

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: 150057	Period: From 01/01/2011 To 12/31/2011	Worksheet S Parts I-III Date/Time Prepared: 5/29/2012 2: 29 pm
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PART I - COST REPORT STATUS

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

Contractor use only
 5. Cost Report Status
 (1) As Submitted
 (2) Settled without Audit
 (3) Settled with Audit
 (4) Reopened
 (5) Amended
 6. Date Received:
 7. Contractor No.
 8. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN
 10. NPR Date:
 11. Contractor's Vendor Code: 04
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 5/29/2012 Time: 2: 29 pm

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above 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 ST. FRANCIS H&H-MOORESVILLE for the cost reporting period beginning 01/01/2011 and ending 12/31/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement 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 identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information
 ECR: Date: 5/29/2012 Time: 2: 29 pm
 NFP4i LmME030cxyWknGvI S50s: WN00
 5CS: BOUGV8i 4yYD1a9Z2Rgl UeyNJrF
 N5DX09nc0h0dMT01
 PI: Date: 5/29/2012 Time: 2: 29 pm
 Vvy5Bi PzXDFJHLi 2: jcgF8pkl RCG. 0
 WI jrA07EEyr9Dgb80bMEI Nt3TJfk5t
 MI JuMu. NT80mi ry5

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

 Title

 Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	52,550	13,496	1,501,597	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
8.00 NURSING FACILITY	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	52,550	13,496	1,501,597	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150057	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/29/2012 2:26 pm
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1.00	2.00	3.00	4.00	1.00
Hospital and Hospital Health Care Complex Address:				
1.00 Street: 1201 HADLEY ROAD		PO Box:	1.00	
2.00 City: MOORESVILLE		State: IN	Zip Code: 46158-	County: MORGAN
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	ST. FRANCIS H&H-MOORESVILLE	150057	26900	1	07/01/1996	N	P	P	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						N	N	N	7.00
8.00	Swing Beds - NF						N			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) 1									17.00
17.10	Hospital-Based (CORF) 1						N	N	N	17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

						From:	To:		
						1.00	2.00		

20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2011	12/31/2011	20.00
21.00	Type of Control (see instructions)	2		21.00

Inpatient PPS Information										
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.					3	N			23.00

	In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	

24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.	423	131	0	0	1,041	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 days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.	0	0	0	0	0	0	25.00

						Urban/Rural S	Date of Geogr		
						1.00	2.00		

26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.	1						26.00
27.00	For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150057	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/29/2012 2:26 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N			57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
64.00	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. If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000	64.00	
		Program Name 1.00	Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet S-2
Part I
Date/Time Prepared:
5/29/2012 2:26 pm

		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	If line 63 is yes or your facility trained residents in the base year period, enter from your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010, the number of unweighted primary care FTE residents for each primary care specialty program in which you train residents. Use subscripted lines 65.01 through 65.50 for each additional primary care program. Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4, the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4.			0.00	0.00	0.000000	65.00	
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
				1.00	2.00	3.00		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations 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	67.00	
						1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N		70.00	
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				N	0	71.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150057		Period: From 01/01/2011 To 12/31/2011		Worksheet S-2 Part I Date/Time Prepared: 5/29/2012 2:26 pm	
				1.00	2.00	3.00	
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.		N				75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	76.00
				1.00			
Long Term Care Hospital PPS							
80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.				N		80.00
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(i)? Enter "Y" for yes and "N" for no.					N	86.00
				V		XIX	
				1.00		2.00	
Title V or XIX Inpatient Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N			Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N			Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N			N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N			N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N			N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00		0.00	97.00
Rural Providers							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		N				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N				108.00
				Physical		Occupational	
				1.00		2.00	
				Speech		Respiratory	
				3.00		4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N		N		109.00
				1.00		2.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.		N				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.		Y				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.				2		118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.			250,000		5,000,000	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? 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? Enter in column 2 "Y" for yes or "N" for no.		N			N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		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

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		1.00	2.00				
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.						134.00
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	158014				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: FRANCISCAN ALLIANCE, INC. AND AFFILI	Contractor's Name: NATIONAL GOVERNMENT SERVICES		Contractor's Number: 0130			141.00
142.00	Street: 1515 W DRAGON TRL	PO Box: 1290					142.00
143.00	City: MISHAWAKA	State: IN		Zip Code: 46544			143.00
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y				144.00
145.00	If costs for renal services are claimed on Worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		N				145.00
						1.00	
						2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N					146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N					147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N					148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N					149.00
						Part A	Part B
						1.00	2.00
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				155.00
156.00	Subprovider - IPF	N	N				156.00
157.00	Subprovider - IRF	N	N				157.00
158.00	SUBPROVIDER	N	N				158.00
159.00	SNF	N	N				159.00
160.00	HOME HEALTH AGENCY	N	N				160.00
161.00	CMHC		N				161.00
161.10	CORF		N				161.10
							1.00
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.		N				165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00
							1.00
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.		Y				167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						1.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150057		Period: From 01/01/2011 To 12/31/2011		Worksheet S-2 Part II Date/Time Prepared: 5/29/2012 2:26 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
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				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	Y					9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	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					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					
		Description	Y/N	Date			
		0	1.00	2.00			
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N					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)	Y		03/27/2012			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					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					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					20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet S-2
Part II
Date/Time Prepared:
5/29/2012 2:26 pm

		Part A			
		Description	Y/N	Date	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	0	N	2.00	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		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.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		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
					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.		Y		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.		Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		Y		40.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet S-2
Part II
Date/Time Prepared:
5/29/2012 2:26 pm

		Part B		
		Y/N	Date	
		3.00	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)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	03/27/2012	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		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		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		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2012 2:26 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	
	Line Number				
	1.00	2.00	3.00	4.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	69	25,185	0.00	1.00
2.00 HMO					2.00
3.00 HMO IPF					3.00
4.00 HMO IRF					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)		69	25,185	0.00	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	34.00	8	2,920	0.00	11.00
12.00 OTHER SPECIAL CARE (SPECIFY)					12.00
13.00 NURSERY					13.00
14.00 Total (see instructions)		77	28,105	0.00	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
25.00 CMHC - CMHC					25.00
25.10 CMHC - CORF	99.10				25.10
26.00 RURAL HEALTH CLINIC					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER					26.25
27.00 Total (sum of lines 14-26)		77			27.00
28.00 Observation Bed Days					28.00
29.00 Ambulance Trips					29.00
30.00 Employee discount days (see instruction)					30.00
31.00 Employee discount days - IRF					31.00
32.00 Labor & delivery days (see instructions)					32.00
33.00 LTCH non-covered days					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2012 2:26 pm

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	5,019	151	10,561		1.00
2.00 HMO		1,027	1,172			2.00
3.00 HMO IPF		0	0			3.00
4.00 HMO IRF		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	5,019	151	10,561		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	0	312	41	1,137		11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0	5,331	423	12,657		14.00
15.00 CAH visits	0	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
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0		25.10
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		65	412		28.00
29.00 Ambulance Trips		0				29.00
30.00 Employee discount days (see instruction)				0		30.00
31.00 Employee discount days - IRF				0		31.00
32.00 Labor & delivery days (see instructions)			0	0		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2012 2:26 pm

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	1,554	1.00
2.00 HMO					0	2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.54	352.61	0.00	0	1,554	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
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00	0.00	0.00			25.10
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.54	352.61	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2012 2:26 pm

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	78	3,756		1.00
2.00 HMO				2.00
3.00 HMO IPF				3.00
4.00 HMO IRF				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF				5.00
6.00 Hospital Adults & Peds. Swing Bed NF				6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)				7.00
8.00 INTENSIVE CARE UNIT				8.00
9.00 CORONARY CARE UNIT				9.00
10.00 BURN INTENSIVE CARE UNIT				10.00
11.00 SURGICAL INTENSIVE CARE UNIT				11.00
12.00 OTHER SPECIAL CARE (SPECIFY)				12.00
13.00 NURSERY				13.00
14.00 Total (see instructions)	78	3,756		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
25.00 CMHC - CMHC				25.00
25.10 CMHC - CORF				25.10
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet S-3
Part II
Date/Time Prepared:
5/29/2012 2:26 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	
	1.00	2.00	3.00	4.00	5.00	
PART II - WAGE DATA						
SALARIES						
1.00	Total salaries (see instructions)	200.00	20,274,630	0	20,274,630	712,994.00 1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00 2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00 3.00
4.00	Physician-Part A		0	0	0	0.00 4.00
4.01	Physicians - Part A - direct teaching		0	0	0	0.00 4.01
5.00	Physician-Part B		0	0	0	0.00 5.00
6.00	Non-physician-Part B		0	0	0	0.00 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00 7.00
7.01	Contracted interns and residents (in approved programs)		0	0	0	0.00 7.01
8.00	Home office personnel		0	0	0	0.00 8.00
9.00	SNF	44.00	0	0	0	0.00 9.00
10.00	Excluded area salaries (see instructions)		783,520	0	783,520	20,429.00 10.00
OTHER WAGES & RELATED COSTS						
11.00	Contract labor (see instructions)		1,396,016	0	1,396,016	47,889.47 11.00
12.00	Management and administrative services		0	0	0	0.00 12.00
13.00	Contract labor: physician-Part A		0	0	0	0.00 13.00
14.00	Home office salaries & wage-related costs		9,616,871	0	9,616,871	177,831.00 14.00
15.00	Home office: physician Part A		0	0	0	0.00 15.00
16.00	Teaching physician salaries (see instructions)		0	0	0	0.00 16.00
WAGE-RELATED COSTS						
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24		6,813,772	0	6,813,772	17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV Line 25		0	0	0	18.00
19.00	Excluded areas		273,906	0	273,906	19.00
20.00	Non-physician anesthetist Part A		0	0	0	20.00
21.00	Non-physician anesthetist Part B		0	0	0	21.00
22.00	Physician Part A		0	0	0	22.00
23.00	Physician Part B		0	0	0	23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0	24.00
25.00	Interns & residents (in an approved program)		0	0	0	25.00
OVERHEAD COSTS - DIRECT SALARIES						
26.00	Employee Benefits	4.00	0	0	0	0.00 26.00
27.00	Administrative & General	5.00	1,444,124	0	1,444,124	60,883.00 27.00
28.00	Administrative & General under contract (see inst.)		284,235	0	284,235	1,226.00 28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00 29.00
30.00	Operation of Plant	7.00	1,174,947	0	1,174,947	53,655.00 30.00
31.00	Laundry & Linen Service	8.00	46,892	0	46,892	4,233.00 31.00
32.00	Housekeeping	9.00	796,073	0	796,073	64,358.00 32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00 33.00
34.00	Dietary	10.00	390,332	-254,827	135,505	9,539.00 34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00 35.00
36.00	Cafeteria	11.00	35	254,827	254,862	17,943.00 36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00 37.00
38.00	Nursing Administration	13.00	0	0	0	0.00 38.00
39.00	Central Services and Supply	14.00	45,479	0	45,479	3,077.06 39.00
40.00	Pharmacy	15.00	711,793	0	711,793	18,726.00 40.00
41.00	Medical Records & Medical Records Library	16.00	8,201	0	8,201	358.00 41.00
42.00	Social Service	17.00	0	0	0	0.00 42.00
43.00	Other General Service	18.00	0	0	0	0.00 43.00

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 150057	Period: From 01/01/2011 To 12/31/2011	Worksheet S-3 Part II Date/Time Prepared: 5/29/2012 2:26 pm
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		Average Hourly Wage (col. 4 ÷ col. 5)	
		6.00	
PART II - WAGE DATA			
SALARIES			
1.00	Total salaries (see instructions)	28.44	1.00
2.00	Non-physician anesthetist Part A	0.00	2.00
3.00	Non-physician anesthetist Part B	0.00	3.00
4.00	Physician-Part A	0.00	4.00
4.01	Physicians - Part A - direct teaching	0.00	4.01
5.00	Physician-Part B	0.00	5.00
6.00	Non-physician-Part B	0.00	6.00
7.00	Interns & residents (in an approved program)	0.00	7.00
7.01	Contracted interns and residents (in approved programs)	0.00	7.01
8.00	Home office personnel	0.00	8.00
9.00	SNF	0.00	9.00
10.00	Excluded area salaries (see instructions)	38.35	10.00
OTHER WAGES & RELATED COSTS			
11.00	Contract labor (see instructions)	29.15	11.00
12.00	Management and administrative services	0.00	12.00
13.00	Contract labor: physician-Part A	0.00	13.00
14.00	Home office salaries & wage-related costs	54.08	14.00
15.00	Home office: physician Part A	0.00	15.00
16.00	Teaching physician salaries (see instructions)	0.00	16.00
WAGE-RELATED COSTS			
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24		17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV Line 25		18.00
19.00	Excluded areas		19.00
20.00	Non-physician anesthetist Part A		20.00
21.00	Non-physician anesthetist Part B		21.00
22.00	Physician Part A		22.00
23.00	Physician Part B		23.00
24.00	Wage-related costs (RHC/FOHC)		24.00
25.00	Interns & residents (in an approved program)		25.00
OVERHEAD COSTS - DIRECT SALARIES			
26.00	Employee Benefits	0.00	26.00
27.00	Administrative & General	23.72	27.00
28.00	Administrative & General under contract (see inst.)	231.84	28.00
29.00	Maintenance & Repairs	0.00	29.00
30.00	Operation of Plant	21.90	30.00
31.00	Laundry & Linen Service	11.08	31.00
32.00	Housekeeping	12.37	32.00
33.00	Housekeeping under contract (see instructions)	0.00	33.00
34.00	Dietary	14.21	34.00
35.00	Dietary under contract (see instructions)	0.00	35.00
36.00	Cafeteria	14.20	36.00
37.00	Maintenance of Personnel	0.00	37.00
38.00	Nursing Administration	0.00	38.00
39.00	Central Services and Supply	14.78	39.00
40.00	Pharmacy	38.01	40.00
41.00	Medical Records & Medical Records Library	22.91	41.00
42.00	Social Service	0.00	42.00
43.00	Other General Service	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 150057		Period: From 01/01/2011 To 12/31/2011		Worksheet S-3 Part III Date/Time Prepared: 5/29/2012 2:26 pm	
	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4		
	1.00	2.00	3.00	4.00	5.00		
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	20,558,865	0	20,558,865	714,220.00		1.00
2.00	Excluded area salaries (see instructions)	783,520	0	783,520	20,429.00		2.00
3.00	Subtotal salaries (line 1 minus line 2)	19,775,345	0	19,775,345	693,791.00		3.00
4.00	Subtotal other wages & related costs (see inst.)	11,012,887	0	11,012,887	225,720.47		4.00
5.00	Subtotal wage-related costs (see inst.)	6,813,772	0	6,813,772	0.00		5.00
6.00	Total (sum of lines 3 thru 5)	37,602,004	0	37,602,004	919,511.47		6.00
7.00	Total overhead cost (see instructions)	4,902,111	0	4,902,111	233,998.06		7.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet S-3
Part III
Date/Time Prepared:
5/29/2012 2:26 pm

		Average Hourly Wage (col. 4 ÷ col. 5)	
		6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY			
1.00	Net salaries (see instructions)	28.79	1.00
2.00	Excluded area salaries (see instructions)	38.35	2.00
3.00	Subtotal salaries (line 1 minus line 2)	28.50	3.00
4.00	Subtotal other wages & related costs (see inst.)	48.79	4.00
5.00	Subtotal wage-related costs (see inst.)	34.46	5.00
6.00	Total (sum of lines 3 thru 5)	40.89	6.00
7.00	Total overhead cost (see instructions)	20.95	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150057	Period: From 01/01/2011 To 12/31/2011	Worksheet S-3 Part IV Date/Time Prepared: 5/29/2012 2:26 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			1,802,586 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			192,305 2.00
3.00	Qualified and Non-Qualified Pension Plan Cost			0 3.00
4.00	Prior Year Pension Service Cost			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)			2,799,670 8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			128,747 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			14,539 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)			97,124 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			223,901 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			1,688,595 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			0 19.00
20.00	State or Federal Unemployment Taxes			25,711 20.00
OTHER				
21.00	Executive Deferred Compensation			0 21.00
22.00	Day Care Cost and Allowances			61,113 22.00
23.00	Tuition Reimbursement			53,388 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			7,087,679 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet S-3
Part V
Date/Time Prepared:
5/29/2012 2:26 pm

Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis			17.00
18.00		0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150057	Period: From 01/01/2011 To 12/31/2011	Worksheet S-10 Date/Time Prepared: 5/29/2012 2:26 pm
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)		0.268765	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		4,441,254	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		29,540,958	6.00	
7.00	Medicaid cost (line 1 times line 6)		7,939,576	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)		3,498,322	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		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)		3,498,322	19.00	
			Uninsured patients	Insured patients	
			1.00	2.00	
			Total (col. 1 + col. 2)		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	22,880,926	0	22,880,926	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	6,149,592	0	6,149,592	21.00
22.00	Partial payment by patients approved for charity care	251,690	0	251,690	22.00
23.00	Cost of charity care (line 21 minus line 22)	5,897,902	0	5,897,902	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)		8,165,549	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		209,242	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		7,956,307	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		2,138,377	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		8,036,279	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		11,534,601	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet A
Date/Time Prepared:
5/29/2012 2:26 pm

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 NEW CAP REL COSTS-BLDG & FIXT		3,071,992	3,071,992	784,208	3,856,200	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP		1,772,989	1,772,989	0	1,772,989	2.00
4.00 EMPLOYEE BENEFITS	0	0	0	0	0	4.00
5.01 ADMIN TTING	772,948	260,198	1,033,146	0	1,033,146	5.01
5.02 PATIENT ACCOUNTING	671,176	1,216,809	1,887,985	0	1,887,985	5.02
5.03 OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	5.03
7.00 OPERATION OF PLANT	1,174,947	2,007,165	3,182,112	0	3,182,112	7.00
8.00 LAUNDRY & LINEN SERVICE	46,892	183,725	230,617	0	230,617	8.00
9.00 HOUSEKEEPING	796,073	475,696	1,271,769	0	1,271,769	9.00
10.00 DIETARY	390,332	349,137	739,469	-482,760	256,709	10.00
11.00 CAFETERIA	35	-37,182	-37,147	482,760	445,613	11.00
13.00 NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	45,479	38,114	83,593	-14,429	69,164	14.00
15.00 PHARMACY	711,793	543,080	1,254,873	0	1,254,873	15.00
16.00 MEDICAL RECORDS & LIBRARY	8,201	-2,558	5,643	0	5,643	16.00
21.00 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	4,760,086	2,105,974	6,866,060	0	6,866,060	30.00
34.00 SURGICAL INTENSIVE CARE UNIT	1,208,433	432,353	1,640,786	0	1,640,786	34.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	1,980,249	23,213,798	25,194,047	-16,420,033	8,774,014	50.00
54.00 RADIOLOGY-DIAGNOSTIC	1,465,716	1,166,450	2,632,166	-22,343	2,609,823	54.00
54.01 ULTRA SOUND	207,247	77,014	284,261	0	284,261	54.01
55.00 RADIOLOGY-THERAPEUTIC	217,828	2,304,813	2,522,641	0	2,522,641	55.00
60.00 LABORATORY	0	2,666,635	2,666,635	-171	2,666,464	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 INTRAVENOUS THERAPY	14,542	62,621	77,163	-58,127	19,036	64.00
65.00 RESPIRATORY THERAPY	723,592	335,471	1,059,063	-100,108	958,955	65.00
66.00 PHYSICAL THERAPY	1,207,699	441,541	1,649,240	-25,091	1,624,149	66.00
67.00 OCCUPATIONAL THERAPY	49,894	27,968	77,862	-3,358	74,504	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	72,207	406,314	478,521	0	478,521	69.00
70.00 ELECTROENCEPHALOGRAPHY	143,069	63,299	206,368	0	206,368	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,109,904	4,109,904	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	12,619,054	12,619,054	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	1,730,631	1,730,631	0	1,730,631	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	236,972	69,226	306,198	-13	306,185	90.00
90.01 WOUND CARE INSTITUTE	24,720	12,479	37,199	0	37,199	90.01
90.02 OP NUTRITIONAL COUNSELING	19,436	5,894	25,330	0	25,330	90.02
90.03 BARIATRIC MEDICINE	0	0	0	0	0	90.03
91.00 EMERGENCY	2,541,544	1,219,271	3,760,815	-72,790	3,688,025	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE		2,578,548	2,578,548	-784,208	1,794,340	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	19,491,110	48,799,465	68,290,575	12,495	68,303,070	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	62,869	95,245	158,114	0	158,114	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	206,516	242,130	448,646	-6,423	442,223	192.00
194.00 COMMUNITY RELATIONS & MARKETING	243,539	1,166,350	1,409,889	0	1,409,889	194.00
194.01 PLAINFIELD RADIOLOGY & PHYSICAL THER	270,596	184,249	454,845	-1,134	453,711	194.01
194.02 JV MV ENDOSCOPY	0	2,833,136	2,833,136	0	2,833,136	194.02
194.03 SOUTHWEST CENTER FOR WOMENS HEALTH	0	185,416	185,416	-4,938	180,478	194.03
200.00 TOTAL (SUM OF LINES 118-199)	20,274,630	53,505,991	73,780,621	0	73,780,621	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet A
Date/Time Prepared:
5/29/2012 2:26 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	-787,011	3,069,189	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	776,160	2,549,149	2.00
4.00	EMPLOYEE BENEFITS	666,142	666,142	4.00
5.01	ADMINISTRATIVE	509,800	1,542,946	5.01
5.02	PATIENT ACCOUNTING	502,112	2,390,097	5.02
5.03	OTHER ADMINISTRATIVE AND GENERAL	9,529,538	9,529,538	5.03
7.00	OPERATION OF PLANT	12,676	3,194,788	7.00
8.00	LAUNDRY & LINEN SERVICE	-15,712	214,905	8.00
9.00	HOUSEKEEPING	-21,000	1,250,769	9.00
10.00	DIETARY	0	256,709	10.00
11.00	CAFETERIA	-241,750	203,863	11.00
13.00	NURSING ADMINISTRATION	272,279	272,279	13.00
14.00	CENTRAL SERVICES & SUPPLY	328,440	397,604	14.00
15.00	PHARMACY	39,915	1,294,788	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	5,643	16.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	33,942	33,942	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	7,195	7,195	22.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-326,989	6,539,071	30.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	1,640,786	34.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	-2,577,410	6,196,604	50.00
54.00	RADIOLOGY-DIAGNOSTIC	-1,573,387	1,036,436	54.00
54.01	ULTRA SOUND	0	284,261	54.01
55.00	RADIOLOGY-THERAPEUTIC	0	2,522,641	55.00
60.00	LABORATORY	475,092	3,141,556	60.00
60.01	BLOOD LABORATORY	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	19,036	64.00
65.00	RESPIRATORY THERAPY	-1,984	956,971	65.00
66.00	PHYSICAL THERAPY	-9,207	1,614,942	66.00
67.00	OCCUPATIONAL THERAPY	0	74,504	67.00
68.00	SPEECH PATHOLOGY	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	478,521	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	206,368	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,109,904	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	12,619,054	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,730,631	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0	306,185	90.00
90.01	WOUND CARE INSTITUTE	0	37,199	90.01
90.02	OP NUTRITIONAL COUNSELING	-3,780	21,550	90.02
90.03	BARITRICAL MEDICINE	0	0	90.03
91.00	EMERGENCY	-4,000	3,684,025	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	-1,794,340	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	5,796,721	74,099,791	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	158,114	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	442,223	192.00
194.00	COMMUNITY RELATIONS & MARKETING	1,348,012	2,757,901	194.00
194.01	PLAINFIELD RADIOLOGY & PHYSICAL THER	0	453,711	194.01
194.02	JV MV ENDOSCOPY	0	2,833,136	194.02
194.03	SOUTHWEST CENTER FOR WOMENS HEALTH	0	180,478	194.03
200.00	TOTAL (SUM OF LINES 118-199)	7,144,733	80,925,354	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00	3.00	4.00	5.00		
A - SUPPLIES CHARGED TO PATIENTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	4,109,904	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
	TOTALS		0	4,109,904	
C - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	254,827	227,933	1.00
	TOTALS		254,827	227,933	
D - INTEREST EXPENSE RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	784,208	1.00
	TOTALS		0	784,208	
E - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	12,619,054	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		0	12,619,054	
500.00	Grand Total: Increases		254,827	17,741,099	500.00

RECLASSIFICATIONS

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet A-6

Date/Time Prepared:
5/29/2012 2:26 pm

Decreases						Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
A - SUPPLIES CHARGED TO PATIENTS							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	14,429	0		1.00
2.00	OPERATING ROOM	50.00	0	3,808,252	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	22,343	0		3.00
4.00	INTRAVENOUS THERAPY	64.00	0	58,127	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	100,108	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	23,912	0		6.00
7.00	OCCUPATIONAL THERAPY	67.00	0	3,358	0		7.00
8.00	CLINIC	90.00	0	13	0		8.00
9.00	EMERGENCY	91.00	0	71,805	0		9.00
10.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	6,423	0		10.00
11.00	PLAINFIELD RADIOLOGY & PHYSICAL THER	194.01	0	1,134	0		11.00
	TOTALS		0	4,109,904			
C - CAFETERIA RECLASS							
1.00	DIETARY	10.00	254,827	227,933	0		1.00
	TOTALS		254,827	227,933			
D - INTEREST EXPENSE RECLASS							
1.00	INTEREST EXPENSE	113.00	0	784,208	11		1.00
	TOTALS		0	784,208			
E - IMPLANTABLE DEVICES							
1.00	SOUTHWEST CENTER FOR WOMENS HEALTH	194.03	0	4,938	0		1.00
2.00	OPERATING ROOM	50.00	0	12,611,781	0		2.00
3.00	LABORATORY	60.00	0	171	0		3.00
4.00	EMERGENCY	91.00	0	985	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	1,179	0		5.00
	TOTALS		0	12,619,054			
500.00	Grand Total: Decreases		254,827	17,741,099			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/29/2012 2:26 pm

	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	1.00
2.00	Land Improvements	1,388,000	30,904	0	30,904	2.00
3.00	Buildings and Fixtures	47,353,720	8,004,888	0	8,004,888	3.00
4.00	Building Improvements	592,542	0	0	0	4.00
5.00	Fixed Equipment	24,496,939	76,037	0	76,037	5.00
6.00	Movable Equipment	22,122,549	784,113	0	784,113	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	95,953,750	8,895,942	0	8,895,942	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	95,953,750	8,895,942	0	8,895,942	10.00
SUMMARY OF CAPITAL						
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	3,071,992	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,772,989	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,844,981	0	0	0	3.00
COMPUTATION OF RATIOS						
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	81,943,030	0	81,943,030	0.781529	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	22,906,662	0	22,906,662	0.218471	2.00
3.00	Total (sum of lines 1-2)	104,849,692	0	104,849,692	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/29/2012 2:26 pm

		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	1,418,904	0		2.00		
3.00	Buildings and Fixtures	55,358,608	0		3.00		
4.00	Building Improvements	592,542	0		4.00		
5.00	Fixed Equipment	24,572,976	0		5.00		
6.00	Movable Equipment	22,906,662	0		6.00		
7.00	HIT designated Assets	0	0		7.00		
8.00	Subtotal (sum of lines 1-7)	104,849,692	0		8.00		
9.00	Reconciling Items	0	0		9.00		
10.00	Total (line 8 minus line 9)	104,849,692	0		10.00		
SUMMARY OF CAPITAL							
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	3,071,992		1.00		
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,772,989		2.00		
3.00	Total (sum of lines 1-2)	0	4,844,981		3.00		
ALLOCATION OF OTHER CAPITAL							
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	3,071,992	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	2,577,821	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,649,813	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/29/2012 2:26 pm

Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	-2,803	0	0	0	3,069,189	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-28,672	0	0	0	2,549,149	2.00
3.00	Total (sum of lines 1-2)	-31,475	0	0	0	5,618,338	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet A-8

Date/Time Prepared:
5/29/2012 2:26 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center		Line #	
			1.00	2.00	3.00	4.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			NEW CAP REL COSTS-BLDG & FIXT		1.00	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-28,672	NEW CAP REL COSTS-MVBLE EQUIP		2.00	2.00
3.00 Investment income - other (chapter 2)		0			0.00	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	B	-148,484	OTHER ADMINISTRATIVE AND GENERAL		5.03	7.00
8.00 Television and radio service (chapter 21)		0			0.00	8.00
9.00 Parking lot (chapter 21)		0			0.00	9.00
10.00 Provider-based physician adjustment	A-8-2	-2,936,430				10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	13,916,062				12.00
13.00 Laundry and linen service		0			0.00	13.00
14.00 Cafeteria-employees and guests	B	-234,957	CAFETERIA		11.00	14.00
15.00 Rental of quarters to employee and others		0			0.00	15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00	16.00
17.00 Sale of drugs to other than patients		0			0.00	17.00
18.00 Sale of medical records and abstracts		0			0.00	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00	19.00
20.00 Vending machines	B	-6,793	CAFETERIA		11.00	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		ORESPIRATORY THERAPY		65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY		66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***		114.00	25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FIXT		1.00	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			NEW CAP REL COSTS-MVBLE EQUIP		2.00	27.00
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***		19.00	28.00
29.00 Physicians' assistant			0		0.00	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY		67.00	30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY		68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	0			0.00	32.00
33.00 JV ENGINEERING REVENUE	B	-3,825	OPERATION OF PLANT		7.00	33.00
34.00 JV COMMUNICATIONS REVENUE	B	-17,272	OTHER ADMINISTRATIVE AND GENERAL		5.03	34.00
35.00 JV LINEN SERVICES REVENUE	B	-15,712	LAUNDRY & LINEN SERVICE		8.00	35.00
36.00 JV ENVIRONMENTAL SERVICE REVENUE	B	-21,000	HOUSEKEEPING		9.00	36.00
37.00 JV PHARMACY REVENUE	B	-46,598	PHARMACY		15.00	37.00
38.00 DISCOUNTS EARNED/REBATES	B	-97,776	PHARMACY		15.00	38.00
39.00 MISC OBSTETRICS REVENUE	B	-20,912	ADULTS & PEDIATRICS		30.00	39.00
40.00 JV RADIOLOGY REVENUE	B	-1,550,887	RADIOLOGY-DIAGNOSTIC		54.00	40.00
41.00 JV RESPIRATORY REVENUE	B	-1,984	RESPIRATORY THERAPY		65.00	41.00
42.00 MISC PT REVENUE	B	-9,207	PHYSICAL THERAPY		66.00	42.00
43.00 JV NUTRITIONAL COUNSELING REVENUE	B	-3,780	OP NUTRITIONAL COUNSELING		90.02	43.00
44.00 NON-ALLOWABLE INTEREST EXPENSE	A	-787,011	NEW CAP REL COSTS-BLDG & FIXT		1.00	44.00
45.01 MISC OTHER OPERATING	B	-553	PHARMACY		15.00	45.01
45.02 JV OR REVENUE	B	-839,476	OPERATING ROOM		50.00	45.02
45.03		0			0.00	45.03
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		7,144,733				50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet A-8

Date/Time Prepared:
5/29/2012 2:26 pm

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	11	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	JV ENGINEERING REVENUE	0	33.00
34.00	JV COMMUNICATIONS REVENUE	0	34.00
35.00	JV LINEN SERVICES REVENUE	0	35.00
36.00	JV ENVIRONMENTAL SERVICE REVENUE	0	36.00
37.00	JV PHARMACY REVENUE	0	37.00
38.00	DISCOUNTS EARNED/REBATES	0	38.00
39.00	MISC OBSTETRICS REVENUE	0	39.00
40.00	JV RADIOLOGY REVENUE	0	40.00
41.00	JV RESPIRATORY REVENUE	0	41.00
42.00	MISC PT REVENUE	0	42.00
43.00	JV NUTRITIONAL COUNSELING REVENUE	0	43.00
44.00	NON-ALLOWABLE INTEREST EXPENSE	11	44.00
45.01	MISC OTHER OPERATING	0	45.01
45.02	JV OR REVENUE	0	45.02
45.03		0	45.03
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

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

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet A-8-1

Date/Time Prepared:
5/29/2012 2:26 pm

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	4.00	EMPLOYEE BENEFITS	EMPLOYEE BENEFITS - SHARED SERVICES	1.00
2.00	5.03	OTHER ADMINISTRATIVE AND GENERAL	ADMIN & GENERAL - SHARED SERVICES	2.00
3.00	5.01	ADMINITTING	BUSINESS OFFICE - SHARED SERVICES	3.00
4.00	5.02	PATIENT ACCOUNTING	OTHER A&G - SHARED SERVICES	4.00
4.01	7.00	OPERATION OF PLANT	PLANT OPS - SHARED SERVICES	4.01
4.02	13.00	NURSING ADMINISTRATION	NURSING ADMIN - SHARED SERVICES	4.02
4.03	14.00	CENTRAL SERVICES & SUPPLY	CENTRAL SUPPLY - SHARED SERVICES	4.03
4.04	194.00	COMMUNITY RELATIONS & MARKETING	MARKETING - SHARED SERVICES	4.04
4.06	2.00	NEW CAP REL COSTS-MVBLE EQUIP	EQUIPMENT DEPRECIATION - HOME OFFICE	4.06
4.07	5.03	OTHER ADMINISTRATIVE AND GENERAL	OTHER A&G - HOME OFFICE	4.07
4.08	15.00	PHARMACY	PHARMACY - HOME OFFICE	4.08
4.09	113.00	INTEREST EXPENSE	INTEREST - HOME OFFICE	4.09
4.10	60.00	LABORATORY	LABORATORY - APHL	4.10
4.11	113.00	INTEREST EXPENSE	SHARED INTEREST EXPENSE	4.11
4.12	21.00	I&R SERVICES-SALARY & FRINGES APPRVD	INDY & MOORESVILLE RESIDENCY COSTS	4.12
4.13	22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	INDY & MOORESVILLE RESIDENCY COSTS	4.13
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5.00

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

	Symbol (1)	Name	Percentage of Ownership	
	1.00	2.00	3.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

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

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

6.00	A	HOME OFFICE	100.00	6.00
7.00			0.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:			100.00

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

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

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

Provider CCN: 150057

Period: From 01/01/2011 To 12/31/2011

Worksheet A-8-1

Date/Time Prepared: 5/29/2012 2:26 pm

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	4.00	5.00	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	666,142	0	666,142	0	1.00
2.00	4,055,311	0	4,055,311	0	2.00
3.00	509,800	0	509,800	0	3.00
4.00	1,159,150	0	1,159,150	0	4.00
4.01	16,501	0	16,501	0	4.01
4.02	318,660	0	318,660	0	4.02
4.03	328,440	0	328,440	0	4.03
4.04	1,348,012	0	1,348,012	0	4.04
4.06	804,832	0	804,832	9	4.06
4.07	5,639,983	0	5,639,983	0	4.07
4.08	184,842	0	184,842	0	4.08
4.09	784,208	0	784,208	0	4.09
4.10	2,665,866	2,028,274	637,592	0	4.10
4.11	0	2,578,548	-2,578,548	0	4.11
4.12	33,942	0	33,942	0	4.12
4.13	7,195	0	7,195	0	4.13
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	4,606,822	13,916,062		5.00

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

Related Organization(s) and/or Home Office			
Name	Percentage of Ownership	Type of Business	
4.00	5.00	6.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:			

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

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

6.00		0.00	6.00
7.00		0.00	7.00
8.00		0.00	8.00
9.00		0.00	9.00
10.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:		100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet A-8-2

Date/Time Prepared:
5/29/2012 2:26 pm

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		5.02	PATIENT ACCOUNTING	636,614	636,614	1.00
2.00		30.00	ADULTS & PEDIATRICS	306,077	306,077	2.00
3.00		50.00	OPERATING ROOM	1,737,934	1,737,934	3.00
4.00		54.00	RADIOLOGY-DIAGNOSTIC	22,500	22,500	4.00
5.00		60.00	LABORATORY	162,500	162,500	5.00
6.00		13.00	NURSING ADMINISTRATION	97,625	0	6.00
7.00		91.00	EMERGENCY	4,000	4,000	7.00
8.00		5.02	PATIENT ACCOUNTING	37,295	0	8.00
9.00		0.00		0	0	9.00
10.00		0.00		0	0	10.00
200.00				3,004,545	2,869,625	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet A-8-2

Date/Time Prepared:
5/29/2012 2:26 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	97,625	159,800	667	51,244	2,562	6.00
7.00	0	0	0	0	0	7.00
8.00	37,295	138,700	253	16,871	844	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	134,920		920	68,115	3,406	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet A-8-2

Date/Time Prepared:
5/29/2012 2:26 pm

	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14 15.00	Adjusted RCE Limit 16.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	51,244	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	16,871	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	0	0	0	0	68,115	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet A-8-2
Date/Time Prepared:
5/29/2012 2:26 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	636,614	1.00
2.00	0	306,077	2.00
3.00	0	1,737,934	3.00
4.00	0	22,500	4.00
5.00	0	162,500	5.00
6.00	46,381	46,381	6.00
7.00	0	4,000	7.00
8.00	20,424	20,424	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	66,805	2,936,430	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet B
Part I
Date/Time Prepared:
5/29/2012 2:26 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	ADMITTING	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT	3,069,189	3,069,189				1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	2,549,149		2,549,149			2.00
4.00 EMPLOYEE BENEFITS	666,142	11,274	9,364	686,780		4.00
5.01 ADMITTING	1,542,946	38,035	31,591	26,183	1,638,755	5.01
5.02 PATIENT ACCOUNTING	2,390,097	0	0	22,735	0	5.02
5.03 OTHER ADMINISTRATIVE AND GENERAL	9,529,538	87,984	73,076	0	0	5.03
7.00 OPERATION OF PLANT	3,194,788	109,379	90,846	39,800	0	7.00
8.00 LAUNDRY & LINEN SERVICE	214,905	5,227	4,341	1,588	0	8.00
9.00 HOUSEKEEPING	1,250,769	21,979	18,255	26,966	0	9.00
10.00 DIETARY	256,709	77,822	64,636	4,590	0	10.00
11.00 CAFETERIA	203,863	5,005	4,157	8,633	0	11.00
13.00 NURSING ADMINISTRATION	272,279	0	0	0	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	397,604	0	0	1,541	0	14.00
15.00 PHARMACY	1,294,788	35,755	29,697	24,111	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	5,643	43,193	35,874	278	0	16.00
21.00 I&R SERVICES-SALARY & FRINGES APPRVD	33,942	0	0	0	0	21.00
22.00 I&R SERVICES-OTHER PRGM COSTS APPRVD	7,195	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	6,539,071	584,875	485,774	161,241	245,699	30.00
34.00 SURGICAL INTENSIVE CARE UNIT	1,640,786	75,278	62,523	40,934	26,112	34.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	6,196,604	459,564	381,696	67,079	286,100	50.00
54.00 RADIOLOGY-DIAGNOSTIC	1,036,436	155,269	128,960	49,650	37,958	54.00
54.01 ULTRA SOUND	284,261	4,727	3,926	7,020	3,481	54.01
55.00 RADIOLOGY-THERAPEUTIC	2,522,641	118,721	98,605	7,379	437	55.00
60.00 LABORATORY	3,141,556	56,497	46,924	0	97,431	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 INTRAVENOUS THERAPY	19,036	0	0	493	4,229	64.00
65.00 RESPIRATORY THERAPY	956,971	18,837	15,645	24,511	30,632	65.00
66.00 PHYSICAL THERAPY	1,614,942	72,790	60,456	40,910	45,793	66.00
67.00 OCCUPATIONAL THERAPY	74,504	0	0	1,690	309	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	478,521	37,382	31,048	2,446	7,081	69.00
70.00 ELECTROENCEPHALOGRAPHY	206,368	50,491	41,936	4,846	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,109,904	17,016	14,133	0	258,406	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	12,619,054	0	0	0	465,859	72.00
73.00 DRUGS CHARGED TO PATIENTS	1,730,631	0	0	0	129,228	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	306,185	87,234	72,453	8,027	0	90.00
90.01 WOUND CARE INSTITUTE	37,199	0	0	837	0	90.01
90.02 OP NUTRITIONAL COUNSELING	21,550	0	0	658	0	90.02
90.03 BARIATRIC MEDICINE	0	0	0	0	0	90.03
91.00 EMERGENCY	3,684,025	117,039	97,208	86,092	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	74,099,791	2,291,373	1,903,124	660,238	1,638,755	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	158,114	0	0	2,130	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	442,223	708,488	588,444	6,996	0	192.00
194.00 COMMUNITY RELATIONS & MARKETING	2,757,901	0	0	8,250	0	194.00
194.01 PLAINFIELD RADIOLOGY & PHYSICAL THER	453,711	0	0	9,166	0	194.01
194.02 JV MV ENDOSCOPY	2,833,136	69,328	57,581	0	0	194.02
194.03 SOUTHWEST CENTER FOR WOMENS HEALTH	180,478	0	0	0	0	194.03
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	80,925,354	3,069,189	2,549,149	686,780	1,638,755	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150057

Period: From 01/01/2011 To 12/31/2011

Worksheet B Part I Date/Time Prepared: 5/29/2012 2:26 pm

Cost Center Description		PATIENT ACCOUNTING	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5.02	5A.02	5.03	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	ADMINISTRATIVE						5.01
5.02	PATIENT ACCOUNTING	2,412,832					5.02
5.03	OTHER ADMINISTRATIVE AND GENERAL	0	9,690,598	9,690,598			5.03
7.00	OPERATION OF PLANT	0	3,434,813	467,262	3,902,075		7.00
8.00	LAUNDRY & LINEN SERVICE	0	226,061	30,753	7,226	264,040	8.00
9.00	HOUSEKEEPING	0	1,317,969	179,293	30,385	0	9.00
10.00	DIETARY	0	403,757	54,926	107,588	0	10.00
11.00	CAFETERIA	0	221,658	30,154	6,919	0	11.00
13.00	NURSING ADMINISTRATION	0	272,279	37,040	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	399,145	54,298	0	0	14.00
15.00	PHARMACY	0	1,384,351	188,323	49,431	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	84,988	11,562	59,713	0	16.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	33,942	4,617	0	0	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	7,195	979	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	171,052	8,187,712	1,113,832	808,578	63,795	30.00
34.00	SURGICAL INTENSIVE CARE UNIT	17,490	1,863,123	253,454	104,070	50,413	34.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	262,666	7,653,709	1,041,188	635,339	49,992	50.00
54.00	RADIOLOGY-DIAGNOSTIC	326,900	1,735,173	236,048	214,656	25,196	54.00
54.01	ULTRA SOUND	33,261	336,676	45,800	6,534	0	54.01
55.00	RADIOLOGY-THERAPEUTIC	66,632	2,814,415	382,865	164,130	527	55.00
60.00	LABORATORY	241,924	3,584,332	487,602	78,106	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	INTRAVENOUS THERAPY	3,039	26,797	3,645	0	0	64.00
65.00	RESPIRATORY THERAPY	28,120	1,074,716	146,201	26,042	0	65.00
66.00	PHYSICAL THERAPY	84,972	1,919,863	261,172	100,630	5,162	66.00
67.00	OCCUPATIONAL THERAPY	2,851	79,354	10,795	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	56,688	613,166	83,413	51,680	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	20,008	323,649	44,028	69,803	843	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	294,177	4,693,636	638,508	23,524	2,501	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	313,862	13,398,775	1,822,763	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	61,739	1,921,598	261,408	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	11,202	485,101	65,992	120,599	1,043	90.00
90.01	WOUND CARE INSTITUTE	3,018	41,054	5,585	0	697	90.01
90.02	OP NUTRITIONAL COUNSELING	427	22,635	3,079	0	0	90.02
90.03	BARITRIC MEDICINE	0	0	0	0	0	90.03
91.00	EMERGENCY	412,804	4,397,168	598,178	161,804	53,787	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,412,832	72,649,408	8,564,763	2,826,757	253,956	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	160,244	21,799	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	1,746,151	237,541	979,473	291	192.00
194.00	COMMUNITY RELATIONS & MARKETING	0	2,766,151	376,299	0	0	194.00
194.01	PLAINFIELD RADIOLOGY & PHYSICAL THER	0	462,877	62,968	0	0	194.01
194.02	JV MV ENDOSCOPY	0	2,960,045	402,676	95,845	9,793	194.02
194.03	SOUTHWEST CENTER FOR WOMENS HEALTH	0	180,478	24,552	0	0	194.03
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)	2,412,832	80,925,354	9,690,598	3,902,075	264,040	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
	9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.01 ADMITTING						5.01
5.02 PATIENT ACCOUNTING						5.02
5.03 OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING	1,527,647					9.00
10.00 DIETARY	42,530	608,801				10.00
11.00 CAFETERIA	2,735	0	261,466			11.00
13.00 NURSING ADMINISTRATION	0	0	0	309,319		13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	0	453,443	14.00
15.00 PHARMACY	19,540	0	9,363	0	71,987	15.00
16.00 MEDICAL RECORDS & LIBRARY	23,605	0	177	0	0	16.00
21.00 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	319,636	549,628	74,204	137,904	141,256	30.00
34.00 SURGICAL INTENSIVE CARE UNIT	41,140	59,173	14,907	27,695	18,245	34.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	251,154	0	38,407	71,369	0	50.00
54.00 RADIOLOGY-DIAGNOSTIC	84,855	0	29,128	0	56,048	54.00
54.01 ULTRA SOUND	2,583	0	2,840	0	1,182	54.01
55.00 RADIOLOGY-THERAPEUTIC	64,881	0	2,642	0	707	55.00
60.00 LABORATORY	30,876	0	0	0	3,694	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 INTRAVENOUS THERAPY	0	0	208	0	0	64.00
65.00 RESPIRATORY THERAPY	10,294	0	11,381	0	0	65.00
66.00 PHYSICAL THERAPY	39,780	0	22,439	0	880	66.00
67.00 OCCUPATIONAL THERAPY	0	0	915	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	20,429	0	863	0	33,256	69.00
70.00 ELECTROENCEPHALOGRAPHY	27,594	0	2,039	0	10,237	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	9,299	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	47,673	0	2,039	0	6,718	90.00
90.01 WOUND CARE INSTITUTE	0	0	406	0	3,316	90.01
90.02 OP NUTRITIONAL COUNSELING	0	0	364	0	0	90.02
90.03 BARIATRIC MEDICINE	0	0	0	0	0	90.03
91.00 EMERGENCY	63,962	0	38,928	72,351	104,517	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1,102,566	608,801	251,250	309,319	452,043	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	2,798	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	387,193	0	3,142	0	0	192.00
194.00 COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01 PLAINFIELD RADIOLOGY & PHYSICAL THER	0	0	4,276	0	1,400	194.01
194.02 JV MV ENDOSCOPY	37,888	0	0	0	0	194.02
194.03 SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
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)	1,527,647	608,801	261,466	309,319	453,443	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	INTERNS & RESIDENTS				Subtotal	
	PHARMACY	MEDICAL RECORDS & LIBRARY	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS		
			21.00	22.00		
15.00	16.00	21.00	22.00	24.00		
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.01	ADMITTING					5.01
5.02	PATIENT ACCOUNTING					5.02
5.03	OTHER ADMINISTRATIVE AND GENERAL					5.03
7.00	OPERATION OF PLANT					7.00
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
13.00	NURSING ADMINISTRATION					13.00
14.00	CENTRAL SERVICES & SUPPLY					14.00
15.00	PHARMACY	1,722,995				15.00
16.00	MEDICAL RECORDS & LIBRARY	0	180,045			16.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	38,559		21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	8,174	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	12,772	38,559	8,174	11,456,050
34.00	SURGICAL INTENSIVE CARE UNIT	0	1,306	0	0	2,433,526
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	19,613	0	0	9,760,771
54.00	RADIOLOGY-DIAGNOSTIC	0	24,409	0	0	2,405,513
54.01	ULTRA SOUND	0	2,484	0	0	398,099
55.00	RADIOLOGY-THERAPEUTIC	0	4,975	0	0	3,435,142
60.00	LABORATORY	0	18,064	0	0	4,202,674
60.01	BLOOD LABORATORY	0	0	0	0	0
64.00	INTRAVENOUS THERAPY	0	227	0	0	30,877
65.00	RESPIRATORY THERAPY	0	2,100	0	0	1,270,734
66.00	PHYSICAL THERAPY	0	6,345	0	0	2,356,271
67.00	OCCUPATIONAL THERAPY	0	213	0	0	91,277
68.00	SPEECH PATHOLOGY	0	0	0	0	0
69.00	ELECTROCARDIOLOGY	0	4,233	0	0	807,040
70.00	ELECTROENCEPHALOGRAPHY	0	1,494	0	0	479,687
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	21,966	0	0	5,389,434
72.00	IMPL. DEV. CHARGED TO PATIENT	0	23,436	0	0	15,244,974
73.00	DRUGS CHARGED TO PATIENTS	1,722,995	4,610	0	0	3,910,611
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	836	0	0	730,001
90.01	WOUND CARE INSTITUTE	0	225	0	0	51,283
90.02	OP NUTRITIONAL COUNSELING	0	32	0	0	26,110
90.03	BARIATRIC MEDICINE	0	0	0	0	0
91.00	EMERGENCY	0	30,705	0	0	5,521,400
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,722,995	180,045	38,559	8,174	70,001,474
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	184,841
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	3,353,791
194.00	COMMUNITY RELATIONS & MARKETING	0	0	0	0	3,142,450
194.01	PLAINFIELD RADIOLOGY & PHYSICAL THER	0	0	0	0	531,521
194.02	JV MV ENDOSCOPY	0	0	0	0	3,506,247
194.03	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	205,030
200.00	Cross Foot Adjustments			0	0	0
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118-201)	1,722,995	180,045	38,559	8,174	80,925,354

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet B
Part I
Date/Time Prepared:
5/29/2012 2:26 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	EMPLOYEE BENEFITS			4.00
5.01	ADMITTING			5.01
5.02	PATIENT ACCOUNTING			5.02
5.03	OTHER ADMINISTRATIVE AND GENERAL			5.03
7.00	OPERATION OF PLANT			7.00
8.00	LAUNDRY & LINEN SERVICE			8.00
9.00	HOUSEKEEPING			9.00
10.00	DIETARY			10.00
11.00	CAFETERIA			11.00
13.00	NURSING ADMINISTRATION			13.00
14.00	CENTRAL SERVICES & SUPPLY			14.00
15.00	PHARMACY			15.00
16.00	MEDICAL RECORDS & LIBRARY			16.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD			21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD			22.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-46,733	11,409,317	30.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	2,433,526	34.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	9,760,771	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	2,405,513	54.00
54.01	ULTRA SOUND	0	398,099	54.01
55.00	RADIOLOGY-THERAPEUTIC	0	3,435,142	55.00
60.00	LABORATORY	0	4,202,674	60.00
60.01	BLOOD LABORATORY	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	30,877	64.00
65.00	RESPIRATORY THERAPY	0	1,270,734	65.00
66.00	PHYSICAL THERAPY	0	2,356,271	66.00
67.00	OCCUPATIONAL THERAPY	0	91,277	67.00
68.00	SPEECH PATHOLOGY	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	807,040	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	479,687	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,389,434	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	15,244,974	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	3,910,611	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0	730,001	90.00
90.01	WOUND CARE INSTITUTE	0	51,283	90.01
90.02	OP NUTRITIONAL COUNSELING	0	26,110	90.02
90.03	BARITRIC MEDICINE	0	0	90.03
91.00	EMERGENCY	0	5,521,400	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE			113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-46,733	69,954,741	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	184,841	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	3,353,791	192.00
194.00	COMMUNITY RELATIONS & MARKETING	0	3,142,450	194.00
194.01	PLAINFIELD RADIOLOGY & PHYSICAL THER	0	531,521	194.01
194.02	JV MV ENDOSCOPY	0	3,506,247	194.02
194.03	SOUTHWEST CENTER FOR WOMENS HEALTH	0	205,030	194.03
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)	-46,733	80,878,621	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet B
Part II
Date/Time Prepared:
5/29/2012 2:26 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	2.00			
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS	0	11,274	9,364	20,638	4.00
5.01	ADMINISTRATIVE	0	38,035	31,591	69,626	5.01
5.02	PATIENT ACCOUNTING	0	0	0	0	5.02
5.03	OTHER ADMINISTRATIVE AND GENERAL	0	87,984	73,076	161,060	5.03
7.00	OPERATION OF PLANT	0	109,379	90,846	200,225	7.00
8.00	LAUNDRY & LINEN SERVICE	0	5,227	4,341	9,568	8.00
9.00	HOUSEKEEPING	0	21,979	18,255	40,234	9.00
10.00	DIETARY	0	77,822	64,636	142,458	10.00
11.00	CAFETERIA	0	5,005	4,157	9,162	11.00
13.00	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	PHARMACY	0	35,755	29,697	65,452	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	43,193	35,874	79,067	16.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	584,875	485,774	1,070,649	30.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	75,278	62,523	137,801	34.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	459,564	381,696	841,260	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	155,269	128,960	284,229	54.00
54.01	ULTRA SOUND	0	4,727	3,926	8,653	54.01
55.00	RADIOLOGY-THERAPEUTIC	0	118,721	98,605	217,326	55.00
60.00	LABORATORY	0	56,497	46,924	103,421	60.00
60.01	BLOOD LABORATORY	0	0	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	18,837	15,645	34,482	65.00
66.00	PHYSICAL THERAPY	0	72,790	60,456	133,246	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	37,382	31,048	68,430	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	50,491	41,936	92,427	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17,016	14,133	31,149	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	87,234	72,453	159,687	90.00
90.01	WOUND CARE INSTITUTE	0	0	0	0	90.01
90.02	OP NUTRITIONAL COUNSELING	0	0	0	0	90.02
90.03	BARIATRIC MEDICINE	0	0	0	0	90.03
91.00	EMERGENCY	0	117,039	97,208	214,247	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	2,291,373	1,903,124	4,194,497	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	708,488	588,444	1,296,932	192.00
194.00	COMMUNITY RELATIONS & MARKETING	0	0	0	0	194.00
194.01	PLAINFIELD RADIOLOGY & PHYSICAL THER	0	0	0	0	194.01
194.02	JV MV ENDOSCOPY	0	69,328	57,581	126,909	194.02
194.03	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	194.03
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	3,069,189	2,549,149	5,618,338	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150057		Period: From 01/01/2011 To 12/31/2011		Worksheet B Part II Date/Time Prepared: 5/29/2012 2:26 pm	
Cost Center Description	ADMITTING	PATIENT ACCOUNTING	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE		
	5.01	5.02	5.03	7.00	8.00		
GENERAL SERVICE COST CENTERS							
1.00 NEW CAP REL COSTS-BLDG & FIXT							1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP							2.00
4.00 EMPLOYEE BENEFITS							4.00
5.01 ADMITTING	70,413						5.01
5.02 PATIENT ACCOUNTING	0	683					5.02
5.03 OTHER ADMINISTRATIVE AND GENERAL	0	0	161,060				5.03
7.00 OPERATION OF PLANT	0	0	7,766	209,187			7.00
8.00 LAUNDRY & LINEN SERVICE	0	0	511	387	10,514		8.00
9.00 HOUSEKEEPING	0	0	2,980	1,629	0		9.00
10.00 DIETARY	0	0	913	5,768	0		10.00
11.00 CAFETERIA	0	0	501	371	0		11.00
13.00 NURSING ADMINISTRATION	0	0	616	0	0		13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	902	0	0		14.00
15.00 PHARMACY	0	0	3,130	2,650	0		15.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	192	3,201	0		16.00
21.00 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	77	0	0		21.00
22.00 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	16	0	0		22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	10,556	56	18,512	43,347	2,538		30.00
34.00 SURGICAL INTENSIVE CARE UNIT	1,122	6	4,213	5,579	2,007		34.00
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	12,292	86	17,305	34,060	1,991		50.00
54.00 RADIOLOGY-DIAGNOSTIC	1,631	106	3,923	11,508	1,003		54.00
54.01 ULTRA SOUND	150	11	761	350	0		54.01
55.00 RADIOLOGY-THERAPEUTIC	19	22	6,363	8,799	21		55.00
60.00 LABORATORY	4,186	79	8,104	4,187	0		60.00
60.01 BLOOD LABORATORY	0	0	0	0	0		60.01
64.00 INTRAVENOUS THERAPY	182	1	61	0	0		64.00
65.00 RESPIRATORY THERAPY	1,316	9	2,430	1,396	0		65.00
66.00 PHYSICAL THERAPY	1,967	28	4,341	5,395	206		66.00
67.00 OCCUPATIONAL THERAPY	13	1	179	0	0		67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0		68.00
69.00 ELECTROCARDIOLOGY	304	18	1,386	2,771	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0	7	732	3,742	34		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	11,102	96	10,612	1,261	100		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	20,021	102	30,294	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	5,552	20	4,345	0	0		73.00
OUTPATIENT SERVICE COST CENTERS							
90.00 CLINIC	0	4	1,097	6,465	42		90.00
90.01 WOUND CARE INSTITUTE	0	1	93	0	28		90.01
90.02 OP NUTRITIONAL COUNSELING	0	0	51	0	0		90.02
90.03 BARIATRIC MEDICINE	0	0	0	0	0		90.03
91.00 EMERGENCY	0	30	9,942	8,674	2,142		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)							92.00
OTHER REIMBURSABLE COST CENTERS							
99.10 CORF	0	0	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS							
113.00 INTEREST EXPENSE							113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	70,413	683	142,348	151,540	10,112		118.00
NONREIMBURSABLE COST CENTERS							
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	362	0	0		190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	3,948	52,509	12		192.00
194.00 COMMUNITY RELATIONS & MARKETING	0	0	6,254	0	0		194.00
194.01 PLAINFIELD RADIOLOGY & PHYSICAL THER	0	0	1,047	0	0		194.01
194.02 JV MV ENDOSCOPY	0	0	6,693	5,138	390		194.02
194.03 SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	408	0	0		194.03
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)	70,413	683	161,060	209,187	10,514		202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150057			Period: From 01/01/2011 To 12/31/2011		Worksheet B Part II Date/Time Prepared: 5/29/2012 2:26 pm	
Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY		
		9.00	10.00	11.00	13.00	14.00		
GENERAL SERVICE COST CENTERS								
1.00	NEW CAP REL COSTS-BLDG & FIXT							1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP							2.00
4.00	EMPLOYEE BENEFITS							4.00
5.01	ADMITTING							5.01
5.02	PATIENT ACCOUNTING							5.02
5.03	OTHER ADMINISTRATIVE AND GENERAL							5.03
7.00	OPERATION OF PLANT							7.00
8.00	LAUNDRY & LINEN SERVICE							8.00
9.00	HOUSEKEEPING	45,653						9.00
10.00	DIETARY	1,271	150,548					10.00
11.00	CAFETERIA	82	0	10,375				11.00
13.00	NURSING ADMINISTRATION	0	0	0	616			13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	948		14.00
15.00	PHARMACY	584	0	372	0	151		15.00
16.00	MEDICAL RECORDS & LIBRARY	705	0	7	0	0		16.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0		21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0		22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	9,552	135,915	2,943	275	295		30.00
34.00	SURGICAL INTENSIVE CARE UNIT	1,229	14,633	592	55	38		34.00
ANCILLARY SERVICE COST CENTERS								
50.00	OPERATING ROOM	7,506	0	1,524	142	0		50.00
54.00	RADIOLOGY-DIAGNOSTIC	2,536	0	1,156	0	117		54.00
54.01	ULTRA SOUND	77	0	113	0	2		54.01
55.00	RADIOLOGY-THERAPEUTIC	1,939	0	105	0	1		55.00
60.00	LABORATORY	923	0	0	0	8		60.00
60.01	BLOOD LABORATORY	0	0	0	0	0		60.01
64.00	INTRAVENOUS THERAPY	0	0	8	0	0		64.00
65.00	RESPIRATORY THERAPY	308	0	452	0	0		65.00
66.00	PHYSICAL THERAPY	1,189	0	890	0	2		66.00
67.00	OCCUPATIONAL THERAPY	0	0	36	0	0		67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0		68.00
69.00	ELECTROCARDIOLOGY	611	0	34	0	70		69.00
70.00	ELECTROENCEPHALOGRAPHY	825	0	81	0	21		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	278	0	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	CLINIC	1,425	0	81	0	14		90.00
90.01	WOUND CARE INSTITUTE	0	0	16	0	7		90.01
90.02	OP NUTRITIONAL COUNSELING	0	0	14	0	0		90.02
90.03	BARIATRIC MEDICINE	0	0	0	0	0		90.03
91.00	EMERGENCY	1,911	0	1,545	144	219		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)							92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	CORF	0	0	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS								
113.00	INTEREST EXPENSE							113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	32,951	150,548	9,969	616	945		118.00
NONREIMBURSABLE COST CENTERS								
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	111	0	0		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	11,570	0	125	0	0		192.00
194.00	COMMUNITY RELATIONS & MARKETING	0	0	0	0	0		194.00
194.01	PLAINFIELD RADIOLOGY & PHYSICAL THER	0	0	170	0	3		194.01
194.02	JV MV ENDOSCOPY	1,132	0	0	0	0		194.02
194.03	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0		194.03
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)	45,653	150,548	10,375	616	948		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet B
Part II
Date/Time Prepared:
5/29/2012 2:26 pm

Cost Center Description	INTERNS & RESIDENTS				Subtotal	
	PHARMACY	MEDICAL RECORDS & LIBRARY	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
			21.00	22.00		
	15.00	16.00	21.00	22.00	24.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
4.00						4.00
5.01						5.01
5.02						5.02
5.03						5.03
7.00						7.00
8.00						8.00
9.00						9.00
10.00						10.00
11.00						11.00
13.00						13.00
14.00						14.00
15.00	73,064					15.00
16.00		83,180				16.00
21.00			77			21.00
22.00				16		22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00		5,903			1,305,386	30.00
34.00		604			169,109	34.00
ANCILLARY SERVICE COST CENTERS						
50.00		9,065			927,247	50.00
54.00		11,282			318,983	54.00
54.01		1,148			11,476	54.01
55.00		2,300			237,117	55.00
60.00		8,349			129,257	60.00
60.01		0			0	60.01
64.00		105			372	64.00
65.00		970			42,100	65.00
66.00		2,933			151,426	66.00
67.00		98			378	67.00
68.00		0			0	68.00
69.00		1,956			75,654	69.00
70.00		691			98,706	70.00
71.00		10,153			64,751	71.00
72.00		10,832			61,249	72.00
73.00	73,064	2,131			85,112	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00		387			169,443	90.00
90.01		104			274	90.01
90.02		15			100	90.02
90.03		0			0	90.03
91.00		14,154			255,595	91.00
92.00						92.00
OTHER REIMBURSABLE COST CENTERS						
99.10		0			0	99.10
SPECIAL PURPOSE COST CENTERS						
113.00						113.00
118.00	73,064	83,180	0	0	4,103,735	118.00
NONREIMBURSABLE COST CENTERS						
190.00		0			537	190.00
192.00		0			1,365,306	192.00
194.00		0			6,502	194.00
194.01		0			1,495	194.01
194.02		0			140,262	194.02
194.03		0			408	194.03
200.00			77	16	93	200.00
201.00		0	0	0	0	201.00
202.00	73,064	83,180	77	16	5,618,338	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet B
Part II
Date/Time Prepared:
5/29/2012 2:26 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	EMPLOYEE BENEFITS			4.00
5.01	ADMITTING			5.01
5.02	PATIENT ACCOUNTING			5.02
5.03	OTHER ADMINISTRATIVE AND GENERAL			5.03
7.00	OPERATION OF PLANT			7.00
8.00	LAUNDRY & LINEN SERVICE			8.00
9.00	HOUSEKEEPING			9.00
10.00	DIETARY			10.00
11.00	CAFETERIA			11.00
13.00	NURSING ADMINISTRATION			13.00
14.00	CENTRAL SERVICES & SUPPLY			14.00
15.00	PHARMACY			15.00
16.00	MEDICAL RECORDS & LIBRARY			16.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD			21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD			22.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	1,305,386	30.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	169,109	34.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	927,247	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	318,983	54.00
54.01	ULTRA SOUND	0	11,476	54.01
55.00	RADIOLOGY-THERAPEUTIC	0	237,117	55.00
60.00	LABORATORY	0	129,257	60.00
60.01	BLOOD LABORATORY	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	372	64.00
65.00	RESPIRATORY THERAPY	0	42,100	65.00
66.00	PHYSICAL THERAPY	0	151,426	66.00
67.00	OCCUPATIONAL THERAPY	0	378	67.00
68.00	SPEECH PATHOLOGY	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	75,654	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	98,706	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	64,751	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	61,249	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	85,112	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0	169,443	90.00
90.01	WOUND CARE INSTITUTE	0	274	90.01
90.02	OP NUTRITIONAL COUNSELING	0	100	90.02
90.03	BARIATRIC MEDICINE	0	0	90.03
91.00	EMERGENCY	0	255,595	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE			113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	4,103,735	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	537	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	1,365,306	192.00
194.00	COMMUNITY RELATIONS & MARKETING	0	6,502	194.00
194.01	PLAINFIELD RADIOLOGY & PHYSICAL THER	0	1,495	194.01
194.02	JV MV ENDOSCOPY	0	140,262	194.02
194.03	SOUTHWEST CENTER FOR WOMENS HEALTH	0	408	194.03
200.00	Cross Foot Adjustments	0	93	200.00
201.00	Negative Cost Centers	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	5,618,338	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet B-1
Date/Time Prepared:
5/29/2012 2:26 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	ADMITTING (INPATIENT CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT	220,777					1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP		220,777				2.00
4.00 EMPLOYEE BENEFITS	811	811	20,274,630			4.00
5.01 ADMITTING	2,736	2,736	772,948	119,126,568		5.01
5.02 PATIENT ACCOUNTING	0	0	671,176	0	261,875,785	5.02
5.03 OTHER ADMINISTRATIVE AND GENERAL	6,329	6,329	0	0	0	5.03
7.00 OPERATION OF PLANT	7,868	7,868	1,174,947	0	0	7.00
8.00 LAUNDRY & LINEN SERVICE	376	376	46,892	0	0	8.00
9.00 HOUSEKEEPING	1,581	1,581	796,073	0	0	9.00
10.00 DIETARY	5,598	5,598	135,505	0	0	10.00
11.00 CAFETERIA	360	360	254,862	0	0	11.00
13.00 NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	45,479	0	0	14.00
15.00 PHARMACY	2,572	2,572	711,793	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	3,107	3,107	8,201	0	0	16.00
21.00 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	42,072	42,072	4,760,086	17,861,243	18,564,371	30.00
34.00 SURGICAL INTENSIVE CARE UNIT	5,415	5,415	1,208,433	1,898,244	1,898,244	34.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	33,058	33,058	1,980,249	20,798,176	28,507,225	50.00
54.00 RADIOLOGY-DIAGNOSTIC	11,169	11,169	1,465,716	2,759,345	35,478,653	54.00
54.01 ULTRA SOUND	340	340	207,247	253,073	3,609,781	54.01
55.00 RADIOLOGY-THERAPEUTIC	8,540	8,540	217,828	31,756	7,231,646	55.00
60.00 LABORATORY	4,064	4,064	0	7,082,824	26,256,158	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 INTRAVENOUS THERAPY	0	0	14,542	307,433	329,817	64.00
65.00 RESPIRATORY THERAPY	1,355	1,355	723,592	2,226,810	3,051,844	65.00
66.00 PHYSICAL THERAPY	5,236	5,236	1,207,699	3,328,929	9,222,086	66.00
67.00 OCCUPATIONAL THERAPY	0	0	49,894	22,488	309,405	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	2,689	2,689	72,207	514,756	6,152,409	69.00
70.00 ELECTROENCEPHALOGRAPHY	3,632	3,632	143,069	0	2,171,532	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,224	1,224	0	18,784,995	31,927,178	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	33,862,169	34,063,653	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	9,394,327	6,700,591	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	6,275	6,275	236,972	0	1,215,799	90.00
90.01 WOUND CARE INSTITUTE	0	0	24,720	0	327,541	90.01
90.02 OP NUTRITIONAL COUNSELING	0	0	19,436	0	46,308	90.02
90.03 BARIATRIC MEDICINE	0	0	0	0	0	90.03
91.00 EMERGENCY	8,419	8,419	2,541,544	0	44,811,544	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	164,826	164,826	19,491,110	119,126,568	261,875,785	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	62,869	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	50,964	50,964	206,516	0	0	192.00
194.00 COMMUNITY RELATIONS & MARKETING	0	0	243,539	0	0	194.00
194.01 PLAINFIELD RADIOLOGY & PHYSICAL THER	0	0	270,596	0	0	194.01
194.02 JMV ENDOSCOPY	4,987	4,987	0	0	0	194.02
194.03 SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	3,069,189	2,549,149	686,780	1,638,755	2,412,832	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	13.901761	11.546262	0.033874	0.013756	0.009214	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			20,638	70,413	683	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.001018	0.000591	0.000003	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet B-1
Date/Time Prepared:
5/29/2012 2:26 pm

Cost Center Description	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
	5A.03	5.03	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.01 ADMITTING						5.01
5.02 PATIENT ACCOUNTING						5.02
5.03 OTHER ADMINISTRATIVE AND GENERAL	-9,690,598	71,234,756				5.03
7.00 OPERATION OF PLANT	0	3,434,813	203,033			7.00
8.00 LAUNDRY & LINEN SERVICE	0	226,061	376	241,045		8.00
9.00 HOUSEKEEPING	0	1,317,969	1,581	0	201,076	9.00
10.00 DIETARY	0	403,757	5,598	0	5,598	10.00
11.00 CAFETERIA	0	221,658	360	0	360	11.00
13.00 NURSING ADMINISTRATION	0	272,279	0	0	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	399,145	0	0	0	14.00
15.00 PHARMACY	0	1,384,351	2,572	0	2,572	15.00
16.00 MEDICAL RECORDS & LIBRARY	0	84,988	3,107	0	3,107	16.00
21.00 I&R SERVICES-SALARY & FRINGES APPRVD	0	33,942	0	0	0	21.00
22.00 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	7,195	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	0	8,187,712	42,072	58,239	42,072	30.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	1,863,123	5,415	46,023	5,415	34.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	7,653,709	33,058	45,638	33,058	50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	1,735,173	11,169	23,002	11,169	54.00
54.01 ULTRA SOUND	0	336,676	340	0	340	54.01
55.00 RADIOLOGY-THERAPEUTIC	0	2,814,415	8,540	481	8,540	55.00
60.00 LABORATORY	0	3,584,332	4,064	0	4,064	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 INTRAVENOUS THERAPY	0	26,797	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	1,074,716	1,355	0	1,355	65.00
66.00 PHYSICAL THERAPY	0	1,919,863	5,236	4,712	5,236	66.00
67.00 OCCUPATIONAL THERAPY	0	79,354	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	613,166	2,689	0	2,689	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	323,649	3,632	770	3,632	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,693,636	1,224	2,283	1,224	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	13,398,775	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	1,921,598	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	485,101	6,275	952	6,275	90.00
90.01 WOUND CARE INSTITUTE	0	41,054	0	636	0	90.01
90.02 OP NUTRITIONAL COUNSELING	0	22,635	0	0	0	90.02
90.03 BARIATRIC MEDICINE	0	0	0	0	0	90.03
91.00 EMERGENCY	0	4,397,168	8,419	49,103	8,419	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-9,690,598	62,958,810	147,082	231,839	145,125	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	160,244	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	1,746,151	50,964	266	50,964	192.00
194.00 COMMUNITY RELATIONS & MARKETING	0	2,766,151	0	0	0	194.00
194.01 PLAINFIELD RADIOLOGY & PHYSICAL THER	0	462,877	0	0	0	194.01
194.02 JV MV ENDOSCOPY	0	2,960,045	4,987	8,940	4,987	194.02
194.03 SOUTHWEST CENTER FOR WOMENS HEALTH	0	180,478	0	0	0	194.03
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)		9,690,598	3,902,075	264,040	1,527,647	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)		0.136037	19.218920	1.095397	7.597361	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)		161,060	209,187	10,514	45,653	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)		0.002261	1.030310	0.043618	0.227044	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet B-1
Date/Time Prepared:
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Cost Center Description	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
	10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.01 ADMITTING						5.01
5.02 PATIENT ACCOUNTING						5.02
5.03 OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY	11,698					10.00
11.00 CAFETERIA	0	25,134				11.00
13.00 NURSING ADMINISTRATION	0	0	332,800			13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	608,142		14.00
15.00 PHARMACY	0	900	0	96,547	100	15.00
16.00 MEDICAL RECORDS & LIBRARY	0	17	0	0	0	16.00
21.00 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	10,561	7,133	148,373	189,450	0	30.00
34.00 SURGICAL INTENSIVE CARE UNIT	1,137	1,433	29,797	24,469	0	34.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	3,692	76,787	0	0	50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	2,800	0	75,169	0	54.00
54.01 ULTRA SOUND	0	273	0	1,585	0	54.01
55.00 RADIOLOGY-THERAPEUTIC	0	254	0	948	0	55.00
60.00 LABORATORY	0	0	0	4,954	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 INTRAVENOUS THERAPY	0	20	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	1,094	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	2,157	0	1,180	0	66.00
67.00 OCCUPATIONAL THERAPY	0	88	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	83	0	44,602	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	196	0	13,730	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	196	0	9,010	0	90.00
90.01 WOUND CARE INSTITUTE	0	39	0	4,447	0	90.01
90.02 OP NUTRITIONAL COUNSELING	0	35	0	0	0	90.02
90.03 BARIATRIC MEDICINE	0	0	0	0	0	90.03
91.00 EMERGENCY	0	3,742	77,843	140,174	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	11,698	24,152	332,800	606,265	100	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	269	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	302	0	0	0	192.00
194.00 COMMUNITY RELATIONS & MARKETING	0	0	0	0	0	194.00
194.01 PLAINFIELD RADIOLOGY & PHYSICAL THER	0	411	0	1,877	0	194.01
194.02 JV MV ENDOSCOPY	0	0	0	0	0	194.02
194.03 SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0	194.03
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)	608,801	261,466	309,319	453,443	1,722,995	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	52.043170	10.402881	0.929444	0.745620	17,229.950000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	150,548	10,375	616	948	73,064	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	12.869550	0.412787	0.001851	0.001559	730.640000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet B-1
Date/Time Prepared:
5/29/2012 2:26 pm

Cost Center Description	INTERNS & RESIDENTS			
	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	
	16.00	21.00	22.00	
GENERAL SERVICE COST CENTERS				
1.00 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00 EMPLOYEE BENEFITS				4.00
5.01 ADMITTING				5.01
5.02 PATIENT ACCOUNTING				5.02
5.03 OTHER ADMINISTRATIVE AND GENERAL				5.03
7.00 OPERATION OF PLANT				7.00
8.00 LAUNDRY & LINEN SERVICE				8.00
9.00 HOUSEKEEPING				9.00
10.00 DIETARY				10.00
11.00 CAFETERIA				11.00
13.00 NURSING ADMINISTRATION				13.00
14.00 CENTRAL SERVICES & SUPPLY				14.00
15.00 PHARMACY				15.00
16.00 MEDICAL RECORDS & LIBRARY	261,875,785			16.00
21.00 I&R SERVICES-SALARY & FRINGES APPRVD	0	100		21.00
22.00 I&R SERVICES-OTHER PRGM COSTS APPRVD	0		100	22.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS	18,564,371	100	100	30.00
34.00 SURGICAL INTENSIVE CARE UNIT	1,898,244	0	0	34.00
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	28,507,225	0	0	50.00
54.00 RADIOLOGY-DIAGNOSTIC	35,478,653	0	0	54.00
54.01 ULTRA SOUND	3,609,781	0	0	54.01
55.00 RADIOLOGY-THERAPEUTIC	7,231,646	0	0	55.00
60.00 LABORATORY	26,256,158	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	60.01
64.00 INTRAVENOUS THERAPY	329,817	0	0	64.00
65.00 RESPIRATORY THERAPY	3,051,844	0	0	65.00
66.00 PHYSICAL THERAPY	9,222,086	0	0	66.00
67.00 OCCUPATIONAL THERAPY	309,405	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	6,152,409	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	2,171,532	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	31,927,178	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	34,063,653	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	6,700,591	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 CLINIC	1,215,799	0	0	90.00
90.01 WOUND CARE INSTITUTE	327,541	0	0	90.01
90.02 OP NUTRITIONAL COUNSELING	46,308	0	0	90.02
90.03 BARIATRIC MEDICINE	0	0	0	90.03
91.00 EMERGENCY	44,811,544	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
OTHER REIMBURSABLE COST CENTERS				
99.10 CORF	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS				
113.00 INTEREST EXPENSE				113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	261,875,785	100	100	118.00
NONREIMBURSABLE COST CENTERS				
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00 COMMUNITY RELATIONS & MARKETING	0	0	0	194.00
194.01 PLAINFIELD RADIOLOGY & PHYSICAL THER	0	0	0	194.01
194.02 JMV ENDOSCOPY	0	0	0	194.02
194.03 SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	194.03
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)	180,045	38,559	8,174	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.000688	385.590000	81.740000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	83,180	77	16	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.000318	0.770000	0.160000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150057	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/29/2012 2:26 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS		11,409,317	0	11,409,317	30.00
34.00	SURGICAL INTENSIVE CARE UNIT		2,433,526	0	2,433,526	34.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM		9,760,771	0	9,760,771	50.00
54.00	RADIOLOGY-DIAGNOSTIC		2,405,513	0	2,405,513	54.00
54.01	ULTRA SOUND		398,099	0	398,099	54.01
55.00	RADIOLOGY-THERAPEUTIC		3,435,142	0	3,435,142	55.00
60.00	LABORATORY		4,202,674	0	4,202,674	60.00
60.01	BLOOD LABORATORY		0	0	0	60.01
64.00	INTRAVENOUS THERAPY		30,877	0	30,877	64.00
65.00	RESPIRATORY THERAPY	0	1,270,734	0	1,270,734	65.00
66.00	PHYSICAL THERAPY	0	2,356,271	0	2,356,271	66.00
67.00	OCCUPATIONAL THERAPY	0	91,277	0	91,277	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY		807,040	0	807,040	69.00
70.00	ELECTROENCEPHALOGRAPHY		479,687	0	479,687	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		5,389,434	0	5,389,434	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT		15,244,974	0	15,244,974	72.00
73.00	DRUGS CHARGED TO PATIENTS		3,910,611	0	3,910,611	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC		730,001	0	730,001	90.00
90.01	WOUND CARE INSTITUTE		51,283	0	51,283	90.01
90.02	OP NUTRITIONAL COUNSELING		26,110	0	26,110	90.02
90.03	BARIATRIC MEDICINE		0	0	0	90.03
91.00	EMERGENCY		5,521,400	0	5,521,400	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		428,381		428,381	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF	0	0		0	99.10
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	0	70,383,122	0	70,383,122	200.00
201.00	Less Observation Beds		428,381		428,381	201.00
202.00	Total (see instructions)	0	69,954,741	0	69,954,741	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet C
Part I
Date/Time Prepared:
5/29/2012 2:26 pm

		Title XVIIII			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	17,861,243		17,861,243			30.00
34.00	SURGICAL INTENSIVE CARE UNIT	1,898,244		1,898,244			34.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	20,798,176	7,709,049	28,507,225	0.342396	0.000000	50.00
54.00	RADIOLOGY-DIAGNOSTIC	2,759,345	32,719,308	35,478,653	0.067802	0.000000	54.00
54.01	ULTRA SOUND	253,073	3,356,708	3,609,781	0.110283	0.000000	54.01
55.00	RADIOLOGY-THERAPEUTIC	31,756	7,199,890	7,231,646	0.475015	0.000000	55.00
60.00	LABORATORY	7,082,824	19,173,334	26,256,158	0.160064	0.000000	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
64.00	INTRAVENOUS THERAPY	234,374	95,443	329,817	0.093619	0.000000	64.00
65.00	RESPIRATORY THERAPY	2,226,810	825,034	3,051,844	0.416382	0.000000	65.00
66.00	PHYSICAL THERAPY	3,328,929	5,893,157	9,222,086	0.255503	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	22,487	286,918	309,405	0.295008	0.000000	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	ELECTROCARDIOLOGY	514,756	5,637,653	6,152,409	0.131175	0.000000	69.00
70.00	ELECTROENCEPHALOGRAPHY	506	2,171,026	2,171,532	0.220898	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,877,311	7,049,867	31,927,178	0.168804	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	33,862,169	201,484	34,063,653	0.447544	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	4,876,471	1,824,120	6,700,591	0.583622	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	1,785	1,214,014	1,215,799	0.600429	0.000000	90.00
90.01	WOUND CARE INSTITUTE	3,396	324,145	327,541	0.156570	0.000000	90.01
90.02	OP NUTRITIONAL COUNSELING	0	46,308	46,308	0.563833	0.000000	90.02
90.03	BARIATRIC MEDICINE	0	0	0	0.000000	0.000000	90.03
91.00	EMERGENCY	3,387,659	41,423,885	44,811,544	0.123214	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	158,283	544,845	703,128	0.609250	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0	0	0			99.10
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	124,179,597	137,696,188	261,875,785			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	124,179,597	137,696,188	261,875,785			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet C
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
34.00	SURGICAL INTENSIVE CARE UNIT				34.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.342396			50.00
54.00	RADIOLOGY-DIAGNOSTIC	0.067802			54.00
54.01	ULTRA SOUND	0.110283			54.01
55.00	RADIOLOGY-THERAPEUTIC	0.475015			55.00
60.00	LABORATORY	0.160064			60.00
60.01	BLOOD LABORATORY	0.000000			60.01
64.00	INTRAVENOUS THERAPY	0.093619			64.00
65.00	RESPIRATORY THERAPY	0.416382			65.00
66.00	PHYSICAL THERAPY	0.255503			66.00
67.00	OCCUPATIONAL THERAPY	0.295008			67.00
68.00	SPEECH PATHOLOGY	0.000000			68.00
69.00	ELECTROCARDIOLOGY	0.131175			69.00
70.00	ELECTROENCEPHALOGRAPHY	0.220898			70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.168804			71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.447544			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.583622			73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0.600429			90.00
90.01	WOUND CARE INSTITUTE	0.156570			90.01
90.02	OP NUTRITIONAL COUNSELING	0.563833			90.02
90.03	BARIATRIC MEDICINE	0.000000			90.03
91.00	EMERGENCY	0.123214			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.609250			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	CORF				99.10
SPECIAL PURPOSE COST CENTERS					
113.00	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: 150057	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/29/2012 2:26 pm
		Title XIX	Hospital	PPS

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS		11,409,317	0	11,409,317	30.00
34.00	SURGICAL INTENSIVE CARE UNIT		2,433,526	0	2,433,526	34.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM		9,760,771	0	9,760,771	50.00
54.00	RADIOLOGY-DIAGNOSTIC		2,405,513	0	2,405,513	54.00
54.01	ULTRA SOUND		398,099	0	398,099	54.01
55.00	RADIOLOGY-THERAPEUTIC		3,435,142	0	3,435,142	55.00
60.00	LABORATORY		4,202,674	0	4,202,674	60.00
60.01	BLOOD LABORATORY		0	0	0	60.01
64.00	INTRAVENOUS THERAPY		30,877	0	30,877	64.00
65.00	RESPIRATORY THERAPY	0	1,270,734	0	1,270,734	65.00
66.00	PHYSICAL THERAPY	0	2,356,271	0	2,356,271	66.00
67.00	OCCUPATIONAL THERAPY	0	91,277	0	91,277	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY		807,040	0	807,040	69.00
70.00	ELECTROENCEPHALOGRAPHY		479,687	0	479,687	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		5,389,434	0	5,389,434	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT		15,244,974	0	15,244,974	72.00
73.00	DRUGS CHARGED TO PATIENTS		3,910,611	0	3,910,611	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC		730,001	0	730,001	90.00
90.01	WOUND CARE INSTITUTE		51,283	0	51,283	90.01
90.02	OP NUTRITIONAL COUNSELING		26,110	0	26,110	90.02
90.03	BARIATRIC MEDICINE		0	0	0	90.03
91.00	EMERGENCY		5,521,400	0	5,521,400	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		428,381		428,381	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF	0	0		0	99.10
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	0	70,383,122	0	70,383,122	200.00
201.00	Less Observation Beds		428,381		428,381	201.00
202.00	Total (see instructions)	0	69,954,741	0	69,954,741	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

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		Title XIX			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	17,861,243		17,861,243			30.00
34.00	SURGICAL INTENSIVE CARE UNIT	1,898,244		1,898,244			34.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	20,798,176	7,709,049	28,507,225	0.342396	0.000000	50.00
54.00	RADIOLOGY-DIAGNOSTIC	2,759,345	32,719,308	35,478,653	0.067802	0.000000	54.00
54.01	ULTRA SOUND	253,073	3,356,708	3,609,781	0.110283	0.000000	54.01
55.00	RADIOLOGY-THERAPEUTIC	31,756	7,199,890	7,231,646	0.475015	0.000000	55.00
60.00	LABORATORY	7,082,824	19,173,334	26,256,158	0.160064	0.000000	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
64.00	INTRAVENOUS THERAPY	234,374	95,443	329,817	0.093619	0.000000	64.00
65.00	RESPIRATORY THERAPY	2,226,810	825,034	3,051,844	0.416382	0.000000	65.00
66.00	PHYSICAL THERAPY	3,328,929	5,893,157	9,222,086	0.255503	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	22,487	286,918	309,405	0.295008	0.000000	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	ELECTROCARDIOLOGY	514,756	5,637,653	6,152,409	0.131175	0.000000	69.00
70.00	ELECTROENCEPHALOGRAPHY	506	2,171,026	2,171,532	0.220898	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,877,311	7,049,867	31,927,178	0.168804	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	33,862,169	201,484	34,063,653	0.447544	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	4,876,471	1,824,120	6,700,591	0.583622	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	1,785	1,214,014	1,215,799	0.600429	0.000000	90.00
90.01	WOUND CARE INSTITUTE	3,396	324,145	327,541	0.156570	0.000000	90.01
90.02	OP NUTRITIONAL COUNSELING	0	46,308	46,308	0.563833	0.000000	90.02
90.03	BARIATRIC MEDICINE	0	0	0	0.000000	0.000000	90.03
91.00	EMERGENCY	3,387,659	41,423,885	44,811,544	0.123214	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	158,283	544,845	703,128	0.609250	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0	0	0			99.10
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	124,179,597	137,696,188	261,875,785			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	124,179,597	137,696,188	261,875,785			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet C
Part I
Date/Time Prepared:
5/29/2012 2:26 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	PPS
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
34.00	SURGICAL INTENSIVE CARE UNIT				34.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.342396			50.00
54.00	RADIOLOGY-DIAGNOSTIC	0.067802			54.00
54.01	ULTRA SOUND	0.110283			54.01
55.00	RADIOLOGY-THERAPEUTIC	0.475015			55.00
60.00	LABORATORY	0.160064			60.00
60.01	BLOOD LABORATORY	0.000000			60.01
64.00	INTRAVENOUS THERAPY	0.093619			64.00
65.00	RESPIRATORY THERAPY	0.416382			65.00
66.00	PHYSICAL THERAPY	0.255503			66.00
67.00	OCCUPATIONAL THERAPY	0.295008			67.00
68.00	SPEECH PATHOLOGY	0.000000			68.00
69.00	ELECTROCARDIOLOGY	0.131175			69.00
70.00	ELECTROENCEPHALOGRAPHY	0.220898			70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.168804			71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.447544			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.583622			73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0.600429			90.00
90.01	WOUND CARE INSTITUTE	0.156570			90.01
90.02	OP NUTRITIONAL COUNSELING	0.563833			90.02
90.03	BARIATRIC MEDICINE	0.000000			90.03
91.00	EMERGENCY	0.123214			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.609250			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	CORF				99.10
SPECIAL PURPOSE COST CENTERS					
113.00	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

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 150057

Period: From 01/01/2011 To 12/31/2011

Worksheet C Part II Date/Time Prepared: 5/29/2012 2:26 pm

Cost Center Description		Title XIX			Hospital		PPS
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	9,760,771	927,247	8,833,524	0	0	50.00
54.00	RADIOLOGY-DIAGNOSTIC	2,405,513	318,983	2,086,530	0	0	54.00
54.01	ULTRA SOUND	398,099	11,476	386,623	0	0	54.01
55.00	RADIOLOGY-THERAPEUTIC	3,435,142	237,117	3,198,025	0	0	55.00
60.00	LABORATORY	4,202,674	129,257	4,073,417	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	INTRAVENOUS THERAPY	30,877	372	30,505	0	0	64.00
65.00	RESPIRATORY THERAPY	1,270,734	42,100	1,228,634	0	0	65.00
66.00	PHYSICAL THERAPY	2,356,271	151,426	2,204,845	0	0	66.00
67.00	OCCUPATIONAL THERAPY	91,277	378	90,899	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	807,040	75,654	731,386	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	479,687	98,706	380,981	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,389,434	64,751	5,324,683	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	15,244,974	61,249	15,183,725	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	3,910,611	85,112	3,825,499	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	730,001	169,443	560,558	0	0	90.00
90.01	WOUND CARE INSTITUTE	51,283	274	51,009	0	0	90.01
90.02	OP NUTRITIONAL COUNSELING	26,110	100	26,010	0	0	90.02
90.03	BARIATRIC MEDICINE	0	0	0	0	0	90.03
91.00	EMERGENCY	5,521,400	255,595	5,265,805	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	428,381	49,013	379,368	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (sum of lines 50 thru 199)	56,540,279	2,678,253	53,862,026	0	0	200.00
201.00	Less Observation Beds	428,381	49,013	379,368	0	0	201.00
202.00	Total (line 200 minus line 201)	56,111,898	2,629,240	53,482,658	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 150057

Period: From 01/01/2011 To 12/31/2011

Worksheet C Part II Date/Time Prepared: 5/29/2012 2:26 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	9,760,771	28,507,225	0.342396		50.00
54.00	RADIOLOGY-DIAGNOSTIC	2,405,513	35,478,653	0.067802		54.00
54.01	ULTRA SOUND	398,099	3,609,781	0.110283		54.01
55.00	RADIOLOGY-THERAPEUTIC	3,435,142	7,231,646	0.475015		55.00
60.00	LABORATORY	4,202,674	26,256,158	0.160064		60.00
60.01	BLOOD LABORATORY	0	0	0.000000		60.01
64.00	INTRAVENOUS THERAPY	30,877	329,817	0.093619		64.00
65.00	RESPIRATORY THERAPY	1,270,734	3,051,844	0.416382		65.00
66.00	PHYSICAL THERAPY	2,356,271	9,222,086	0.255503		66.00
67.00	OCCUPATIONAL THERAPY	91,277	309,405	0.295008		67.00
68.00	SPEECH PATHOLOGY	0	0	0.000000		68.00
69.00	ELECTROCARDIOLOGY	807,040	6,152,409	0.131175		69.00
70.00	ELECTROENCEPHALOGRAPHY	479,687	2,171,532	0.220898		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,389,434	31,927,178	0.168804		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	15,244,974	34,063,653	0.447544		72.00
73.00	DRUGS CHARGED TO PATIENTS	3,910,611	6,700,591	0.583622		73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	730,001	1,215,799	0.600429		90.00
90.01	WOUND CARE INSTITUTE	51,283	327,541	0.156570		90.01
90.02	OP NUTRITIONAL COUNSELING	26,110	46,308	0.563833		90.02
90.03	BARIATRIC MEDICINE	0	0	0.000000		90.03
91.00	EMERGENCY	5,521,400	44,811,544	0.123214		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	428,381	703,128	0.609250		92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF	0	0	0.000000		99.10
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
200.00	Subtotal (sum of lines 50 thru 199)	56,540,279	0			200.00
201.00	Less Observation Beds	428,381	0			201.00
202.00	Total (line 200 minus line 201)	56,111,898	242,116,298			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150057		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part I Date/Time Prepared: 5/29/2012 2:26 pm	
Cost Center Description		Title XVIII		Hospital		PPS	
		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	1,305,386	0	1,305,386	10,973	118.96	30.00
34.00	SURGICAL INTENSIVE CARE UNIT	169,109		169,109	1,137	148.73	34.00
200.00	Total (lines 30-199)	1,474,495		1,474,495	13,069		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150057		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part I Date/Time Prepared: 5/29/2012 2:26 pm	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Title XVIII	Hospital	PPS	
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	5,019	597,060				30.00
34.00	SURGICAL INTENSIVE CARE UNIT	312	46,404				34.00
200.00	Total (lines 30-199)	5,331	643,464				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150057	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part II Date/Time Prepared: 5/29/2012 2:26 pm
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Cost Center Description		Title XVIII			Hospital	PPS	
		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	OPERATING ROOM	927,247	28,507,225	0.032527	9,569,686	311,273	50.00
54.00	RADIOLOGY-DIAGNOSTIC	318,983	35,478,653	0.008991	1,263,852	11,363	54.00
54.01	ULTRA SOUND	11,476	3,609,781	0.003179	77,386	246	54.01
55.00	RADIOLOGY-THERAPEUTIC	237,117	7,231,646	0.032789	17,282	567	55.00
60.00	LABORATORY	129,257	26,256,158	0.004923	3,263,589	16,067	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
64.00	INTRAVENOUS THERAPY	372	329,817	0.001128	139,958	158	64.00
65.00	RESPIRATORY THERAPY	42,100	3,051,844	0.013795	893,547	12,326	65.00
66.00	PHYSICAL THERAPY	151,426	9,222,086	0.016420	1,739,575	28,564	66.00
67.00	OCCUPATIONAL THERAPY	378	309,405	0.001222	5,183	6	67.00
68.00	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	75,654	6,152,409	0.012297	305,756	3,760	69.00
70.00	ELECTROENCEPHALOGRAPHY	98,706	2,171,532	0.045455	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	64,751	31,927,178	0.002028	8,588,443	17,417	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	61,249	34,063,653	0.001798	16,050,467	28,859	72.00
73.00	DRUGS CHARGED TO PATIENTS	85,112	6,700,591	0.012702	4,569,871	58,047	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	169,443	1,215,799	0.139368	0	0	90.00
90.01	WOUND CARE INSTITUTE	274	327,541	0.000837	0	0	90.01
90.02	OP NUTRITIONAL COUNSELING	100	46,308	0.002159	0	0	90.02
90.03	BARIATRIC MEDICINE	0	0	0.000000	0	0	90.03
91.00	EMERGENCY	255,595	44,811,544	0.005704	1,418,757	8,093	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	49,013	703,128	0.069707	143,624	10,012	92.00
200.00	Total (Lines 50-199)	2,678,253	242,116,298		48,046,976	506,758	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150057		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part III Date/Time Prepared: 5/29/2012 2:26 pm	
Cost Center Description		Title XVIII		Hospital		PPS	
		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	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
200.00	Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150057		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part III Date/Time Prepared: 5/29/2012 2:26 pm	
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)	PPS	
		6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	10,973	0.00	5,019	0	30.00	
34.00	SURGICAL INTENSIVE CARE UNIT	1,137	0.00	312	0	34.00	
200.00	Total (Lines 30-199)	13,069		5,331	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150057	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 5/29/2012 2:26 pm
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Cost Center Description	Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col 4)
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
	1.00	2.00	3.00	4.00		5.00	
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	0	0	0	0		0	50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0		0	54.00
54.01 ULTRA SOUND	0	0	0	0		0	54.01
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0		0	55.00
60.00 LABORATORY	0	0	0	0		0	60.00
60.01 BLOOD LABORATORY	0	0	0	0		0	60.01
64.00 INTRAVENOUS THERAPY	0	0	0	0		0	64.00
65.00 RESPIRATORY THERAPY	0	0	0	0		0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0		0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0		0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0		0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0		0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0		0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0		0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0		0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00 CLINIC	0	0	0	0		0	90.00
90.01 WOUND CARE INSTITUTE	0	0	0	0		0	90.01
90.02 OP NUTRITIONAL COUNSELING	0	0	0	0		0	90.02
90.03 BARIATRIC MEDICINE	0	0	0	0		0	90.03
91.00 EMERGENCY	0	0	0	0		0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0		0	92.00
200.00 Total (lines 50-199)	0	0	0	0		0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet D
Part IV
Date/Time Prepared:
5/29/2012 2:26 pm

Cost Center Description		Title XVIII			Hospital		PPS
		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	OPERATING ROOM	0	28,507,225	0.000000	0.000000	9,569,686	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	35,478,653	0.000000	0.000000	1,263,852	54.00
54.01	ULTRA SOUND	0	3,609,781	0.000000	0.000000	77,386	54.01
55.00	RADIOLOGY-THERAPEUTIC	0	7,231,646	0.000000	0.000000	17,282	55.00
60.00	LABORATORY	0	26,256,158	0.000000	0.000000	3,263,589	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
64.00	INTRAVENOUS THERAPY	0	329,817	0.000000	0.000000	139,958	64.00
65.00	RESPIRATORY THERAPY	0	3,051,844	0.000000	0.000000	893,547	65.00
66.00	PHYSICAL THERAPY	0	9,222,086	0.000000	0.000000	1,739,575	66.00
67.00	OCCUPATIONAL THERAPY	0	309,405	0.000000	0.000000	5,183	67.00
68.00	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	ELECTROCARDIOLOGY	0	6,152,409	0.000000	0.000000	305,756	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	2,171,532	0.000000	0.000000	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	31,927,178	0.000000	0.000000	8,588,443	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	34,063,653	0.000000	0.000000	16,050,467	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	6,700,591	0.000000	0.000000	4,569,871	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	0	1,215,799	0.000000	0.000000	0	90.00
90.01	WOUND CARE INSTITUTE	0	327,541	0.000000	0.000000	0	90.01
90.02	OP NUTRITIONAL COUNSELING	0	46,308	0.000000	0.000000	0	90.02
90.03	BARIATRIC MEDICINE	0	0	0.000000	0.000000	0	90.03
91.00	EMERGENCY	0	44,811,544	0.000000	0.000000	1,418,757	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	703,128	0.000000	0.000000	143,624	92.00
200.00	Total (Lines 50-199)	0	242,116,298			48,046,976	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet D
Part IV
Date/Time Prepared:
5/29/2012 2:26 pm

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)	
		11.00	12.00	13.00	
Title XVIII Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	638,284	0	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	8,821,681	0	54.00
54.01	ULTRA SOUND	0	613,390	0	54.01
55.00	RADIOLOGY-THERAPEUTIC	0	2,699,407	0	55.00
60.00	LABORATORY	0	222,989	0	60.00
60.01	BLOOD LABORATORY	0	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	95,443	0	64.00
65.00	RESPIRATORY THERAPY	0	246,926	0	65.00
66.00	PHYSICAL THERAPY	0	7,376	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	2,480,376	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	438,296	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,200,563	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	57,030	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,243,007	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0	508,162	0	90.00
90.01	WOUND CARE INSTITUTE	0	0	0	90.01
90.02	OP NUTRITIONAL COUNSELING	0	44	0	90.02
90.03	BARIATRIC MEDICINE	0	0	0	90.03
91.00	EMERGENCY	0	6,101,563	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	475,964	0	92.00
200.00	Total (Lines 50-199)	0	25,850,501	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150057	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/29/2012 2:26 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	
		1.00	2.00				
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	0.342396		638,284	0	0		50.00
54.00 RADIOLOGY-DIAGNOSTIC	0.067802		8,821,681	0	0		54.00
54.01 ULTRA SOUND	0.110283		613,390	0	0		54.01
55.00 RADIOLOGY-THERAPEUTIC	0.475015		2,699,407	0	0		55.00
60.00 LABORATORY	0.160064		222,989	0	0		60.00
60.01 BLOOD LABORATORY	0.000000		0	0	0		60.01
64.00 INTRAVENOUS THERAPY	0.093619		95,443	0	0		64.00
65.00 RESPIRATORY THERAPY	0.416382		246,926	0	0		65.00
66.00 PHYSICAL THERAPY	0.255503		7,376	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0.295008		0	0	0		67.00
68.00 SPEECH PATHOLOGY	0.000000		0	0	0		68.00
69.00 ELECTROCARDIOLOGY	0.131175		2,480,376	0	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0.220898		438,296	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.168804		1,200,563	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.447544		57,030	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.583622		1,243,007	0	0		73.00
OUTPATIENT SERVICE COST CENTERS							
90.00 CLINIC	0.600429		508,162	0	0		90.00
90.01 WOUND CARE INSTITUTE	0.156570		0	0	0		90.01
90.02 OP NUTRITIONAL COUNSELING	0.563833		44	0	0		90.02
90.03 BARIATRIC MEDICINE	0.000000		0	0	0		90.03
91.00 EMERGENCY	0.123214		6,101,563	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.609250		475,964	0	0		92.00
200.00 Subtotal (see instructions)			25,850,501	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0	0		201.00
202.00 Net Charges (line 200 +/- line 201)			25,850,501	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150057	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/29/2012 2:26 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	218,546	0	0		50.00
54.00 RADIOLOGY-DIAGNOSTIC	598,128	0	0		54.00
54.01 ULTRA SOUND	67,646	0	0		54.01
55.00 RADIOLOGY-THERAPEUTIC	1,282,259	0	0		55.00
60.00 LABORATORY	35,693	0	0		60.00
60.01 BLOOD LABORATORY	0	0	0		60.01
64.00 INTRAVENOUS THERAPY	8,935	0	0		64.00
65.00 RESPIRATORY THERAPY	102,816	0	0		65.00
66.00 PHYSICAL THERAPY	1,885	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00 SPEECH PATHOLOGY	0	0	0		68.00
69.00 ELECTROCARDIOLOGY	325,363	0	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	96,819	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	202,660	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	25,523	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	725,446	0	0		73.00
OUTPATIENT SERVICE COST CENTERS					
90.00 CLINIC	305,115	0	0		90.00
90.01 WOUND CARE INSTITUTE	0	0	0		90.01
90.02 OP NUTRITIONAL COUNSELING	25	0	0		90.02
90.03 BARIATRIC MEDICINE	0	0	0		90.03
91.00 EMERGENCY	751,798	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	289,981	0	0		92.00
200.00 Subtotal (see instructions)	5,038,638	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)	5,038,638	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150057		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part I Date/Time Prepared: 5/29/2012 2:26 pm	
Cost Center Description		Title XIX		Hospital		PPS	
		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	1,305,386	0	1,305,386	10,973	118.96	30.00
34.00	SURGICAL INTENSIVE CARE UNIT	169,109		169,109	1,137	148.73	34.00
200.00	Total (lines 30-199)	1,474,495		1,474,495	13,069		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150057		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part I Date/Time Prepared: 5/29/2012 2:26 pm	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Title XIX	Hospital	PPS	
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	151	17,963				30.00
34.00	SURGICAL INTENSIVE CARE UNIT	41	6,098				34.00
200.00	Total (lines 30-199)	423	24,061				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150057	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part II Date/Time Prepared: 5/29/2012 2:26 pm
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Cost Center Description		Title XIX			Hospital	PPS	
		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	OPERATING ROOM	927,247	28,507,225	0.032527	207,598	6,753	50.00
54.00	RADIOLOGY-DIAGNOSTIC	318,983	35,478,653	0.008991	76,481	688	54.00
54.01	ULTRA SOUND	11,476	3,609,781	0.003179	19,360	62	54.01
55.00	RADIOLOGY-THERAPEUTIC	237,117	7,231,646	0.032789	0	0	55.00
60.00	LABORATORY	129,257	26,256,158	0.004923	294,810	1,451	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
64.00	INTRAVENOUS THERAPY	372	329,817	0.001128	0	0	64.00
65.00	RESPIRATORY THERAPY	42,100	3,051,844	0.013795	73,394	1,012	65.00
66.00	PHYSICAL THERAPY	151,426	9,222,086	0.016420	18,395	302	66.00
67.00	OCCUPATIONAL THERAPY	378	309,405	0.001222	172	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	75,654	6,152,409	0.012297	11,689	144	69.00
70.00	ELECTROENCEPHALOGRAPHY	98,706	2,171,532	0.045455	506	23	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	64,751	31,927,178	0.002028	317,758	644	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	61,249	34,063,653	0.001798	152,503	274	72.00
73.00	DRUGS CHARGED TO PATIENTS	85,112	6,700,591	0.012702	306,600	3,894	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	169,443	1,215,799	0.139368	0	0	90.00
90.01	WOUND CARE INSTITUTE	274	327,541	0.000837	0	0	90.01
90.02	OP NUTRITIONAL COUNSELING	100	46,308	0.002159	0	0	90.02
90.03	BARIATRIC MEDICINE	0	0	0.000000	0	0	90.03
91.00	EMERGENCY	255,595	44,811,544	0.005704	106,716	609	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	49,013	703,128	0.069707	0	0	92.00
200.00	Total (Lines 50-199)	2,678,253	242,116,298		1,585,982	15,856	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150057		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part III Date/Time Prepared: 5/29/2012 2:26 pm	
Cost Center Description		Title XIX		Hospital		PPS	
		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	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
200.00	Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150057		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part III Date/Time Prepared: 5/29/2012 2:26 pm	
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)	PPS	
		6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	10,973	0.00	151	0	30.00	
34.00	SURGICAL INTENSIVE CARE UNIT	1,137	0.00	41	0	34.00	
200.00	Total (Lines 30-199)	13,069		423	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet D
Part IV
Date/Time Prepared:
5/29/2012 2:26 pm

Cost Center Description		Title XIX				Hospital	PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	ULTRA SOUND	0	0	0	0	0	54.01
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	LABORATORY	0	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	0	0	0	0	0	90.00
90.01	WOUND CARE INSTITUTE	0	0	0	0	0	90.01
90.02	OP NUTRITIONAL COUNSELING	0	0	0	0	0	90.02
90.03	BARIATRIC MEDICINE	0	0	0	0	0	90.03
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet D
Part IV
Date/Time Prepared:
5/29/2012 2:26 pm

Cost Center Description		Title XIX			Hospital		PPS
		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	OPERATING ROOM	0	28,507,225	0.000000	0.000000	207,598	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	35,478,653	0.000000	0.000000	76,481	54.00
54.01	ULTRA SOUND	0	3,609,781	0.000000	0.000000	19,360	54.01
55.00	RADIOLOGY-THERAPEUTIC	0	7,231,646	0.000000	0.000000	0	55.00
60.00	LABORATORY	0	26,256,158	0.000000	0.000000	294,810	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
64.00	INTRAVENOUS THERAPY	0	329,817	0.000000	0.000000	0	64.00
65.00	RESPIRATORY THERAPY	0	3,051,844	0.000000	0.000000	73,394	65.00
66.00	PHYSICAL THERAPY	0	9,222,086	0.000000	0.000000	18,395	66.00
67.00	OCCUPATIONAL THERAPY	0	309,405	0.000000	0.000000	172	67.00
68.00	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	ELECTROCARDIOLOGY	0	6,152,409	0.000000	0.000000	11,689	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	2,171,532	0.000000	0.000000	506	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	31,927,178	0.000000	0.000000	317,758	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	34,063,653	0.000000	0.000000	152,503	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	6,700,591	0.000000	0.000000	306,600	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	0	1,215,799	0.000000	0.000000	0	90.00
90.01	WOUND CARE INSTITUTE	0	327,541	0.000000	0.000000	0	90.01
90.02	OP NUTRITIONAL COUNSELING	0	46,308	0.000000	0.000000	0	90.02
90.03	BARIATRIC MEDICINE	0	0	0.000000	0.000000	0	90.03
91.00	EMERGENCY	0	44,811,544	0.000000	0.000000	106,716	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	703,128	0.000000	0.000000	0	92.00
200.00	Total (Lines 50-199)	0	242,116,298			1,585,982	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Title XIX			Hospital	PPS
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0		50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	ULTRA SOUND	0	0	0		54.01
55.00	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
60.00	LABORATORY	0	0	0		60.00
60.01	BLOOD LABORATORY	0	0	0		60.01
64.00	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	RESPIRATORY THERAPY	0	0	0		65.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
67.00	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	SPEECH PATHOLOGY	0	0	0		68.00
69.00	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0		90.00
90.01	WOUND CARE INSTITUTE	0	0	0		90.01
90.02	OP NUTRITIONAL COUNSELING	0	0	0		90.02
90.03	BARIATRIC MEDICINE	0	0	0		90.03
91.00	EMERGENCY	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00	Total (Lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150057	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/29/2012 2:26 pm
	Title XIX	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see instructions)	Charges			
			Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
	1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0.342396	0	45,547	0		50.00
54.00 RADIOLOGY-DIAGNOSTIC	0.067802	0	1,060,199	0		54.00
54.01 ULTRA SOUND	0.110283	0	174,875	0		54.01
55.00 RADIOLOGY-THERAPEUTIC	0.475015	0	223,184	0		55.00
60.00 LABORATORY	0.160064	0	756,415	0		60.00
60.01 BLOOD LABORATORY	0.000000	0	0	0		60.01
64.00 INTRAVENOUS THERAPY	0.093619	0	0	0		64.00
65.00 RESPIRATORY THERAPY	0.416382	0	35,995	0		65.00
66.00 PHYSICAL THERAPY	0.255503	0	75,468	0		66.00
67.00 OCCUPATIONAL THERAPY	0.295008	0	9,763	0		67.00
68.00 SPEECH PATHOLOGY	0.000000	0	0	0		68.00
69.00 ELECTROCARDIOLOGY	0.131175	0	89,781	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0.220898	0	52,250	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.168804	0	103,299	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.447544	0	7,323	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.583622	0	137,000	0		73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0.600429	0	40,345	0		90.00
90.01 WOUND CARE INSTITUTE	0.156570	0	1,606	0		90.01
90.02 OP NUTRITIONAL COUNSELING	0.563833	0	70	0		90.02
90.03 BARIATRIC MEDICINE	0.000000	0	0	0		90.03
91.00 EMERGENCY	0.123214	0	3,055,686	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.609250	0	0	0		92.00
200.00 Subtotal (see instructions)		0	5,868,806	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00 Net Charges (line 200 +/- line 201)		0	5,868,806	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150057	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/29/2012 2:26 pm
	Title XIX	Hospital	PPS

Cost Center Description	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	15,595	0		50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	71,884	0		54.00
54.01 ULTRA SOUND	0	19,286	0		54.01
55.00 RADIOLOGY-THERAPEUTIC	0	106,016	0		55.00
60.00 LABORATORY	0	121,075	0		60.00
60.01 BLOOD LABORATORY	0	0	0		60.01
64.00 INTRAVENOUS THERAPY	0	0	0		64.00
65.00 RESPIRATORY THERAPY	0	14,988	0		65.00
66.00 PHYSICAL THERAPY	0	19,282	0		66.00
67.00 OCCUPATIONAL THERAPY	0	2,880	0		67.00
68.00 SPEECH PATHOLOGY	0	0	0		68.00
69.00 ELECTROCARDIOLOGY	0	11,777	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0	11,542	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17,437	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	3,277	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	79,956	0		73.00
OUTPATIENT SERVICE COST CENTERS					
90.00 CLINIC	0	24,224	0		90.00
90.01 WOUND CARE INSTITUTE	0	251	0		90.01
90.02 OP NUTRITIONAL COUNSELING	0	39	0		90.02
90.03 BARIATRIC MEDICINE	0	0	0		90.03
91.00 EMERGENCY	0	376,503	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00 Subtotal (see instructions)	0	896,012	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	896,012	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150057	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/29/2012 2:26 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		10,973	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		10,973	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		10,973	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)		5,019	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)		11,409,317	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)		11,409,317	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		17,868,035	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		17,868,035	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.638532	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)		1,628.36	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)		11,409,317	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)		1,039.76	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,218,555	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)		5,218,555	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150057	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1 Date/Time Prepared: 5/29/2012 2:26 pm		
Cost Center Description			Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
Title XVIII			Hospital		PPS		
Intensive Care Type Inpatient Hospital Units			1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)						42.00
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	2,433,526	1,137	2,140.30	312	667,774	46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					16,335,149	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					22,221,478	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)					643,464	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					506,758	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,150,222	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					21,071,256	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					412	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,039.76	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					428,381	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150057		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1 Date/Time Prepared: 5/29/2012 2:26 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,305,386	11,409,317	0.114414	428,381	49,013	90.00
91.00	Nursing School cost	0	11,409,317	0.000000	428,381	0	91.00
92.00	Allied health cost	0	11,409,317	0.000000	428,381	0	92.00
93.00	All other Medical Education	0	11,409,317	0.000000	428,381	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150057	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/29/2012 2:26 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		10,973	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		10,973	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		10,973	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)		151	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)		959	15.00
16.00	Nursery days (title V or XIX only)		231	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)		11,409,317	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)		11,409,317	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		17,868,035	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		17,868,035	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.638532	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)		1,628.36	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)		11,409,317	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)		1,039.76	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		157,004	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)		157,004	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150057	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1 Date/Time Prepared: 5/29/2012 2:26 pm
Cost Center Description			Title XIX	Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	2,433,526	1,137	2,140.30	41	87,752
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)				476,525
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				721,281
PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				24,061
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				15,856
52.00	Total Program excludable cost (sum of lines 50 and 51)				39,917
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				681,364
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				0
55.00	Target amount per discharge				0.00
56.00	Target amount (line 54 x line 55)				0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0
58.00	Bonus payment (see instructions)				0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0
62.00	Relief payment (see instructions)				0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)				70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				71.00
72.00	Program routine service cost (line 9 x line 71)				72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				76.00
77.00	Program capital-related costs (line 9 x line 76)				77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				80.00
81.00	Inpatient routine service cost per diem limitation				81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				82.00
83.00	Reasonable inpatient routine service costs (see instructions)				83.00
84.00	Program inpatient ancillary services (see instructions)				84.00
85.00	Utilization review - physician compensation (see instructions)				85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)				412
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,039.76
89.00	Observation bed cost (line 87 x line 88) (see instructions)				428,381

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150057		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1 Date/Time Prepared: 5/29/2012 2:26 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,305,386	11,409,317	0.114414	428,381	49,013	90.00
91.00	Nursing School cost	0	11,409,317	0.000000	428,381	0	91.00
92.00	Allied health cost	0	11,409,317	0.000000	428,381	0	92.00
93.00	All other Medical Education	0	11,409,317	0.000000	428,381	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150057	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/29/2012 2:26 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		5,575,752		30.00
34.00	SURGICAL INTENSIVE CARE UNIT		1,075,792		34.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.342396	9,569,686	3,276,622	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0.067802	1,263,852	85,692	54.00
54.01	ULTRA SOUND	0.110283	77,386	8,534	54.01
55.00	RADIOLOGY-THERAPEUTIC	0.475015	17,282	8,209	55.00
60.00	LABORATORY	0.160064	3,263,589	522,383	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
64.00	INTRAVENOUS THERAPY	0.093619	139,958	13,103	64.00
65.00	RESPIRATORY THERAPY	0.416382	893,547	372,057	65.00
66.00	PHYSICAL THERAPY	0.255503	1,739,575	444,467	66.00
67.00	OCCUPATIONAL THERAPY	0.295008	5,183	1,529	67.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.131175	305,756	40,108	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.220898	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.168804	8,588,443	1,449,764	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.447544	16,050,467	7,183,290	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.583622	4,569,871	2,667,077	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0.600429	0	0	90.00
90.01	WOUND CARE INSTITUTE	0.156570	0	0	90.01
90.02	OP NUTRITIONAL COUNSELING	0.563833	0	0	90.02
90.03	BARIATRIC MEDICINE	0.000000	0	0	90.03
91.00	EMERGENCY	0.123214	1,418,757	174,811	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.609250	143,624	87,503	92.00
200.00	Total (sum of lines 50-94 and 96-98)		48,046,976	16,335,149	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		48,046,976		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150057	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/29/2012 2:26 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		1,550,240		30.00
34.00	SURGICAL INTENSIVE CARE UNIT		45,880		34.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.342396	207,598	71,081	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0.067802	76,481	5,186	54.00
54.01	ULTRA SOUND	0.110283	19,360	2,135	54.01
55.00	RADIOLOGY-THERAPEUTIC	0.475015	0	0	55.00
60.00	LABORATORY	0.160064	294,810	47,188	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
64.00	INTRAVENOUS THERAPY	0.093619	0	0	64.00
65.00	RESPIRATORY THERAPY	0.416382	73,394	30,560	65.00
66.00	PHYSICAL THERAPY	0.255503	18,395	4,700	66.00
67.00	OCCUPATIONAL THERAPY	0.295008	172	51	67.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.131175	11,689	1,533	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.220898	506	112	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.168804	317,758	53,639	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.447544	152,503	68,252	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.583622	306,600	178,939	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0.600429	0	0	90.00
90.01	WOUND CARE INSTITUTE	0.156570	0	0	90.01
90.02	OP NUTRITIONAL COUNSELING	0.563833	0	0	90.02
90.03	BARIATRIC MEDICINE	0.000000	0	0	90.03
91.00	EMERGENCY	0.123214	106,716	13,149	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.609250	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,585,982	476,525	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		1,585,982		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150057	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part A Date/Time Prepared: 5/29/2012 2:26 pm
		Title XVII I	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		14,476,708	1.00
2.00	Outlier payments for discharges. (see instructions)		112,521	2.00
3.00	Managed Care Simulated Payments		2,818,649	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		75.87	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)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.54	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)		0.54	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.29	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.29	12.00
13.00	Total allowable FTE count for the prior year.		0.34	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.		0.37	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.33	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		0.33	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.004350	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.004512	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.004350	21.00
22.00	IME payment adjustment (see instructions)		41,076	22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment. (see instructions)		0.000000	27.00
28.00	IME Adjustment (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		41,076	29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		0.00	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		0.00	31.00
32.00	Sum of lines 30 and 31		0.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00	33.00
34.00	Disproportionate share adjustment (see instructions)		0	34.00
Additional payment for high percentage of ESRD beneficiary discharges				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0	46.00
47.00	Subtotal (see instructions)		14,630,305	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		14,630,305	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		1,181,542	50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		10,951	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0	55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0	56.00
57.00	Routine service other pass through costs		0	57.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150057	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part A Date/Time Prepared: 5/29/2012 2:26 pm
		Title XVIII	Hospital	PPS
				1.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)			0 58.00
59.00	Total (sum of amounts on lines 49 through 58)			15,822,798 59.00
60.00	Primary payer payments			0 60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			15,822,798 61.00
62.00	Deductibles billed to program beneficiaries			1,500,744 62.00
63.00	Coinsurance billed to program beneficiaries			6,792 63.00
64.00	Allowable bad debts (see instructions)			150,862 64.00
65.00	Adjusted reimbursable bad debts (see instructions)			105,603 65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			101,667 66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			14,420,865 67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)			0 68.00
69.00	Outlier payments reconciliation			0 69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 70.00
70.95	Recovery of Accelerated Depreciation			0 70.95
70.96	Low Volume Payment-1			494,132 70.96
70.97	Low Volume Payment-2			0 70.97
70.98	Low Volume Payment-3			0 70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			14,914,997 71.00
72.00	Interim payments			14,862,447 72.00
73.00	Tentative settlement (for contractor use only)			0 73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)			52,550 74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 75.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Operating outlier amount from Worksheet E, Part A line 2			0 90.00
91.00	Capital outlier from Worksheet L, Part I, line 2			0 91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0 92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0 93.00
94.00	The rate used to calculate the Time Value of Money			0.00 94.00
95.00	Time Value of Money for operating expenses(see instructions)			0 95.00
96.00	Time Value of Money for capital related expenses (see instructions)			0 96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150057	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/29/2012 2:26 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		5,038,638	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		3,791,935	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.686	5.00
6.00	Line 2 times line 5		3,456,506	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		3,791,935	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		160	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		985,418	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		2,806,357	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		2,483	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,808,840	30.00
31.00	Primary payer payments		222	31.00
32.00	Subtotal (line 30 minus line 31)		2,808,618	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		148,056	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		103,639	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		91,058	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		2,912,257	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		2,912,257	40.00
41.00	Interim payments		2,898,761	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		13,496	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2012 2:26 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		14,841,210		2,893,888	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	09/19/2011	13,693	09/19/2011	3,053	3.01	
3.02		11/11/2011	7,544	11/11/2011	1,820	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)		21,237		4,873	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)		14,862,447		2,898,761	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		52,550		13,496	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		14,914,997		2,912,257	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 150057	Period: From 01/01/2011 To 12/31/2011	Worksheet E-1 Part II Date/Time Prepared: 5/29/2012 2:26 pm
		Title XVIII	Hospital	PPS
				1.00
DATA COLLECTION NEEDED FOR THE HIT CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			3,756 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			5,331 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2			1,027 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			11,698 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			261,875,785 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			22,880,926 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			1,501,597 8.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial /interim HIT payment(s)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 minus line 30, plus or minus line 31)			1,501,597 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150057	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part VII Date/Time Prepared: 5/29/2012 2:26 pm
		Title XIX	Hospital	PPS
		1.00		
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		0	1.00
2.00	Medical and other services		896,012	2.00
3.00	Organ acquisition (certified transplant centers only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		896,012	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)		896,012	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		1,596,120	8.00
9.00	Ancillary service charges		7,454,788	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)		9,050,908	12.00
CUSTOMARY CHRGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		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	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	15.00
16.00	Total customary charges (see instructions)		9,050,908	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		8,154,896	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		896,012	21.00
PROSPECTIVE PAYMENT AMOUNT				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		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	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		9,050,908	28.00
29.00	Titles V or XIX enter the sum of lines 27 and 21.		896,012	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		896,012	31.00
32.00	Deductibles		0	32.00
33.00	Coinsurance		0	33.00
34.00	Allowable bad debts (see instructions)		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)		896,012	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		896,012	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)		896,012	40.00
41.00	Interim payments		896,012	41.00
42.00	Balance due provider/program (line 40 minus 41)		0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 150057	Period: From 01/01/2011 To 12/31/2011	Worksheet E-4 Date/Time Prepared: 5/29/2012 2:26 pm	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.54	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 plus line 4.02 plus applicable subscripts)			0.54	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.29	6.00
7.00	Enter the lesser of line 5 or line 6			0.29	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.	0.29	0.00	0.29	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.	0.29	0.00	0.29	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
11.00	Total weighted FTE count	0.29	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.29	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.37	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.32	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
17.00	Adjusted rolling average FTE count	0.32	0.00		17.00
18.00	Per resident amount	79,040.03	0.00		18.00
19.00	Approved amount for resident costs	25,293	0	25,293	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	GME FTE weighted Resident count over Cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			25,293	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days	5,331	1,027		26.00
27.00	Total Inpatient Days	11,698	11,698		27.00
28.00	Ratio of inpatient days to total inpatient days	0.455719	0.087793		28.00
29.00	Program direct GME amount	11,527	2,221		29.00
30.00	Reduction for nursing/allied health		314		30.00
31.00	Net Program direct GME amount			13,434	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 150057	Period: From 01/01/2011 To 12/31/2011	Worksheet E-4 Date/Time Prepared: 5/29/2012 2:26 pm
		Title XVIII	Hospital	PPS
				1.00
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Worksheet C, Part I, column 8, sum of lines 74 and 94)		0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		22,221,478	37.00
38.00	Organ acquisition costs (Worksheet D-4, Part III, column 1, line 69)		0	38.00
39.00	Cost of teaching physicians (Worksheet D-5, Part II, column 3, line 20)		0	39.00
40.00	Primary payer payments (see instructions)		0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		22,221,478	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		5,038,638	42.00
43.00	Primary payer payments (see instructions)		222	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		5,038,416	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		27,259,894	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.815171	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.184829	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		13,434	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (Title XVIII only) (see instructions)		10,951	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		2,483	50.00

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

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet G
Date/Time Prepared:
5/29/2012 2:26 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	5,474,735	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	37,798,955	0	0	0	4.00
5.00	Other receivable	390,093	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-25,502,387	0	0	0	6.00
7.00	Inventory	3,455,895	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	431,995	0	0	0	9.00
10.00	Due from other funds	317,390	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	22,366,676	0	0	0	11.00
FIXED ASSETS						
12.00	Land	922,177	0	0	0	12.00
13.00	Land improvements	1,418,904	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	79,931,584	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	592,542	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	23,758,038	0	0	0	19.00
20.00	Accumulated depreciation	-35,077,708	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	71,545,537	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,301,197	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	620,931	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,922,128	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	95,834,341	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	6,179,535	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,269,273	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	91,533	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,540,341	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	8,540,341	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	87,294,000				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)	87,294,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	95,834,341	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet G-1

Date/Time Prepared:
5/29/2012 2:26 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		72,895,899	
2.00	Net income (loss) (From Wkst. G-3, line 29)		14,398,101			2.00
3.00	Total (sum of line 1 and line 2)		87,294,000		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		87,294,000		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		87,294,000		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet G-1

Date/Time Prepared:
5/29/2012 2:26 pm

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet G-2 Parts

Date/Time Prepared:
5/29/2012 2:26 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	17,868,035		17,868,035	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)	17,868,035		17,868,035	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT	1,893,588		1,893,588	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	1,893,588		1,893,588	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	19,761,623		19,761,623	17.00
18.00	Ancillary services	102,839,271	145,087,829	247,927,100	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	122,600,894	145,087,829	267,688,723	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		73,780,621		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		73,780,621		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150057

Period:
From 01/01/2011
To 12/31/2011

Worksheet G-3

Date/Time Prepared:
5/29/2012 2:26 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	267,688,723	1.00
2.00	Less contractual allowances and discounts on patients' accounts	171,026,670	2.00
3.00	Net patient revenues (line 1 minus line 2)	96,662,053	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	73,780,621	4.00
5.00	Net income from service to patients (line 3 minus line 4)	22,881,432	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 telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	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	OTHER (SPECIFY)	4,545,678	24.00
25.00	Total other income (sum of lines 6-24)	4,545,678	25.00
26.00	Total (line 5 plus line 25)	27,427,110	26.00
27.00	ALLOCATED OVERHEAD	13,029,009	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	13,029,009	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	14,398,101	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150057	Period: From 01/01/2011 To 12/31/2011	Worksheet L Parts I-III Date/Time Prepared: 5/29/2012 2:26 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,171,435	1.00
2.00	Capital DRG outlier payments		6,710	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		32.05	3.00
4.00	Number of interns & residents (see instructions)		0.33	4.00
5.00	Indirect medical education percentage (see instructions)		0.29	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		3,397	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		1,181,542	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