	0	651,558	0	1,317,876	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	2,574	0	1,626,286	0	13,618,005	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	56,952,726	18,506,268	114,248,436		226,016,659	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.158123	2.940393	0.275901		0.357931	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			606,927		20,725,425	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001466		0.032822	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet B-1 | Date/Time Prepared: 4/29/2016 10:03 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	1,197,112					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,530	2,232,635				8.00
9.00	00900	HOUSEKEEPING	20,258	0	1,159,324			9.00
10.00	01000	DIETARY	1,007	0	1,007	612,015		10.00
11.00	01100	CAFETERIA	42,074	0	42,074	367,084	6,644,529	11.00
13.00	01300	NURSING ADMINISTRATION	12,277	0	12,277	0	73,358	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	77,981	0	77,981	0	128,703	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	31,337	0	31,337	0	142,500	16.00
17.00	01700	SOCIAL SERVICE	3,618	0	3,618	0	6,661	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,039	0	1,039	0	818,436	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	173,498	22.00
23.00	02300	ALLIED HEALTH	125	0	125	0	9,085	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	269,454	589,719	269,454	176,183	1,221,252	30.00
31.00	03100	INTENSIVE CARE UNIT	28,051	90,155	28,051	10,420	185,670	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	5,988	68,353	5,988	2,182	44,337	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	9,435	92,345	9,435	3,393	83,955	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	6,647	22,231	6,647	1,403	49,357	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	22,684	102,130	22,684	2,854	108,737	34.02
34.03	02400	NEURO INTENSIVE CARE	4,740	8,520	4,740	3,973	74,022	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	12,087	81,089	12,087	0	183,053	34.04
43.00	04300	NURSERY	8,647	28,470	8,647	0	52,628	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	69,211	310,669	69,211	0	601,892	50.00
51.00	05100	RECOVERY ROOM	13,355	98,897	13,355	0	49,896	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,232	122,136	13,232	0	77,102	52.00
53.00	05300	ANESTHESIOLOGY	4,615	15,778	4,615	0	56,593	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	98,156	228,143	98,156	0	355,903	54.00
60.00	06000	LABORATORY	76,945	0	76,945	0	419,987	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,758	0	2,758	0	33,380	62.00
65.00	06500	RESPIRATORY THERAPY	5,508	0	5,508	0	157,881	65.00
66.00	06600	PHYSICAL THERAPY	4,673	17,949	4,673	0	42,938	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,434	0	4,434	0	13,786	67.00
68.00	06800	SPEECH PATHOLOGY	2,400	0	2,400	0	14,281	68.00
69.00	06900	ELECTROCARDIOLOGY	21,407	24,737	21,407	0	123,216	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,483	0	11,483	0	503,908	73.00
74.00	07400	RENAL DIALYSIS	2,326	0	2,326	0	64,370	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	187,328	14,731	187,328	13,590	143,101	90.00
91.00	09100	EMERGENCY	76,174	316,583	76,174	30,933	590,279	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,168,984	2,232,635	1,131,196	612,015	6,603,765	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	DENTISTRY	4,544	0	4,544	0	0	190.01
190.02	19002	ACHN SATELITTE CLINICS	0	0	0	0	0	190.02
190.03	19003	SPECIAL FUNDS	21,010	0	21,010	0	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	2,574	0	2,574	0	40,764	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	74,670,016	3,703,404	19,621,280	14,852,259	14,804,179	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	62.375129	1.658759	16.924760	24.267802	2.228025	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	22,335,149	796,814	1,311,827	406,487	2,159,233	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	18.657527	0.356894	1.131545	0.664178	0.324964	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet B-1 | Date/Time Prepared: 4/29/2016 10:03 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			13.00	14.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	5,825,400					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	29,325,878				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,225,447,369			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	56,160		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	8,319	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	21,836	0	0		22.00
23.00	02300	ALLIED HEALTH	0	0	0	0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	966,827	97,496	186,333,342	16,994	0	30.00
31.00	03100	INTENSIVE CARE UNIT	181,014	0	21,713,888	1,386	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	36,373	1,159	4,351,943	690	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	82,239	2,281	7,701,277	1,040	0	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	42,285	0	2,530,337	690	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	94,280	40	10,341,681	1,040	0	34.02
34.03	02400	NEURO INTENSIVE CARE	70,195	0	7,277,620	1,040	0	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	148,938	12,314	27,461,279	1,040	0	34.04
43.00	04300	NURSERY	52,628	0	1,782,683	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	515,459	10,517,227	178,344,390	0	0	50.00
51.00	05100	RECOVERY ROOM	47,130	0	17,138,205	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	76,990	0	3,935,526	0	0	52.00
53.00	05300	ANESTHESIOLOGY	49,884	65,135	57,724,435	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	291,980	1,406,894	161,303,914	0	0	54.00
60.00	06000	LABORATORY	379,644	0	144,097,896	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	33,380	0	9,180,456	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	138,201	113,876	6,385,889	0	0	65.00
66.00	06600	PHYSICAL THERAPY	42,938	118,625	3,401,658	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,786	0	1,611,314	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	14,281	500	1,221,072	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	108,746	1,224,744	27,570,329	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	15,046,056	10,521,015	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	18,926,501	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	492,400	56,231	132,784,581	0	0	73.00
74.00	07400	RENAL DIALYSIS	16,750	9,081	8,747,720	2,080	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,378,530	318,149	111,914,932	19,760	0	90.00
91.00	09100	EMERGENCY	521,529	47,112	61,143,486	10,400	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,796,407	29,067,075	1,225,447,369	56,160	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	DENTISTRY	28,993	258,803	0	0	0	190.01
190.02	19002	ACHN SATELITTE CLINICS	0	0	0	0	0	190.02
190.03	19003	SPECIAL FUNDS	0	0	0	0	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	COUNTYCARE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,274,262	17,049,352	10,633,486	1,226,157	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.248715	0.581376	0.008677	21.833280	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	984,434	4,602,821	1,588,717	181,017	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.168990	0.156954	0.001296	3.223237	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet B-1 | Date/Time Prepared: 4/29/2016 10:03 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	ALLIED HEALTH (ASSIGNED TIME)		
			21.00	22.00	23.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	47,363				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		47,363			22.00
23.00	02300	ALLIED HEALTH			10,000		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	10,864	10,864	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,687	1,687	0		31.00
33.00	03300	BURN INTENSIVE CARE UNIT	317	317	0		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	524	524	0		34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	202	202	0		34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	0	0		34.02
34.03	02400	NEURO INTENSIVE CARE	85	85	0		34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	903	903	0		34.04
43.00	04300	NURSERY	290	290	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	7,817	7,817	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	704	704	0		52.00
53.00	05300	ANESTHESIOLOGY	3,210	3,210	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,038	2,038	0		54.00
60.00	06000	LABORATORY	822	822	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	1,008	1,008	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	1,183	1,183	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100	100	10,000		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	6,430	6,430	0		90.00
91.00	09100	EMERGENCY	8,104	8,104	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	46,288	46,288	10,000		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
190.01	19001	DENTISTRY	882	882	0		190.01
190.02	19002	ACHN SATELITTE CLINICS	0	0	0		190.02
190.03	19003	SPECIAL FUNDS	193	193	0		190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0		190.04
194.00	07950	COUNTYCARE	0	0	0		194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	56,978,370	37,080,983	496,262		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1,203.014378	782.910352	49.626200		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,677,503	978,695	19,977		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	35.418006	20.663704	1.997700		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet C Part I Date/Time Prepared: 4/29/2016 10:03 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	115,950,083		115,950,083	4,603,712	120,553,795	30.00
31.00	03100	INTENSIVE CARE UNIT	18,940,718		18,940,718	80,377	19,021,095	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	4,074,460		4,074,460	145,014	4,219,474	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,834,923		7,834,923	19,593	7,854,516	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	4,250,667		4,250,667	18,104	4,268,771	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	11,081,461		11,081,461	229,526	11,310,987	34.02
34.03	02400	NEURO INTENSIVE CARE	5,934,414		5,934,414	53,644	5,988,058	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	14,691,082		14,691,082	279,012	14,970,094	34.04
43.00	04300	NURSERY	4,644,063		4,644,063	0	4,644,063	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	63,010,054		63,010,054	1,419,199	64,429,253	50.00
51.00	05100	RECOVERY ROOM	5,480,696		5,480,696	32,953	5,513,649	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,148,596		8,148,596	0	8,148,596	52.00
53.00	05300	ANESTHESIOLOGY	6,140,964		6,140,964	981,282	7,122,246	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	49,244,432		49,244,432	606,819	49,851,251	54.00
60.00	06000	LABORATORY	54,512,168		54,512,168	50,684	54,562,852	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	6,518,002		6,518,002	0	6,518,002	62.00
65.00	06500	RESPIRATORY THERAPY	11,595,095	0	11,595,095	233,424	11,828,519	65.00
66.00	06600	PHYSICAL THERAPY	3,837,958	0	3,837,958	0	3,837,958	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,457,597	0	1,457,597	0	1,457,597	67.00
68.00	06800	SPEECH PATHOLOGY	1,613,633	0	1,613,633	0	1,613,633	68.00
69.00	06900	ELECTROCARDIOLOGY	13,930,682		13,930,682	203,292	14,133,974	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	29,270,204		29,270,204	0	29,270,204	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,967,925		8,967,925	0	8,967,925	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	115,801,859		115,801,859	0	115,801,859	73.00
74.00	07400	RENAL DIALYSIS	6,695,845		6,695,845	0	6,695,845	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	108,690,192		108,690,192	1,172,499	109,862,691	90.00
91.00	09100	EMERGENCY	53,825,736		53,825,736	1,246,220	55,071,956	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	19,100,613		19,100,613		19,100,613	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	755,244,122	0	755,244,122	11,375,354	766,619,476	200.00
201.00		Less Observation Beds	19,100,613		19,100,613		19,100,613	201.00
202.00		Total (see instructions)	736,143,509	0	736,143,509	11,375,354	747,518,863	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet C Part I Date/Time Prepared: 4/29/2016 10:03 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	156,897,390		156,897,390			30.00
31.00	03100	INTENSIVE CARE UNIT	21,713,888		21,713,888			31.00
33.00	03300	BURN INTENSIVE CARE UNIT	4,351,943		4,351,943			33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,701,277		7,701,277			34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	2,530,337		2,530,337			34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	10,341,681		10,341,681			34.02
34.03	02400	NEURO INTENSIVE CARE	7,277,620		7,277,620			34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	27,461,279		27,461,279			34.04
43.00	04300	NURSERY	1,782,683		1,782,683			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	100,143,866	78,200,524	178,344,390	0.353306	0.000000	50.00
51.00	05100	RECOVERY ROOM	6,499,347	10,638,858	17,138,205	0.319794	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,867,798	67,728	3,935,526	2.070523	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	38,394,799	19,329,636	57,724,435	0.106384	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,182,945	120,120,969	161,303,914	0.305290	0.000000	54.00
60.00	06000	LABORATORY	44,288,785	99,809,111	144,097,896	0.378300	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	7,353,716	1,826,740	9,180,456	0.709987	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	4,760,086	1,625,803	6,385,889	1.815737	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	935,897	2,465,761	3,401,658	1.128261	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	466,714	1,144,600	1,611,314	0.904601	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	18,482	1,202,590	1,221,072	1.321489	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	14,890,570	12,679,759	27,570,329	0.505278	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,805,350	3,715,665	10,521,015	2.782070	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,642,993	6,283,508	18,926,501	0.473829	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,549,825	62,234,756	132,784,581	0.872103	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,736,853	6,010,867	8,747,720	0.765439	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,195,539	110,719,393	111,914,932	0.971186	0.000000	90.00
91.00	09100	EMERGENCY	11,532,766	49,610,720	61,143,486	0.880318	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	13,580,126	15,855,826	29,435,952	0.648887	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	621,904,555	603,542,814	1,225,447,369			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	621,904,555	603,542,814	1,225,447,369			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet C Part I Date/Time Prepared: 4/29/2016 10:03 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
33.00	03300	BURN INTENSIVE CARE UNIT		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT		34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT		34.02
34.03	02400	NEURO INTENSIVE CARE		34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT		34.04
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.361263	50.00
51.00	05100	RECOVERY ROOM	0.321717	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.070523	52.00
53.00	05300	ANESTHESIOLOGY	0.123384	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.309052	54.00
60.00	06000	LABORATORY	0.378651	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.709987	62.00
65.00	06500	RESPIRATORY THERAPY	1.852290	65.00
66.00	06600	PHYSICAL THERAPY	1.128261	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.904601	67.00
68.00	06800	SPEECH PATHOLOGY	1.321489	68.00
69.00	06900	ELECTROCARDIOLOGY	0.512652	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2.782070	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.473829	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.872103	73.00
74.00	07400	RENAL DIALYSIS	0.765439	74.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.981662	90.00
91.00	09100	EMERGENCY	0.900700	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.648887	92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet C Part I Date/Time Prepared: 4/29/2016 10:03 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	115,950,083		115,950,083	4,603,712	120,553,795	30.00
31.00	03100	INTENSIVE CARE UNIT	18,940,718		18,940,718	80,377	19,021,095	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	4,074,460		4,074,460	145,014	4,219,474	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,834,923		7,834,923	19,593	7,854,516	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	4,250,667		4,250,667	18,104	4,268,771	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	11,081,461		11,081,461	229,526	11,310,987	34.02
34.03	02400	NEURO INTENSIVE CARE	5,934,414		5,934,414	53,644	5,988,058	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	14,691,082		14,691,082	279,012	14,970,094	34.04
43.00	04300	NURSERY	4,644,063		4,644,063	0	4,644,063	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	63,010,054		63,010,054	1,419,199	64,429,253	50.00
51.00	05100	RECOVERY ROOM	5,480,696		5,480,696	32,953	5,513,649	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,148,596		8,148,596	0	8,148,596	52.00
53.00	05300	ANESTHESIOLOGY	6,140,964		6,140,964	981,282	7,122,246	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	49,244,432		49,244,432	606,819	49,851,251	54.00
60.00	06000	LABORATORY	54,512,168		54,512,168	50,684	54,562,852	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	6,518,002		6,518,002	0	6,518,002	62.00
65.00	06500	RESPIRATORY THERAPY	11,595,095	0	11,595,095	233,424	11,828,519	65.00
66.00	06600	PHYSICAL THERAPY	3,837,958	0	3,837,958	0	3,837,958	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,457,597	0	1,457,597	0	1,457,597	67.00
68.00	06800	SPEECH PATHOLOGY	1,613,633	0	1,613,633	0	1,613,633	68.00
69.00	06900	ELECTROCARDIOLOGY	13,930,682		13,930,682	203,292	14,133,974	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	29,270,204		29,270,204	0	29,270,204	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,967,925		8,967,925	0	8,967,925	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	115,801,859		115,801,859	0	115,801,859	73.00
74.00	07400	RENAL DIALYSIS	6,695,845		6,695,845	0	6,695,845	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	108,690,192		108,690,192	1,172,499	109,862,691	90.00
91.00	09100	EMERGENCY	53,825,736		53,825,736	1,246,220	55,071,956	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	19,100,613		19,100,613		19,100,613	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	755,244,122	0	755,244,122	11,375,354	766,619,476	200.00
201.00		Less Observation Beds	19,100,613		19,100,613		19,100,613	201.00
202.00		Total (see instructions)	736,143,509	0	736,143,509	11,375,354	747,518,863	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet C Part I Date/Time Prepared: 4/29/2016 10:03 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	156,897,390		156,897,390			30.00
31.00	03100	INTENSIVE CARE UNIT	21,713,888		21,713,888			31.00
33.00	03300	BURN INTENSIVE CARE UNIT	4,351,943		4,351,943			33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,701,277		7,701,277			34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	2,530,337		2,530,337			34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	10,341,681		10,341,681			34.02
34.03	02400	NEURO INTENSIVE CARE	7,277,620		7,277,620			34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	27,461,279		27,461,279			34.04
43.00	04300	NURSERY	1,782,683		1,782,683			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	100,143,866	78,200,524	178,344,390	0.353306	0.000000	50.00
51.00	05100	RECOVERY ROOM	6,499,347	10,638,858	17,138,205	0.319794	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,867,798	67,728	3,935,526	2.070523	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	38,394,799	19,329,636	57,724,435	0.106384	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,182,945	120,120,969	161,303,914	0.305290	0.000000	54.00
60.00	06000	LABORATORY	44,288,785	99,809,111	144,097,896	0.378300	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	7,353,716	1,826,740	9,180,456	0.709987	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	4,760,086	1,625,803	6,385,889	1.815737	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	935,897	2,465,761	3,401,658	1.128261	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	466,714	1,144,600	1,611,314	0.904601	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	18,482	1,202,590	1,221,072	1.321489	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	14,890,570	12,679,759	27,570,329	0.505278	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,805,350	3,715,665	10,521,015	2.782070	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,642,993	6,283,508	18,926,501	0.473829	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,549,825	62,234,756	132,784,581	0.872103	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,736,853	6,010,867	8,747,720	0.765439	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,195,539	110,719,393	111,914,932	0.971186	0.000000	90.00
91.00	09100	EMERGENCY	11,532,766	49,610,720	61,143,486	0.880318	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	13,580,126	15,855,826	29,435,952	0.648887	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	621,904,555	603,542,814	1,225,447,369			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	621,904,555	603,542,814	1,225,447,369			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet C Part I Date/Time Prepared: 4/29/2016 10:03 am

Title XIX | Hospital | Cost

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet D Part I Date/Time Prepared: 4/29/2016 10:03 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	20,438,141	0	20,438,141	83,741	244.06	30.00
31.00	INTENSIVE CARE UNIT	1,753,246		1,753,246	7,440	235.65	31.00
33.00	BURN INTENSIVE CARE UNIT	396,947		396,947	1,423	278.95	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	657,249		657,249	2,649	248.11	34.00
34.01	PEDIATRIC INTENSIVE CARE UNIT	412,942		412,942	868	475.74	34.01
34.02	TRAUMA INTENSIVE CARE UNIT	1,562,280		1,562,280	2,489	627.67	34.02
34.03	NEURO INTENSIVE CARE	386,693		386,693	2,480	155.92	34.03
34.04	NEONATAL INTENSIVE CARE UNIT	1,036,204		1,036,204	9,096	113.92	34.04
43.00	NURSERY	502,467		502,467	1,845	272.34	43.00
200.00	Total (lines 30-199)	27,146,169		27,146,169	112,031		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	9,315	2,273,419				30.00
31.00	INTENSIVE CARE UNIT	1,415	333,445				31.00
33.00	BURN INTENSIVE CARE UNIT	184	51,327				33.00
34.00	SURGICAL INTENSIVE CARE UNIT	412	102,221				34.00
34.01	PEDIATRIC INTENSIVE CARE UNIT	0	0				34.01
34.02	TRAUMA INTENSIVE CARE UNIT	366	229,727				34.02
34.03	NEURO INTENSIVE CARE	244	38,044				34.03
34.04	NEONATAL INTENSIVE CARE UNIT	0	0				34.04
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30-199)	11,936	3,028,183				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet D Part II Date/Time Prepared: 4/29/2016 10:03 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,758,926	178,344,390	0.054720	9,639,873	527,494	50.00
51.00	05100	RECOVERY ROOM	756,498	17,138,205	0.044141	521,500	23,020	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	819,616	3,935,526	0.208261	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,012,024	57,724,435	0.017532	3,223,872	56,521	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,047,872	161,303,914	0.037494	4,727,972	177,271	54.00
60.00	06000	LABORATORY	5,833,373	144,097,896	0.040482	5,964,997	241,475	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	305,437	9,180,456	0.033270	799,468	26,598	62.00
65.00	06500	RESPIRATORY THERAPY	1,767,924	6,385,889	0.276849	869,939	240,842	65.00
66.00	06600	PHYSICAL THERAPY	336,132	3,401,658	0.098814	157,374	15,551	66.00
67.00	06700	OCCUPATIONAL THERAPY	225,326	1,611,314	0.139840	70,395	9,844	67.00
68.00	06800	SPEECH PATHOLOGY	160,089	1,221,072	0.131105	2,054	269	68.00
69.00	06900	ELECTROCARDIOLOGY	2,838,944	27,570,329	0.102971	2,789,049	287,191	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,869,024	10,521,015	0.272695	582,627	158,879	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	237,320	18,926,501	0.012539	600,625	7,531	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,698,247	132,784,581	0.027851	7,970,864	221,997	73.00
74.00	07400	RENAL DIALYSIS	341,962	8,747,720	0.039092	535,200	20,922	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	12,612,218	111,914,932	0.112695	265,972	29,974	90.00
91.00	09100	EMERGENCY	5,232,374	61,143,486	0.085575	1,505,177	128,806	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,238,222	29,435,952	0.110009	1,145,587	126,025	92.00
200.00		Total (lines 50-199)	58,091,528	985,389,271		41,372,545	2,300,210	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet D Part III Date/Time Prepared: 4/29/2016 10:03 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0		0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0		0	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0		0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	0	0		0	34.02
34.03	02400	NEURO INTENSIVE CARE	0	0	0		0	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0		0	34.04
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	83,741	0.00	9,315	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	7,440	0.00	1,415	0	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	1,423	0.00	184	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	2,649	0.00	412	0	0	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	868	0.00	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	2,489	0.00	366	0	0	34.02
34.03	02400	NEURO INTENSIVE CARE	2,480	0.00	244	0	0	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	9,096	0.00	0	0	0	34.04
43.00	04300	NURSERY	1,845	0.00	0	0	0	43.00
200.00		Total (lines 30-199)	112,031		11,936	0	0	200.00

		Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost	
			12.00	13.00	
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	0	34.02
34.03	02400	NEURO INTENSIVE CARE	0	0	34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT	0	0	34.04
43.00	04300	NURSERY	0	0	43.00
200.00		Total (lines 30-199)	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet D Part IV | Date/Time Prepared: 4/29/2016 10:03 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	496,262	0	496,262	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	496,262	0	496,262	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet D Part IV Date/Time Prepared: 4/29/2016 10:03 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	178,344,390	0.000000	0.000000	9,639,873	50.00
51.00	05100	RECOVERY ROOM	0	17,138,205	0.000000	0.000000	521,500	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,935,526	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	57,724,435	0.000000	0.000000	3,223,872	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	161,303,914	0.000000	0.000000	4,727,972	54.00
60.00	06000	LABORATORY	0	144,097,896	0.000000	0.000000	5,964,997	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	9,180,456	0.000000	0.000000	799,468	62.00
65.00	06500	RESPIRATORY THERAPY	0	6,385,889	0.000000	0.000000	869,939	65.00
66.00	06600	PHYSICAL THERAPY	0	3,401,658	0.000000	0.000000	157,374	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,611,314	0.000000	0.000000	70,395	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,221,072	0.000000	0.000000	2,054	68.00
69.00	06900	ELECTROCARDIOLOGY	0	27,570,329	0.000000	0.000000	2,789,049	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	10,521,015	0.000000	0.000000	582,627	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	18,926,501	0.000000	0.000000	600,625	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	496,262	132,784,581	0.003737	0.003737	7,970,864	73.00
74.00	07400	RENAL DIALYSIS	0	8,747,720	0.000000	0.000000	535,200	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	111,914,932	0.000000	0.000000	265,972	90.00
91.00	09100	EMERGENCY	0	61,143,486	0.000000	0.000000	1,505,177	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	29,435,952	0.000000	0.000000	1,145,587	92.00
200.00		Total (lines 50-199)	496,262	985,389,271			41,372,545	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet D Part IV | Date/Time Prepared: 4/29/2016 10:03 am

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,367,748	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	561,900	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	72	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	702,392	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,760,446	0	0	0	54.00
60.00	06000	LABORATORY	0	4,513,665	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	79,851	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	104,007	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	237	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	85,212	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,213,980	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	221,583	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	266,168	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,787	7,655,647	28,609	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	1,338	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	15,769,382	0	0	0	90.00
91.00	09100	EMERGENCY	0	2,226,192	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,404,813	0	0	0	92.00
200.00		Total (lines 50-199)	29,787	46,934,633	28,609	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet D Part IV | Date/Time Prepared: 4/29/2016 10:03 am

Title XVIII | Hospital | PPS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet D Part V Date/Time Prepared: 4/29/2016 10:03 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.353306	2,367,748	0	0	836,540	50.00
51.00	05100	RECOVERY ROOM	0.319794	561,900	0	0	179,692	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.070523	72	0	0	149	52.00
53.00	05300	ANESTHESIOLOGY	0.106384	702,392	0	0	74,723	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.305290	9,760,446	0	0	2,979,767	54.00
60.00	06000	LABORATORY	0.378300	4,513,665	0	1,368	1,707,519	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.709987	79,851	0	0	56,693	62.00
65.00	06500	RESPIRATORY THERAPY	1.815737	104,007	0	0	188,849	65.00
66.00	06600	PHYSICAL THERAPY	1.128261	237	0	0	267	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.904601	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.321489	85,212	0	0	112,607	68.00
69.00	06900	ELECTROCARDIOLOGY	0.505278	1,213,980	0	0	613,397	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2.782070	221,583	0	0	616,459	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.473829	266,168	0	0	126,118	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.872103	7,655,647	0	327,391	6,676,513	73.00
74.00	07400	RENAL DIALYSIS	0.765439	1,338	0	0	1,024	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.971186	15,769,382	0	0	15,315,003	90.00
91.00	09100	EMERGENCY	0.880318	2,226,192	0	0	1,959,757	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.648887	1,404,813	0	0	911,565	92.00
200.00		Subtotal (see instructions)		46,934,633	0	328,759	32,356,642	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		46,934,633	0	328,759	32,356,642	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet D Part V Date/Time Prepared: 4/29/2016 10:03 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	518		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	285,519		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	286,037		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	286,037		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet D Part V Date/Time Prepared: 4/29/2016 10:03 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.353306	10,190,352	0	0	3,600,313	50.00
51.00	05100	RECOVERY ROOM	0.319794	1,552,970	0	0	496,630	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.070523	38,781	0	0	80,297	52.00
53.00	05300	ANESTHESIOLOGY	0.106384	3,077,044	0	0	327,348	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.305290	17,260,449	0	0	5,269,442	54.00
60.00	06000	LABORATORY	0.378300	13,208,052	0	0	4,996,606	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.709987	278,581	0	0	197,789	62.00
65.00	06500	RESPIRATORY THERAPY	1.815737	270,177	0	0	490,570	65.00
66.00	06600	PHYSICAL THERAPY	1.128261	363,572	0	0	410,204	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.904601	197,726	0	0	178,863	67.00
68.00	06800	SPEECH PATHOLOGY	1.321489	201,142	0	0	265,807	68.00
69.00	06900	ELECTROCARDIOLOGY	0.505278	1,671,283	0	0	844,463	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2.782070	502,316	0	0	1,397,478	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.473829	903,831	0	0	428,261	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.872103	8,522,493	0	0	7,432,492	73.00
74.00	07400	RENAL DIALYSIS	0.765439	1,810,524	0	0	1,385,846	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.971186	16,091,314	0	0	15,627,659	90.00
91.00	09100	EMERGENCY	0.880318	10,130,284	0	0	8,917,871	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.648887	4,809,416	0	0	3,120,768	92.00
200.00		Subtotal (see instructions)		91,080,307	0	0	55,468,707	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		91,080,307	0	0	55,468,707	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet D Part V Date/Time Prepared: 4/29/2016 10:03 am

Title XIX | Hospital | Cost

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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet D-1 | Date/Time Prepared: 4/29/2016 10:03 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	83,741	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	83,741	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	70,473	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	9,315	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	120,553,795	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	120,553,795	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	120,553,795	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,439.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	13,409,874	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	13,409,874	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet D-1 | Date/Time Prepared: 4/29/2016 10:03 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	19,021,095	7,440	2,556.60	1,415	3,617,589	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	4,219,474	1,423	2,965.20	184	545,597	45.00
46.00	SURGICAL INTENSIVE CARE UNIT	7,854,516	2,649	2,965.09	412	1,221,617	46.00
46.01	PEDIATRIC INTENSIVE CARE UNIT	4,268,771	868	4,917.94	0	0	46.01
46.02	TRAUMA INTENSIVE CARE UNIT	11,310,987	2,489	4,544.39	366	1,663,247	46.02
46.03	NEURO INTENSIVE CARE	5,988,058	2,480	2,414.54	244	589,148	46.03
46.04	NEONATAL INTENSIVE CARE UNIT	14,970,094	9,096	1,645.79	0	0	46.04
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	23,247,419	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	44,294,491	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	3,028,183	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	2,329,997	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	5,358,180	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	38,936,311	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	13,268	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,439.60	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	19,100,613	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet D-1 | Date/Time Prepared: 4/29/2016 10:03 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	20,438,141	120,553,795	0.169535	19,100,613	3,238,222	90.00
91.00	Nursing School cost	0	120,553,795	0.000000	19,100,613	0	91.00
92.00	Allied health cost	0	120,553,795	0.000000	19,100,613	0	92.00
93.00	All other Medical Education	0	120,553,795	0.000000	19,100,613	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet D-1 | Date/Time Prepared: 4/29/2016 10:03 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	83,741	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	83,741	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	70,473	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	20,993	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	1,845	15.00
16.00	Nursery days (title V or XIX only)	1,232	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	115,950,083	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	115,950,083	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	115,950,083	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,384.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	29,067,538	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	29,067,538	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet D-1 | Date/Time Prepared: 4/29/2016 10:03 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	4,644,063	1,845	2,517.11	1,232	3,101,080	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	18,940,718	7,440	2,545.80	2,057	5,236,711	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	4,074,460	1,423	2,863.29	397	1,136,726	45.00
46.00	SURGICAL INTENSIVE CARE UNIT	7,834,923	2,649	2,957.69	569	1,682,926	46.00
46.01	PEDIATRIC INTENSIVE CARE UNIT	4,250,667	868	4,897.08	582	2,850,101	46.01
46.02	TRAUMA INTENSIVE CARE UNIT	11,081,461	2,489	4,452.17	1,338	5,957,003	46.02
46.03	NEURO INTENSIVE CARE	5,934,414	2,480	2,392.91	793	1,897,578	46.03
46.04	NEONATAL INTENSIVE CARE UNIT	14,691,082	9,096	1,615.11	6,035	9,747,189	46.04
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	56,158,214	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	116,835,066	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	13,268	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,384.63	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	18,371,271	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet D-1 | Date/Time Prepared: 4/29/2016 10:03 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	20,438,141	115,950,083	0.176267	18,371,271	3,238,249	90.00
91.00	Nursing School cost	0	115,950,083	0.000000	18,371,271	0	91.00
92.00	Allied health cost	0	115,950,083	0.000000	18,371,271	0	92.00
93.00	All other Medical Education	0	115,950,083	0.000000	18,371,271	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet D-3 | Date/Time Prepared: 4/29/2016 10:03 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		19,913,500		30.00
31.00	03100	INTENSIVE CARE UNIT		4,091,900		31.00
33.00	03300	BURN INTENSIVE CARE UNIT		660,300		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		1,107,800		34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT		0		34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT		1,109,800		34.02
34.03	02400	NEURO INTENSIVE CARE		701,800		34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT		0		34.04
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.361263	9,639,873	3,482,529	50.00
51.00	05100	RECOVERY ROOM	0.321717	521,500	167,775	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.070523	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.123384	3,223,872	397,774	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.309052	4,727,972	1,461,189	54.00
60.00	06000	LABORATORY	0.378651	5,964,997	2,258,652	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.709987	799,468	567,612	62.00
65.00	06500	RESPIRATORY THERAPY	1.852290	869,939	1,611,379	65.00
66.00	06600	PHYSICAL THERAPY	1.128261	157,374	177,559	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.904601	70,395	63,679	67.00
68.00	06800	SPEECH PATHOLOGY	1.321489	2,054	2,714	68.00
69.00	06900	ELECTROCARDIOLOGY	0.512652	2,789,049	1,429,812	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2.782070	582,627	1,620,909	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.473829	600,625	284,594	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.872103	7,970,864	6,951,414	73.00
74.00	07400	RENAL DIALYSIS	0.765439	535,200	409,663	74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.981662	265,972	261,095	90.00
91.00	09100	EMERGENCY	0.900700	1,505,177	1,355,713	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.648887	1,145,587	743,357	92.00
200.00		Total (sum of lines 50-94 and 96-98)		41,372,545	23,247,419	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		41,372,545		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet D-3 | Date/Time Prepared: 4/29/2016 10:03 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		40,331,792		30.00
31.00	03100	INTENSIVE CARE UNIT		5,489,169		31.00
33.00	03300	BURN INTENSIVE CARE UNIT		1,122,200		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		1,709,407		34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT		1,412,300		34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT		3,932,107		34.02
34.03	02400	NEURO INTENSIVE CARE		2,320,422		34.03
34.04	02060	NEONATAL INTENSIVE CARE UNIT		18,876,808		34.04
43.00	04300	NURSERY		900,800		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.353306	28,311,806	10,002,731	50.00
51.00	05100	RECOVERY ROOM	0.319794	1,480,387	473,419	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.070523	1,859,207	3,849,531	52.00
53.00	05300	ANESTHESIOLOGY	0.106384	11,009,688	1,171,255	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.305290	10,093,071	3,081,314	54.00
60.00	06000	LABORATORY	0.378300	11,689,866	4,422,276	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.709987	2,060,894	1,463,208	62.00
65.00	06500	RESPIRATORY THERAPY	1.815737	760,985	1,381,749	65.00
66.00	06600	PHYSICAL THERAPY	1.128261	231,157	260,805	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.904601	132,057	119,459	67.00
68.00	06800	SPEECH PATHOLOGY	1.321489	6,913	9,135	68.00
69.00	06900	ELECTROCARDIOLOGY	0.505278	3,391,404	1,713,602	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2.782070	1,609,617	4,478,067	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.473829	2,501,094	1,185,091	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.872103	21,345,062	18,615,093	73.00
74.00	07400	RENAL DIALYSIS	0.765439	404,356	309,510	74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.971186	246,130	239,038	90.00
91.00	09100	EMERGENCY	0.880318	2,587,407	2,277,741	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.648887	1,703,209	1,105,190	92.00
200.00		Total (sum of lines 50-94 and 96-98)		101,424,310	56,158,214	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		101,424,310		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet E Part A Date/Time Prepared: 4/29/2016 10:03 am

Title XVIII | Hospital | PPS

			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments		0			1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		15,353,847			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		2,578,727			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0			1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0			1.04
2.00	Outlier payments for discharges. (see instructions)		2,643,769			2.00
2.01	Outlier reconciliation amount		0			2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0			2.02
3.00	Managed Care Simulated Payments		1,882,907			3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		416.01			4.00
	Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		522.08			5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00			6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		36.60			7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00			7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		-85.00			8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00			8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00			8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		400.48			9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		460.64			10.00
11.00	FTE count for residents in dental and podiatric programs.		12.96			11.00
12.00	Current year allowable FTE (see instructions)		413.44			12.00
13.00	Total allowable FTE count for the prior year.		414.69			13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		413.08			14.00
15.00	Sum of lines 12 through 14 divided by 3.		413.74			15.00
16.00	Adjustment for residents in initial years of the program		0.00			16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00			17.00
18.00	Adjusted rolling average FTE count		413.74			18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.994543			19.00
20.00	Prior year resident to bed ratio (see instructions)		0.976063			20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.976063			21.00
22.00	IME payment adjustment (see instructions)		7,689,936			22.00
22.01	IME payment adjustment - Managed Care (see instructions)		807,438			22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00			23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		60.16			24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00			25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000			26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000			27.00
28.00	IME add-on adjustment amount (see instructions)		0			28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0			28.01
29.00	Total IME payment (sum of lines 22 and 28)		7,689,936			29.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet E Part A Date/Time Prepared: 4/29/2016 10:03 am

Title XVIII | Hospital | PPS

			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		807,438			29.01
	Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		12.64			30.00
31.00	Percentage of Medicaid patient days (see instructions)		39.93			31.00
32.00	Sum of lines 30 and 31		52.57			32.00
33.00	Allowable disproportionate share percentage (see instructions)		32.59			33.00
34.00	Disproportionate share adjustment (see instructions)		1,461,057			34.00

			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
	Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0		0	35.00
35.01	Factor 3 (see instructions)		0.000000000		0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		11,318,254		9,987,477	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		9,426,713		1,664,583	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		11,091,296			36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0			40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0			46.00
47.00	Subtotal (see instructions)		40,818,632			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		0			48.00
49.00	Total payment for inpatient operating costs (see instructions)		41,626,070			49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,921,897			50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0			51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		3,019,642			52.00
53.00	Nursing and Allied Health Managed Care payment		0			53.00
54.00	Special add-on payments for new technologies		0			54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0			55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0			56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0			57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		29,787			58.00
59.00	Total (sum of amounts on lines 49 through 58)		47,597,396			59.00
60.00	Primary payer payments		9,100			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		47,588,296			61.00
62.00	Deductibles billed to program beneficiaries		2,094,000			62.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet E Part A Date/Time Prepared: 4/29/2016 10:03 am

Title XVIII | Hospital | PPS

			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
63.00	Coinsurance billed to program beneficiaries		87,980			63.00
64.00	Allowable bad debts (see instructions)		941,559			64.00
65.00	Adjusted reimbursable bad debts (see instructions)		612,013			65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		762,277			66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		46,018,329			67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0			68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0			69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0			70.00
70.50	RURAL DEMONSTRATION PROJECT		0			70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0			70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0			70.91
70.92	Bundled Model 1 discount amount (see instructions)		0			70.92
70.93	HVBP payment adjustment amount (see instructions)		17,367			70.93
70.94	HRR adjustment amount (see instructions)		-43,566			70.94
70.95	Recovery of accelerated depreciation		0			70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0			70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0			70.97
70.98	Low Volume Payment-3		0			70.98
70.99	HAC adjustment amount (see instructions)		378,669			70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		45,613,461			71.00
71.01	Sequestration adjustment (see instructions)		912,269			71.01
72.00	Interim payments		44,018,849			72.00
73.00	Tentative settlement (for contractor use only)		0			73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		682,343			74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		515,491			75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0			90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0			91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0			92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0			93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00			94.00
95.00	Time value of money for operating expenses (see instructions)		0			95.00
96.00	Time value of money for capital related expenses (see instructions)		0			96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet E Part A Date/Time Prepared: 4/29/2016 10:03 am

Title XVIII | Hospital | PPS

		Prior to 10/1		On/After 10/1	
		1.00	1.01	2.00	
	HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)	0		0	100.00
	HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	1.0008711634		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0		0	102.00
	HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.9977		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0		0	104.00

CALCULATION OF DSH PAYMENT PERCENTAGE | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet DSH | Date/Time Prepared: 4/29/2016 10:03 am

Title XVIII | Hospital | PPS

		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
	CALCULATION OF THE DSH PAYMENT PERCENTAGE						
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	12.64	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	39.93	0.00			39.93	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	52.57	0.00			39.93	3.00
4.00	Provider Type * (urban, rural,SCH, RRC, pickle - If pickle worksheet NA)	Urban				Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	416.01	0.00			416.01	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	32.59	0.00			22.16	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes				No	9.00
10.00	S-2, Line 45	Yes				Yes	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 geater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	12.64	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
	CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS						
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	25,456	0			25,456	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	8,405	0			8,405	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	6,356	0			6,356	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	40,217	0			40,217	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	98,763	0			98,763	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	1,964	0			1,964	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	100,727	0			100,727	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	39.93	0.00			39.93	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet DSH | Date/Time Prepared: 4/29/2016 10:03 am

Title XVIII | Hospital | PPS

		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE						
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	32.59		0.00	True	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	False	29.00
30.00	Line 28 or 29 as applicable		32.59		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		32.59		0.00		31.00

		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
	DETERMINATION OF PROVIDER TYPE						
32.00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Cummunity hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE	Provider CCN: 140124	Period: From 12/01/2014 To 11/30/2015	Worksheet DSH Date/Time Prepared: 4/29/2016 10:03 am
	Title XVIII	Hospital	PPS

		Revised Percentage 6.00		
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE			
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	22.16		28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00		29.00
30.00	Line 28 or 29 as applicable	22.16		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	22.16		31.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 4/29/2016 10:03 am

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	15,353,847	15,353,847		15,353,847	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,578,727		2,578,727	2,578,727	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	2,643,769	2,225,690	418,079	2,643,769	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	1,882,907	1,352,396	530,511	1,882,907	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.976063	0.976063	0.976063		5.00
6.00	IME payment adjustment (see instructions)	22.00	7,689,936	6,584,113	1,105,823	7,689,936	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	807,438	579,942	227,496	807,438	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	7,689,936	6,584,113	1,105,823	7,689,936	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	807,438	579,942	227,496	807,438	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.3259	0.3259	0.3259		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	1,461,057	1,250,955	210,102	1,461,057	11.00
11.01	Uncompensated care payments	36.00	11,091,296	9,426,713	1,664,583	11,091,296	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	40,818,632	34,841,318	5,977,314	40,818,632	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	41,626,070	35,421,260	6,204,810	41,626,070	15.00
16.00	Payment for inpatient program capital	50.00	2,921,897	2,467,552	454,345	2,921,897	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			37,888,812	6,659,155	44,547,967	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 4/29/2016 10:03 am

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,434,385	1,227,536	206,849	1,434,385	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	570,366	455,129	115,237	570,366	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.5270	0.5270	0.5270		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	755,921	646,912	109,009	755,921	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1124	0.1124	0.1124		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	161,225	137,975	23,250	161,225	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,921,897	2,467,552	454,345	2,921,897	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	17,367	13,375	3,992	17,367	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-43,566	-35,314	-8,252	-43,566	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		378,669	0	378,669	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140124	Period: From 12/01/2014 To 11/30/2015	Worksheet E Part B Date/Time Prepared: 4/29/2016 10:03 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	286,037	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	32,328,033	2.00
3.00	PPS payments	16,073,417	3.00
4.00	Outlier payment (see instructions)	1,386,786	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	28,609	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	286,037	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	328,759	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	328,759	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	328,759	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	42,722	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	286,037	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	17,488,812	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	4,036,016	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	13,738,833	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	2,225,770	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	15,964,603	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	15,964,603	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	529,854	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	344,405	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	260,560	36.00
37.00	Subtotal (see instructions)	16,309,008	37.00
38.00	MSP-LCC reconciliation amount from PS&R	4,716	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	16,304,292	40.00
40.01	Sequestration adjustment (see instructions)	326,086	40.01
41.00	Interim payments	15,776,388	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	201,818	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

		Overrides 1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 4/29/2016 10:03 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		43,608,105		15,384,482	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	07/16/2015	175,553	07/16/2015	272,700	3.01
3.02		11/24/2015	235,191	11/24/2015	119,206	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		410,744		391,906	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		44,018,849		15,776,388	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		682,343		201,818	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		44,701,192		15,978,206	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 140124	Period: From 12/01/2014 To 11/30/2015	Worksheet E-1 Part II Date/Time Prepared: 4/29/2016 10:03 am
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	21,577	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	11,936	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	3,115	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	96,918	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	1,225,447,369	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	346,198,932	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	329,231	8.00
9.00	Sequestration adjustment amount (see instructions)	6,585	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	322,646	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	225,618	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	97,028	32.00
		Overrides	
		1.00	
	CONTRACTOR OVERRIDES		
108.00	Override of HIT payment	0	108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet E-3 Part VII | Date/Time Prepared: 4/29/2016 10:03 am

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	116,835,066		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	116,835,066	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	116,835,066	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	91,080,306		8.00
9.00	Ancillary service charges	101,424,310	91,080,307	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	192,504,616	91,080,307	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	192,504,616	91,080,307	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	75,669,550	91,080,307	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	116,835,066	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	116,835,066	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	116,835,066	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	116,835,066	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	116,835,066	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	116,835,066	0	40.00
41.00	Interim payments	116,768,473	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	66,593	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00
	OVERRIDES			
109.00	Override Ancillary service charges (line 9)	0	0	109.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet E-4 | Date/Time Prepared: 4/29/2016 10:03 am

Title XVIII | Hospital | PPS

				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			526.48	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			65.83	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			-60.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts			400.65	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			464.27	6.00
7.00	Enter the lesser of line 5 or line 6			400.65	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	198.74	221.89	420.63	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	171.51	191.48	362.99	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		12.63		10.00
11.00	Total weighted FTE count	171.51	204.11		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	174.25	202.37		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	173.73	199.12		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	173.16	201.87		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
17.00	Adjusted rolling average FTE count	173.16	201.87		17.00
18.00	Per resident amount	95,090.74	94,285.64		18.00
19.00	Approved amount for resident costs	16,465,913	19,033,442	35,499,355	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			63.62	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			35,499,355	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions)	11,936	3,115		26.00
27.00	Total Inpatient Days (see instructions)	98,882	98,882		27.00
28.00	Ratio of inpatient days to total inpatient days	0.120710	0.031502		28.00
29.00	Program direct GME amount	4,285,127	1,118,301		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		158,016		30.00
31.00	Net Program direct GME amount			5,245,412	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet E-4 | Date/Time Prepared: 4/29/2016 10:03 am

Title XVIII | Hospital | PPS

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)		
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	8,747,720	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)	66,608	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
37.00	Reasonable cost (see instructions)	44,294,491	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)	0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)	0	39.00
40.00	Primary payer payments (see instructions)	9,100	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	44,285,391	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	32,642,679	42.00
43.00	Primary payer payments (see instructions)	0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	32,642,679	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	76,928,070	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.575673	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.424327	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	5,245,412	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	3,019,642	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	2,225,770	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet G | Date/Time Prepared: 4/29/2016 10:03 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,341,868	0	0	0	1.00
2.00	Temporary investments	54,338,173	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	65,432,652	0	0	0	4.00
5.00	Other receivable	209,913,010	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	3,445,406	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	334,471,109	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	2,717,512	0	0	0	13.00
14.00	Accumulated depreciation	-1,830,026	0	0	0	14.00
15.00	Buildings	523,136,202	0	0	0	15.00
16.00	Accumulated depreciation	-262,139,967	0	0	0	16.00
17.00	Leasehold improvements	95,416,166	0	0	0	17.00
18.00	Accumulated depreciation	-28,039,498	0	0	0	18.00
19.00	Fixed equipment	176,243,825	0	0	0	19.00
20.00	Accumulated depreciation	-146,996,471	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	5,996,853	0	0	0	23.00
24.00	Accumulated depreciation	-5,369,628	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	10,641,119	0	0	0	27.00
28.00	Accumulated depreciation	-7,512,178	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	362,263,909	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	696,735,018	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	-878,828,762	0	0	0	37.00
38.00	Salaries, wages, and fees payable	42,241,849	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	371,381,389	0	0	0	43.00
44.00	Other current liabilities	52,479	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-465,153,045	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	0	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	-465,153,045	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	1,161,888,063				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	1,161,888,063	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	696,735,018	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet G-1 | Date/Time Prepared: 4/29/2016 10:03 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		1,015,826,470		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		146,061,594				2.00
3.00	Total (sum of line 1 and line 2)		1,161,888,064		0		3.00
4.00	INVESTMENTS IN CAPITAL ASSESTS	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		1,161,888,064		0		11.00
12.00	ROUNDING	1		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		1		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		1,161,888,063		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	INVESTMENTS IN CAPITAL ASSESTS		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	ROUNDING		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 4/29/2016 10:03 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	158,680,073		158,680,073	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	158,680,073		158,680,073	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	21,713,888		21,713,888	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT	4,351,943		4,351,943	13.00
14.00	SURGICAL INTENSIVE CARE UNIT	7,701,277		7,701,277	14.00
14.01	PEDIATRIC INTENSIVE CARE UNIT	2,530,337		2,530,337	14.01
14.02	TRAUMA INTENSIVE CARE UNIT	10,341,681		10,341,681	14.02
14.03	NEURO INTENSIVE CARE	7,277,620		7,277,620	14.03
14.04	NEONATAL INTENSIVE CARE UNIT	27,462,279		27,462,279	14.04
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	81,379,025		81,379,025	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	240,059,098		240,059,098	17.00
18.00	Ancillary services	355,538,027	427,356,876	782,894,903	18.00
19.00	Outpatient services	26,308,431	176,185,939	202,494,370	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEE CAPITATION & SENGSTACKE	2,517,471	34,296,922	36,814,393	27.00
27.01	COUNTY CARE REVENUE	0	861,572,979	861,572,979	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	624,423,027	1,499,412,716	2,123,835,743	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		1,431,320,227		29.00
30.00	POST CLOSING JOURNAL ENTRIES	0			30.00
31.00	INTERCOMPANY ACCOUNTS NOT ON W/S A	0			31.00
32.00	POST CLOSING ENTRY RESERVE 4 CLAIMS	0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	COUNTY CARE REVENUE	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		1,431,320,227		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet G-3 | Date/Time Prepared: 4/29/2016 10:03 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	2,123,835,743	1.00
2.00	Less contractual allowances and discounts on patients' accounts	652,154,857	2.00
3.00	Net patient revenues (line 1 minus line 2)	1,471,680,886	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	1,431,320,227	4.00
5.00	Net income from service to patients (line 3 minus line 4)	40,360,659	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00		0	24.00
24.01	MISCELLANEOUS INCOME	5,648,038	24.01
24.02	REVENUE FROM COUNTY	93,969,436	24.02
24.03	EHR INCENTIVE REVENUE	6,083,461	24.03
25.00	Total other income (sum of lines 6-24)	105,700,935	25.00
26.00	Total (line 5 plus line 25)	146,061,594	26.00
27.00	ROUNDING	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	146,061,594	29.00

ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

Provider CCN: 140124 | Component CCN: 142313 | Period: From 12/01/2014 To 11/30/2015 | Worksheet I-1 | Date/Time Prepared: 4/29/2016 10:03 am

Renal Dialysis

		Total Costs	Basis	Statistics	FTEs per 2080 Hours	
		1.00	2.00	3.00	4.00	
1.00	REGISTERED NURSES	1,033,190	Hours of Service	23,840.00	11.46	1.00
2.00	LICENSED PRACTICAL NURSES	373,076	Hours of Service	9,155.00	4.40	2.00
3.00	NURSES AIDES	121,477	Hours of Service	5,896.00	2.83	3.00
4.00	TECHNICIANS	159,986	Hours of Service	4,160.00	2.00	4.00
5.00	SOCIAL WORKERS	0	Hours of Service	0.00	0.00	5.00
6.00	DIETICIANS	0	Hours of Service	0.00	0.00	6.00
7.00	PHYSICIANS	1,705,842	Accumulated Cost			7.00
8.00	NON-PATIENT CARE SALARY	113,365	Accumulated Cost			8.00
9.00	SUBTOTAL (SUM OF LINES 1-8)	3,506,936				9.00
10.00	EMPLOYEE BENEFITS	0	Salary			10.00
11.00	CAPITAL RELATED COSTS-BLDGS. & FIXTURES	0	Square Feet			11.00
12.00	CAPITAL RELATED COSTS-MOV. EQUIP.	0	Percentage of Time			12.00
13.00	MACHINE COSTS & REPAIRS	0	Percentage of Time			13.00
14.00	SUPPLIES	9,111	Requisitions			14.00
15.00	DRUGS	0	Requisitions			15.00
16.00	OTHER	0	Accumulated Cost			16.00
17.00	SUBTOTAL (SUM OF LINES 9-16)*	3,516,047				17.00
18.00	CAPITAL RELATED COSTS-BLDGS. & FIXTURES	53,866	Square Feet			18.00
19.00	CAPITAL RELATED COSTS-MOV. EQUIP.	43,359	Percentage of Time			19.00
20.00	EMPLOYEE BENEFITS DEPARTMENT	967,567	Salary			20.00
21.00	ADMINISTRATIVE & GENERAL	1,639,624	Accumulated Cost			21.00
22.00	MAINT./REPAIRS-OPER-HOUSEKEEPING	184,452	Square Feet			22.00
23.00	MEDICAL EDUCATION PROGRAM COSTS	0				23.00
24.00	CENTRAL SERVICE & SUPPLIES	5,279	Requisitions			24.00
25.00	PHARMACY	0	Requisitions			25.00
26.00	OTHER ALLOCATED COSTS	285,651	Accumulated Cost			26.00
27.00	SUBTOTAL (SUM OF LINES 17-26)*	6,695,845				27.00
28.00	LABORATORY (SEE INSTRUCTIONS)	0	Charges	0		28.00
29.00	RESPIRATORY THERAPY (SEE INSTRUCTIONS)	0	Charges	0		29.00
30.00	WAIVER PURCHASED PATIENT SERVICES	0	Charges	0		30.00
31.00	TOTAL COSTS (SUM OF LINES 27-30)	6,695,845				31.00

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

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES

Provider CCN: 140124 | Component CCN: 142313 | Period: From 12/01/2014 To 11/30/2015 | Worksheet I-2 | Date/Time Prepared: 4/29/2016 10:03 am

Renal Dialysis

		Capital Related Costs		Direct Patient Care Salary				
		Building	Equipment	RNs	Other	Employee Benefits Department	Drugs	
		1.00	2.00	3.00	4.00	5.00	6.00	
1.00	Total Renal Department Costs	238,318	43,359	1,033,190	654,539	967,567	0	1.00
	MAINTENANCE							
2.00	Hemodialysis	150,289	27,343	651,553	412,767	610,169	0	2.00
3.00	Intermittent Peritoneal	0	0	0	0	0	0	3.00
	TRAINING							
4.00	Hemodialysis	0	0	0	0	0	0	4.00
5.00	Intermittent Peritoneal	0	0	0	0	0	0	5.00
6.00	CAPD	0	0	0	0	0	0	6.00
7.00	CCPD	0	0	0	0	0	0	7.00
	HOME							
8.00	Hemodialysis	0	0	0	0	0	0	8.00
9.00	Intermittent Peritoneal	0	0	0	0	0	0	9.00
10.00	CAPD	0	0	0	0	0	0	10.00
11.00	CCPD	0	0	0	0	0	0	11.00
	OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis	88,029	16,016	381,637	241,772	357,398	0	12.00
13.00	Method II Home Patient	0	0	0	0	0	0	13.00
14.00	EPO (include in Renal Department)						0	14.00
15.00	ARANESP (include in Renal Department)						0	15.00
16.00	Other	0	0	0	0	0	0	16.00
17.00	Total (sum of lines 2 through 16)	238,318	43,359	1,033,190	654,539	967,567	0	17.00
18.00	Medical Educational Program Costs							18.00
19.00	Total Renal Costs (line 17 + line 18)							19.00

		Medical Supplies	Routine Ancillary Services	Subtotal (sum of cols. 1-8)	Overhead	Total (col. 9 + col. 10)		
		7.00	8.00	9.00	10.00	11.00		
1.00	Total Renal Department Costs	14,390	0	2,951,363	3,744,482	6,695,845		1.00
	MAINTENANCE							
2.00	Hemodialysis	9,075	0	1,861,196	2,361,354	4,222,550		2.00
3.00	Intermittent Peritoneal	0	0	0	0	0		3.00
	TRAINING							
4.00	Hemodialysis	0	0	0	0	0		4.00
5.00	Intermittent Peritoneal	0	0	0	0	0		5.00
6.00	CAPD	0	0	0	0	0		6.00
7.00	CCPD	0	0	0	0	0		7.00
	HOME							
8.00	Hemodialysis	0	0	0	0	0		8.00
9.00	Intermittent Peritoneal	0	0	0	0	0		9.00
10.00	CAPD	0	0	0	0	0		10.00
11.00	CCPD	0	0	0	0	0		11.00
	OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis	5,315	0	1,090,167	1,383,128	2,473,295		12.00
13.00	Method II Home Patient	0	0	0	0	0		13.00
14.00	EPO (include in Renal Department)							14.00
15.00	ARANESP (include in Renal Department)							15.00
16.00	Other	0	0	0	0	0		16.00
17.00	Total (sum of lines 2 through 16)	14,390	0	2,951,363	3,744,482	6,695,845		17.00
18.00	Medical Educational Program Costs					0		18.00
19.00	Total Renal Costs (line 17 + line 18)					6,695,845		19.00

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140124 | Component CCN: 142313 | Period: From 12/01/2014 To 11/30/2015 | Worksheet I-3 | Date/Time Prepared: 4/29/2016 10:03 am

Renal Dialysis

			Capital Related Costs		Direct Patient Care Salary			
			Building (Square Feet)	Equipment (% of Time)	RNs (Hours)	Other (Hours)	Employee Benefits Department (Salary)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	Total Renal Department Costs		238,318	43,359	1,033,190	654,539	967,567	1.00
	MAINTENANCE							
2.00	Hemodialysis		4,094	4,094.00	4,094.00	4,094.00	4,094	2.00
3.00	Intermittent Peritoneal		0	0.00	0.00	0.00	0	3.00
	TRAINING							
4.00	Hemodialysis		0	0.00	0.00	0.00	0	4.00
5.00	Intermittent Peritoneal		0	0.00	0.00	0.00	0	5.00
6.00	CAPD		0	0.00	0.00	0.00	0	6.00
7.00	CCPD		0	0.00	0.00	0.00	0	7.00
	HOME							
8.00	Hemodialysis		0	0.00	0.00	0.00	0	8.00
9.00	Intermittent Peritoneal		0	0.00	0.00	0.00	0	9.00
10.00	CAPD		0	0.00	0.00	0.00	0	10.00
11.00	CCPD		0	0.00	0.00	0.00	0	11.00
	OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis Treatments	2,398	2,398	2,398.00	2,398.00	2,398.00	2,398	12.00
13.00	Method II Home Patient		0	0.00	0.00	0.00	0	13.00
14.00	EPO							14.00
15.00	ARANESP							15.00
16.00	Other		0	0.00	0.00	0.00	0	16.00
17.00	Total Statistical Basis		6,492	6,492.00	6,492.00	6,492.00	6,492	17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)		36.709489	6.678835	159.148182	100.822397	149.039895	18.00

		Drugs (Requist.)	Medical Supplies (Requist.)	Routine Ancillary Services (Charges)	Subtotal	Overhead (Accum. Cost)		
		6.00	7.00	8.00	9.00	10.00		
1.00	Total Renal Department Costs	0	14,390	0	2,951,363	3,744,482		1.00
	MAINTENANCE							
2.00	Hemodialysis	0	4,094	0				2.00
3.00	Intermittent Peritoneal	0	0	0				3.00
	TRAINING							
4.00	Hemodialysis	0	0	0				4.00
5.00	Intermittent Peritoneal	0	0	0				5.00
6.00	CAPD	0	0	0				6.00
7.00	CCPD	0	0	0				7.00
	HOME							
8.00	Hemodialysis	0	0	0				8.00
9.00	Intermittent Peritoneal	0	0	0				9.00
10.00	CAPD	0	0	0				10.00
11.00	CCPD	0	0	0				11.00
	OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis Treatments	0	2,398	0				12.00
13.00	Method II Home Patient	0	0	0				13.00
14.00	EPO	0						14.00
15.00	ARANESP	0						15.00
16.00	Other	0	0	0				16.00
17.00	Total Statistical Basis	0	6,492	0		2,951,363		17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)	0.000000	2.216574	0.000000		1.268730		18.00

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

Provider CCN: 140124 | Component CCN: 142313 | Period: From 12/01/2014 To 11/30/2015 | Worksheet I-4 | Date/Time Prepared: 4/29/2016 10:03 am

Rate 0 | Renal Dialysis

		Number of Total Treatments	Total Cost (from Wkst. I-2, col. 11)	Average Cost of Treatments (col. 2 ÷ col. 1)	Number of Program Treatments	Total Program Expenses (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
1.00	Maintenance - Hemodialysis	6,492	4,222,550	650.42	651	423,423	1.00
2.00	Maintenance - Peritoneal Dialysis	0	0	0.00	0	0	2.00
3.00	Training - Hemodialysis	0	0	0.00	0	0	3.00
4.00	Training - Peritoneal Dialysis	0	0	0.00	0	0	4.00
5.00	Training - Continuous Ambulatory Peritoneal Dialysis	0	0	0.00	0	0	5.00
6.00	Training - Continuous Cycling Peritoneal Dialysis	0	0	0.00	0	0	6.00
7.00	Home Program - Hemodialysis	0	0	0.00	0	0	7.00
8.00	Home Program - Peritoneal Dialysis	0	0	0.00	0	0	8.00
		Patient Weeks			Patient Weeks		
		1.00	2.00	3.00	4.00	5.00	
9.00	Home Program - Continuous Ambulatory Peritoneal Dialysis	0	0	0.00	0	0	9.00
10.00	Home Program - Continuous Cycling Peritoneal Dialysis	0	0	0.00	0	0	10.00
11.00	Totals (sum of lines 1-8, columns 1 and 4) (sum of lines 1-10, columns 2, 5, and 6) (see instruction)	6,492	4,222,550		651	423,423	11.00
12.00	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instruction)	6,492					12.00

		Total Program Payment	Average Payment Rate (col. 6 ÷ col. 4)				
		6.00	7.00				
1.00	Maintenance - Hemodialysis	149,296	229.33				1.00
2.00	Maintenance - Peritoneal Dialysis	0	0.00				2.00
3.00	Training - Hemodialysis	0	0.00				3.00
4.00	Training - Peritoneal Dialysis	0	0.00				4.00
5.00	Training - Continuous Ambulatory Peritoneal Dialysis	0	0.00				5.00
6.00	Training - Continuous Cycling Peritoneal Dialysis	0	0.00				6.00
7.00	Home Program - Hemodialysis	0	0.00				7.00
8.00	Home Program - Peritoneal Dialysis	0	0.00				8.00
		6.00	7.00				
9.00	Home Program - Continuous Ambulatory Peritoneal Dialysis	0	0.00				9.00
10.00	Home Program - Continuous Cycling Peritoneal Dialysis	0	0.00				10.00
11.00	Totals (sum of lines 1-8, columns 1 and 4) (sum of lines 1-10, columns 2, 5, and 6) (see instruction)	149,296					11.00
12.00	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instruction)						12.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B | Provider CCN: 140124 | Period: From 12/01/2014 To 11/30/2015 | Worksheet I-5 | Date/Time Prepared: 4/29/2016 10:03 am

		1.00	2.00	
	PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B			
1.00	Total expenses related to care of program beneficiaries (see instructions)	423,423		1.00
2.00	Total payment due (from Wkst. I-4, col. 6, line 11) (see instructions)	149,296	149,296	2.00
2.01	Total payment due (from Wkst. I-4, col. 6.01, line 11) (see instructions)			2.01
2.02	Total payment due(from Wkst. I-4, col. 6.02, line 11) (see instructions)			2.02
2.03	Total payment due (see instructions)	149,296	149,296	2.03
2.04	Outlier payments	0		2.04
3.00	Deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.00
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)			3.01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)			3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.03
4.00	Coinsurance billed to Medicare (Part B) patients	0	0	4.00
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.01
4.02	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	4.03
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries	0	0	5.00
5.01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012			5.01
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013			5.02
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014			5.03
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014	0	0	5.04
5.05	Total bad debts (sum of line 5 through line 5.04)	0	0	5.05
6.00	Allowable bad debts (see instructions)	0		6.00
7.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0		7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	8.00
9.00	Program payment (see instructions)	119,437	119,437	9.00
10.00	Unrecovered from Medicare (Part B) patients (see instructions)			10.00
11.00	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)	0		11.00
	PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE			
12.00	Total allowable expenses (see instructions)	4,222,550		12.00
13.00	Total composite costs (from Wkst. I-4, col. 2, line 11)	4,222,550		13.00
14.00	Facility specific composite cost percentage (line 13 divided by line 12)	1.000000		14.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140124	Period: From 12/01/2014 To 11/30/2015	Worksheet L Parts I-III Date/Time Prepared: 4/29/2016 10:03 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,434,385	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	570,366	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	270.91	3.00
4.00	Number of interns & residents (see instructions)	413.74	4.00
5.00	Indirect medical education percentage (see instructions)	52.70	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	755,921	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	12.64	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	39.93	8.00
9.00	Sum of lines 7 and 8	52.57	9.00
10.00	Allowable disproportionate share percentage (see instructions)	11.24	10.00
11.00	Disproportionate share adjustment (see instructions)	161,225	11.00
12.00	Total prospective capital payments (see instructions)	2,921,897	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00