

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: 140033	Period: From 12/01/2010 To 11/30/2011	Worksheet S Parts I-III Date/Time Prepared: 5/24/2012 11:06 am
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/24/2012	Time: 11:06 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 04 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above 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 VISTA MEDICAL CENTER WEST for the cost reporting period beginning 12/01/2010 and ending 11/30/2011 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.

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

 Title

 Date

Cost Center Description	Title V		Title XVIII		HIT	Title XIX	
	1.00	2.00	Part A	Part B			
PART III - SETTLEMENT SUMMARY							
1.00 Hospital	0	0		-10,439	0	0	1.00
2.00 Subprovider - IPF	0	-15,398		0		0	2.00
3.00 Subprovider - IRF	0	10,483		0		0	3.00
4.00 SUBPROVIDER I	0	0		0		0	4.00
5.00 Swing bed - SNF	0	0		0		0	5.00
6.00 Swing bed - NF	0					0	6.00
7.00 SKILLED NURSING FACILITY	0	0		0		0	7.00
8.00 NURSING FACILITY	0					0	8.00
9.00 HOME HEALTH AGENCY I	0	0		0		0	9.00
10.00 RURAL HEALTH CLINIC I	0			0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0			0		0	11.00
12.00 CMHC I	0			0		0	12.00
200.00 Total	0	-4,915		-10,439	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140033		Period: From 12/01/2010 To 11/30/2011		Worksheet S-2 Part I Date/Time Prepared: 5/22/2012 11:42 am					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1324 NORTH SHERIDAN ROAD			PO Box:						1.00	
2.00	City: WAUKEGAN			State: IL		Zip Code: 60085-		County: LAKE		2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
								V	XVIII	XIX	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		VI STA MEDICAL CENTER WEST	140033	29404	1	07/01/1966	N	P	N	3.00
4.00	Subprovider - IPF		VI STA MEDICAL CENTER MENTAL HEALTH	14S033	29404	4	01/01/1990	N	P	N	4.00
5.00	Subprovider - IRF		VI STA MEDICAL CENTER REHAB	14T033	29404	5	09/01/1989	N	P	N	5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF							N	N	N	7.00
8.00	Swing Beds - NF							N		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							N	N	N	15.00
16.00	Hospital-Based Health Clinic - FQHC							N	N	N	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)						12/01/2010	11/30/2011		20.00	
21.00	Type of Control (see instructions)						4			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			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.			0	0	0	0	0	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.			261	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: 140033	Period: From 12/01/2010 To 11/30/2011	Worksheet S-2 Part I Date/Time Prepared: 5/22/2012 11:42 am		
		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.	N			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.				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)		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: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet S-2
Part I
Date/Time Prepared:
5/22/2012 11:42 am

		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.				Y		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: 140033	Period: From 12/01/2010 To 11/30/2011	Worksheet S-2 Part I Date/Time Prepared: 5/22/2012 11:42 am	
			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.		Y		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)		N	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	N	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	Speech
			1.00	2.00	3.00
			Respiratory		4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		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.		N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1	118.00
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.		5,000,000	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.		N		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	449008		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: COMMUNITY HEALTH SYSTEMS		Contractor's Name: WPS		Contractor's Number: 52280			141.00	
142.00	Street: 4000 MERIDIAN BLVD		PO Box:					142.00	
143.00	City: FRANKLIN		State: TN		Zip Code: 37067			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	166.00
							1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140033		Period: From 12/01/2010 To 11/30/2011		Worksheet S-2 Part II Date/Time Prepared: 5/22/2012 11:42 am		
		Y/N	Date					
		1.00	2.00					
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.								
COMPLETED BY ALL HOSPITALS								
Provider Organization and Operation								
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00	
		Y/N	Date					
		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)	N					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.	N					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.	N					9.00	
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00	
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00	
		Y/N						
		1.00						
Bad Debts								
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00	
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00	
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00	
Bed Complement								
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00	
		Part A						
		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)	Y		03/26/2012			16.00	
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N					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:	Y					20.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140033	Period: From 12/01/2010 To 11/30/2011	Worksheet S-2 Part II Date/Time Prepared: 5/22/2012 11:42 am
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		Part A			
		Description	Y/N	Date	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	0	1.00 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.		N		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		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.		Y	12/31/2011	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: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet S-2
Part II
Date/Time Prepared:
5/22/2012 11:42 am

		Part B		
		Y/N	Date	
PS&R Data		3.00	4.00	
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	03/26/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet S-3
Part I
Date/Time Prepared:
5/22/2012 11:42 am

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	16	5,840	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)		16	5,840	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						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		16	5,840	0.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	40.00	26	9,490			16.00
17.00 SUBPROVIDER - IRF	41.00	25	9,125			17.00
18.00 SUBPROVIDER	42.00	0	0			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	88.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00					26.25
27.00 Total (sum of lines 14-26)		67				27.00
28.00 Observation Bed Days						28.00
28.01 SUBPROVIDER - IPF	40.00					28.01
28.02 SUBPROVIDER - IRF	41.00					28.02
28.03 SUBPROVIDER	42.00					28.03
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: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet S-3
Part I
Date/Time Prepared:
5/22/2012 11:42 am

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	0	2,630	3,711		1.00
2.00 HMO		128	0			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	0	2,630	3,711		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	0	2,630	3,711		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF	0	2,439	1,651	6,045		16.00
17.00 SUBPROVIDER - IRF	0	3,586	261	4,938		17.00
18.00 SUBPROVIDER	0	0	0	0		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	0	0	0	0		26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		0	0		28.00
28.01 SUBPROVIDER - IPF				0		28.01
28.02 SUBPROVIDER - IRF				0		28.02
28.03 SUBPROVIDER				0		28.03
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: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet S-3
Part I
Date/Time Prepared:
5/22/2012 11:42 am

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	0	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)	0.00	80.41	0.00	0	0	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	22.36	0.00	0	309	16.00
17.00 SUBPROVIDER - IRF	0.00	25.16	0.00	0	244	17.00
18.00 SUBPROVIDER	0.00	0.00	0.00	0	0	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	0.00	0.00	0.00			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
27.00 Total (sum of lines 14-26)	0.00	127.93	0.00			27.00
28.00 Observation Bed Days						28.00
28.01 SUBPROVIDER - IPF						28.01
28.02 SUBPROVIDER - IRF						28.02
28.03 SUBPROVIDER						28.03
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: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet S-3
Part I
Date/Time Prepared:
5/22/2012 11:42 am

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)	288	446		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)	288	446		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF	318	1,028		16.00
17.00 SUBPROVIDER - IRF	11	331		17.00
18.00 SUBPROVIDER	0	0		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
28.01 SUBPROVIDER - IPF				28.01
28.02 SUBPROVIDER - IRF				28.02
28.03 SUBPROVIDER				28.03
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: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet S-3
Part II
Date/Time Prepared:
5/22/2012 11:42 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	
	1.00	2.00	3.00	4.00	5.00	
PART II - WAGE DATA						
SALARIES						
1.00	Total salaries (see instructions)	200.00	7,732,498	0	7,732,498	266,072.00 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)		2,810,932	0	2,810,932	98,846.00 10.00
OTHER WAGES & RELATED COSTS						
11.00	Contract labor (see instructions)		0	0	0	0.00 11.00
12.00	Management and administrative services		0	0	0	0.00 12.00
13.00	Contract labor: physician-Part A		25,369	0	25,369	243.00 13.00
14.00	Home office salaries & wage-related costs		455,189	0	455,189	7,108.00 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		990,832	0	990,832	
18.00	Wage-related costs (other)Wkst S-3, Part IV Line 25		0	0	0	
19.00	Excluded areas		565,910	0	565,910	
20.00	Non-physician anesthetist Part A		0	0	0	
21.00	Non-physician anesthetist Part B		0	0	0	
22.00	Physician Part A		0	0	0	
23.00	Physician Part B		0	0	0	
24.00	Wage-related costs (RHC/FQHC)		0	0	0	
25.00	Interns & residents (in an approved program)		0	0	0	
OVERHEAD COSTS - DIRECT SALARIES						
26.00	Employee Benefits	4.00	0	0	0	0.00 26.00
27.00	Administrative & General	5.00	207,456	0	207,456	14,937.00 27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00 28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00 29.00
30.00	Operation of Plant	7.00	252,859	0	252,859	10,102.00 30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00 31.00
32.00	Housekeeping	9.00	0	0	0	0.00 32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00 33.00
34.00	Dietary	10.00	0	0	0	0.00 34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00 35.00
36.00	Cafeteria	11.00	0	0	0	0.00 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	0	0	0	0.00 39.00
40.00	Pharmacy	15.00	0	0	0	0.00 40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00 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: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet S-3
Part II
Date/Time Prepared:
5/22/2012 11:42 am

		Average Hourly Wage (col. 4 ÷ col. 5)	
		6.00	
PART II - WAGE DATA			
SALARIES			
1.00	Total salaries (see instructions)	29.06	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)	28.44	10.00
OTHER WAGES & RELATED COSTS			
11.00	Contract labor (see instructions)	0.00	11.00
12.00	Management and administrative services	0.00	12.00
13.00	Contract labor: physician-Part A	104.40	13.00
14.00	Home office salaries & wage-related costs	64.04	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	13.89	27.00
28.00	Administrative & General under contract (see inst.)	0.00	28.00
29.00	Maintenance & Repairs	0.00	29.00
30.00	Operation of Plant	25.03	30.00
31.00	Laundry & Linen Service	0.00	31.00
32.00	Housekeeping	0.00	32.00
33.00	Housekeeping under contract (see instructions)	0.00	33.00
34.00	Dietary	0.00	34.00
35.00	Dietary under contract (see instructions)	0.00	35.00
36.00	Cafeteria	0.00	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	0.00	39.00
40.00	Pharmacy	0.00	40.00
41.00	Medical Records & Medical Records Library	0.00	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: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet S-3
Part III
Date/Time Prepared:
5/22/2012 11:42 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	
	1.00	2.00	3.00	4.00	5.00	
PART III - HOSPITAL WAGE INDEX SUMMARY						
1.00	Net salaries (see instructions)	7,732,498	0	7,732,498	266,072.00	1.00
2.00	Excluded area salaries (see instructions)	2,810,932	0	2,810,932	98,846.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	4,921,566	0	4,921,566	167,226.00	3.00
4.00	Subtotal other wages & related costs (see inst.)	480,558	0	480,558	7,351.00	4.00
5.00	Subtotal wage-related costs (see inst.)	990,832	0	990,832	0.00	5.00
6.00	Total (sum of lines 3 thru 5)	6,392,956	0	6,392,956	174,577.00	6.00
7.00	Total overhead cost (see instructions)	460,315	0	460,315	25,039.00	7.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet S-3
Part III
Date/Time Prepared:
5/22/2012 11:42 am

		Average Hourly Wage (col. 4 ÷ col. 5)	
		6.00	

PART III - HOSPITAL WAGE INDEX SUMMARY			
1.00	Net salaries (see instructions)	29.06	1.00
2.00	Excluded area salaries (see instructions)	28.44	2.00
3.00	Subtotal salaries (line 1 minus line 2)	29.43	3.00
4.00	Subtotal other wages & related costs (see inst.)	65.37	4.00
5.00	Subtotal wage-related costs (see inst.)	20.13	5.00
6.00	Total (sum of lines 3 thru 5)	36.62	6.00
7.00	Total overhead cost (see instructions)	18.38	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 140033	Period: From 12/01/2010 To 11/30/2011	Worksheet S-3 Part IV Date/Time Prepared: 5/22/2012 11:42 am
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	194,763	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	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)	573,115	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	12,573	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	7,628	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)	34,063	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	102,895	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	460,746	17.00
18.00	Medicare Taxes - Employers Portion Only	107,755	18.00
19.00	Unemployment Insurance	63,201	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	3	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	1,556,742	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: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet S-3
Part V
Date/Time Prepared:
5/22/2012 11:42 am

Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	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	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	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: 140033	Period: From 12/01/2010 To 11/30/2011	Worksheet S-10 Date/Time Prepared: 5/22/2012 11:42 am
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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)		0.183927		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		1,835,014		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		1,648,580		5.00
6.00	Medicaid charges		30,145,518		6.00
7.00	Medicaid cost (line 1 times line 6)		5,544,575		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)		2,060,981		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)		2,060,981		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	2,871,104	344,132	3,215,236	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	528,074	63,295	591,369	21.00
22.00	Partial payment by patients approved for charity care	3,620	90	3,710	22.00
23.00	Cost of charity care (line 21 minus line 22)	524,454	63,205	587,659	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)		5,237,310		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		148,697		27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		5,088,613		28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		935,933		29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		1,523,592		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,584,573		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet A
Date/Time Prepared:
5/22/2012 11:42 am

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT		710,067	710,067	320,079	1,030,146	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP		535,460	535,460	65,978	601,438	2.00
4.00 EMPLOYEE BENEFITS	0	0	0	926,360	926,360	4.00
5.00 ADMINISTRATIVE & GENERAL	207,456	12,064,840	12,272,296	-1,236,947	11,035,349	5.00
6.00 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 OPERATION OF PLANT	252,859	1,481,911	1,734,770	-7,437	1,727,333	7.00
8.00 LAUNDRY & LINEN SERVICE	0	119,590	119,590	0	119,590	8.00
9.00 HOUSEKEEPING	0	2,848	2,848	0	2,848	9.00
10.00 DIETARY	0	349,108	349,108	0	349,108	10.00
11.00 CAFETERIA	0	0	0	0	0	11.00
13.00 NURSING ADMINISTRATION	0	11,015	11,015	0	11,015	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00 PHARMACY	0	256,281	256,281	-247,303	8,978	15.00
16.00 MEDICAL RECORDS & LIBRARY	0	2,155	2,155	0	2,155	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	971,805	98,470	1,070,275	287	1,070,562	30.00
40.00 SUBPROVIDER - IPF	1,256,813	224,558	1,481,371	-159	1,481,212	40.00
41.00 SUBPROVIDER - IRF	1,554,119	185,413	1,739,532	-508	1,739,024	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
54.00 RADIOLOGY-DIAGNOSTIC	12,726	29,791	42,517	380,195	422,712	54.00
54.01 ULTRA SOUND	15,787	16,728	32,515	-32,515	0	54.01
54.02 CT SCAN	0	0	0	0	0	54.02
57.00 CT SCAN	187,989	159,691	347,680	-347,680	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	726,034	611,717	1,337,751	-11,441	1,326,310	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	0	23,186	23,186	-23,186	0	65.00
66.00 PHYSICAL THERAPY	464,697	50,843	515,540	273,302	788,842	66.00
67.00 OCCUPATIONAL THERAPY	172,605	19,810	192,415	-192,415	0	67.00
68.00 SPEECH PATHOLOGY	74,487	6,400	80,887	-80,887	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	9,583	9,583	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	218,786	218,786	73.00
76.00 MENTAL HEALTH ANCILLARY	830,616	135,036	965,652	-90	965,562	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	1,004,505	253,041	1,257,546	-2,114	1,255,432	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						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	7,732,498	17,347,959	25,080,457	11,888	25,092,345	118.00
NONREIMBURSABLE COST CENTERS						
190.02 WORKPOWER/CORP HEALTH	0	0	0	0	0	190.02
192.00 PHYSICIANS' PRIVATE OFFICES	0	29,558	29,558	-29,558	0	192.00
192.01 VISTA MEDICAL CENTER EAST	0	0	0	17,670	17,670	192.01
200.00 TOTAL (SUM OF LINES 118-199)	7,732,498	17,377,517	25,110,015	0	25,110,015	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet A
Date/Time Prepared:
5/22/2012 11:42 am

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	882,270	1,912,416	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-76,528	524,910	2.00
4.00	EMPLOYEE BENEFITS	17,000	943,360	4.00
5.00	ADMINISTRATIVE & GENERAL	-9,893,538	1,141,811	5.00
6.00	MAINTENANCE & REPAIRS	0	0	6.00
7.00	OPERATION OF PLANT	234,110	1,961,443	7.00
8.00	LAUNDRY & LINEN SERVICE	449	120,039	8.00
9.00	HOUSEKEEPING	730,899	733,747	9.00
10.00	DIETARY	0	349,108	10.00
11.00	CAFETERIA	0	0	11.00
13.00	NURSING ADMINISTRATION	0	11,015	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	PHARMACY	0	8,978	15.00
16.00	MEDICAL RECORDS & LIBRARY	-25	2,130	16.00
17.00	SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-7,711	1,062,851	30.00
40.00	SUBPROVIDER - 1PF	-28,289	1,452,923	40.00
41.00	SUBPROVIDER - 1RF	0	1,739,024	41.00
42.00	SUBPROVIDER	0	0	42.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	0	50.00
51.00	RECOVERY ROOM	0	0	51.00
54.00	RADIOLOGY-DIAGNOSTIC	0	422,712	54.00
54.01	ULTRA SOUND	0	0	54.01
54.02	CT SCAN	0	0	54.02
57.00	CT SCAN	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	59.00
60.00	LABORATORY	-201,731	1,124,579	60.00
60.01	BLOOD LABORATORY	0	0	60.01
65.00	RESPIRATORY THERAPY	0	0	65.00
66.00	PHYSICAL THERAPY	0	788,842	66.00
67.00	OCCUPATIONAL THERAPY	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,583	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	218,786	73.00
76.00	MENTAL HEALTH ANCILLARY	-42,891	922,671	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	CLINIC	0	0	90.00
91.00	EMERGENCY	12,495	1,267,927	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				
109.00	PANCREAS ACQUISITION	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	110.00
111.00	ISLET ACQUISITION	0	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-8,373,490	16,718,855	118.00
NONREIMBURSABLE COST CENTERS				
190.02	WORKPOWER/CORP HEALTH	0	0	190.02
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	VI STA MEDICAL CENTER EAST	0	17,670	192.01
200.00	TOTAL (SUM OF LINES 118-199)	-8,373,490	16,736,525	200.00

RECLASSIFICATIONS

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet A-6

Date/Time Prepared:
5/22/2012 11:42 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - RECLASS EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS	4.00	0	926,360	1.00
	TOTALS		0	926,360	
B - RECLASS OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	9,583	1.00
	TOTALS		0	9,583	
C - RECLASS RENTAL AND LEASE EXP					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	65,978	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	287	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
	TOTALS		0	66,265	
D - RECLASS OTHER CAPITAL COSTS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	320,079	1.00
	TOTALS		0	320,079	
E - RECLASS DRUGS/IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	218,786	1.00
	TOTALS		0	218,786	
F - RECLASS PT, OT AND SP					
1.00	PHYSICAL THERAPY	66.00	247,092	26,210	1.00
2.00		0.00	0	0	2.00
	TOTALS		247,092	26,210	
G - RECLASS OF OTHER RADIOLOGY COSTS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	203,776	176,419	1.00
2.00		0.00	0	0	2.00
	TOTALS		203,776	176,419	
H - RECLASS MOB COSTS					
1.00	VI STA MEDICAL CENTER EAST	192.01	0	17,670	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	11,888	2.00
	TOTALS		0	29,558	
500.00	Grand Total: Increases		450,868	1,773,260	500.00

RECLASSIFICATIONS

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet A-6

Date/Time Prepared:
5/22/2012 11:42 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - RECLASS EMPLOYEE BENEFITS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	926,360	0		1.00
	TOTALS		0	926,360			
B - RECLASS OXYGEN COSTS							
1.00	RESPIRATORY THERAPY	65.00	0	9,583	0		1.00
	TOTALS		0	9,583			
C - RECLASS RENTAL AND LEASE EXP							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,396	10		1.00
2.00	OPERATION OF PLANT	7.00	0	7,437	0		2.00
3.00	PHARMACY	15.00	0	28,517	0		3.00
4.00	SUBPROVIDER - IPF	40.00	0	159	0		4.00
5.00	SUBPROVIDER - IRF	41.00	0	508	0		5.00
6.00	LABORATORY	60.00	0	11,441	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	13,603	0		7.00
8.00	MENTAL HEALTH ANCILLARY	76.00	0	90	0		8.00
9.00	EMERGENCY	91.00	0	2,114	0		9.00
	TOTALS		0	66,265			
D - RECLASS OTHER CAPITAL COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	320,079	13		1.00
	TOTALS		0	320,079			
E - RECLASS DRUGS/IV SOLUTIONS							
1.00	PHARMACY	15.00	0	218,786	0		1.00
	TOTALS		0	218,786			
F - RECLASS PT, OT AND SP							
1.00	OCCUPATIONAL THERAPY	67.00	172,605	19,810	0		1.00
2.00	SPEECH PATHOLOGY	68.00	74,487	6,400	0		2.00
	TOTALS		247,092	26,210			
G - RECLASS OF OTHER RADIOLOGY COSTS							
1.00	ULTRA SOUND	54.01	15,787	16,728	0		1.00
2.00	CT SCAN	57.00	187,989	159,691	0		2.00
	TOTALS		203,776	176,419			
H - RECLASS MOB COSTS							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	29,558	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	29,558			
500.00	Grand Total: Decreases		450,868	1,773,260			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/22/2012 11:42 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,970,715	0	0	0	1.00
2.00	Land Improvements	516,681	0	0	0	2.00
3.00	Buildings and Fixtures	27,310,374	0	0	0	3.00
4.00	Building Improvements	2,950,749	3,367	0	3,367	4.00
5.00	Fixed Equipment	4,985,318	135,326	0	135,326	5.00
6.00	Movable Equipment	23,473,953	29,229	0	29,229	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	61,207,790	167,922	0	167,922	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	61,207,790	167,922	0	167,922	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	710,067	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	535,460	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,245,527	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	0	0	0	1.000000	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/22/2012 11:42 am

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,970,715	0		1.00		
2.00	Land Improvements	516,681	0		2.00		
3.00	Buildings and Fixtures	27,310,374	0		3.00		
4.00	Building Improvements	2,954,116	0		4.00		
5.00	Fixed Equipment	5,120,644	0		5.00		
6.00	Movable Equipment	23,503,182	0		6.00		
7.00	HIT designated Assets	0	0		7.00		
8.00	Subtotal (sum of lines 1-7)	61,375,712	0		8.00		
9.00	Reconciling Items	0	0		9.00		
10.00	Total (line 8 minus line 9)	61,375,712	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	710,067		1.00		
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	535,460		2.00		
3.00	Total (sum of lines 1-2)	0	1,245,527		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	681,120	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	458,932	65,978	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,140,052	65,978	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/22/2012 11:42 am

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	911,217	0	320,079	0	1,912,416	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	524,910	2.00
3.00	Total (sum of lines 1-2)	911,217	0	320,079	0	2,437,326	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet A-8

Date/Time Prepared:
5/22/2012 11:42 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center		Line #
			1.00	2.00	3.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			NEW CAP REL COSTS-MVBLE EQUIP		2.00
3.00 Investment income - other (chapter 2)		0			0.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00
8.00 Television and radio service (chapter 21)		0			0.00
9.00 Parking lot (chapter 21)		0			0.00
10.00 Provider-based physician adjustment	A-8-2	-706,230			10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00
12.00 Related organization transactions (chapter 10)	A-8-1	1,405,965			12.00
13.00 Laundry and linen service		0			0.00
14.00 Cafeteria-employees and guests		0			0.00
15.00 Rental of quarters to employee and others		0			0.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00
17.00 Sale of drugs to other than patients		0			0.00
18.00 Sale of medical records and abstracts	B	-25	MEDICAL RECORDS & LIBRARY		16.00
19.00 Nursing school (tuition, fees, books, etc.)	B	-74,895	ADMINISTRATIVE & GENERAL		5.00
20.00 Vending machines		0			0.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		RESPIRATORY THERAPY		65.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY		66.00
25.00 Utilization review - physicians' compensation (chapter 21)			*** Cost Center Deleted ***		114.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT	A	15,900	NEW CAP REL COSTS-BLDG & FIXT		1.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	A	-116,039	NEW CAP REL COSTS-MVBLE EQUIP		2.00
28.00 Non-physician Anesthetist			*** Cost Center Deleted ***		19.00
29.00 Physicians' assistant		0			0.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY		67.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		SPEECH PATHOLOGY		68.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	0			0.00
33.00 RENTAL INCOME	B	-61,155	NEW CAP REL COSTS-BLDG & FIXT		1.00
35.00 BAD DEBTS	A	-7,812,260	ADMINISTRATIVE & GENERAL		5.00
36.00 PHONE & TV DEPRECIATION	A	-1,093	NEW CAP REL COSTS-MVBLE EQUIP		2.00
36.01 PHONE & TV	A	-9,313	ADMINISTRATIVE & GENERAL		5.00
37.00 STATE OPERATING TAX	A	-2,016,516	ADMINISTRATIVE & GENERAL		5.00
38.00 MEMBERSHIP DUES	A	-2,400	ADMINISTRATIVE & GENERAL		5.00
39.00 ALLOCATED SECURITY / PLANT OPS	A	234,110	OPERATION OF PLANT		7.00
40.00 ALLOCATED HOUSEKEEPING	A	730,899	HOUSEKEEPING		9.00
41.00 ALLOCATED LAUNDRY & LINEN	A	449	LAUNDRY & LINEN SERVICE		8.00
42.00 ALLOCATED RECOVERY ROOM	A	9,050	MENTAL HEALTH ANCILLARY		76.00
43.00 ALLOCATED ANESTHESIA	A	568	MENTAL HEALTH ANCILLARY		76.00
44.00 ALLOCATED EKG	A	12,495	EMERGENCY		91.00
45.00 EMP BENEFITS FROM VISTA EAST	A	17,000	EMPLOYEE BENEFITS		4.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,373,490			50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet A-8

Date/Time Prepared:
5/22/2012 11:42 am

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)	0	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	9	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	9	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	RENTAL INCOME	9	33.00
35.00	BAD DEBTS	0	35.00
36.00	PHONE & TV DEPRECIATION	9	36.00
36.01	PHONE & TV	0	36.01
37.00	STATE OPERATING TAX	0	37.00
38.00	MEMBERSHIP DUES	0	38.00
39.00	ALLOCATED SECURITY / PLANT OPS	0	39.00
40.00	ALLOCATED HOUSEKEEPING	0	40.00
41.00	ALLOCATED LAUNDRY & LINEN	0	41.00
42.00	ALLOCATED RECOVERY ROOM	0	42.00
43.00	ALLOCATED ANESTHESIA	0	43.00
44.00	ALLOCATED EKG	0	44.00
45.00	EMP BENEFITS FROM VISTA EAST	0	45.00
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: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet A-8-1

Date/Time Prepared:
5/22/2012 11:42 am

	Line No.	Cost Center	Expense Items	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00		1.00 NEW CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	1.00
2.00		5.00 ADMINISTRATIVE & GENERAL	PASI OPERATING COSTS	2.00
3.00		1.00 NEW CAP REL COSTS-BLDG & FIXT	PASI CAPITAL	3.00
4.00		1.00 NEW CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIXTURES	4.00
4.01		2.00 NEW CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPMENT	4.01
4.02		5.00 ADMINISTRATIVE & GENERAL	NON-CAPITAL HOME OFFICE COSTS	4.02
4.03		5.00 ADMINISTRATIVE & GENERAL	MALPRACTICE COST	4.03
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	
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		B	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: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet A-8-1

Date/Time Prepared:
5/22/2012 11:42 am

	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	911,217	0	911,217	11	1.00	
2.00	99,349	172,633	-73,284	0	2.00	
3.00	9,065	0	9,065	9	3.00	
4.00	7,243	0	7,243	9	4.00	
4.01	40,604	0	40,604	9	4.01	
4.02	361,781	0	361,781	0	4.02	
4.03	149,339	0	149,339	0	4.03	
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	1,578,598	172,633	1,405,965		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	COMMUNITY HEALTH SYSTEMS	0.00	HOME OFFICE	6.00
7.00	0	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: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet A-8-2

Date/Time Prepared:
5/22/2012 11:42 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	30.00	ADULTS & PEDIATRICS	7,711	7,711	1.00
2.00	40.00	SUBPROVIDER - IPF	43,032	23,132	2.00
3.00	60.00	LABORATORY	201,731	201,731	3.00
4.00	76.00	MENTAL HEALTH ANCI LLARY	55,769	50,301	4.00
5.00	5.00	ADMINI STRATI VE & GENERAL	415,990	415,990	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
200.00			724,233	698,865	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet A-8-2

Date/Time Prepared:
5/22/2012 11:42 am

	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	19,900	154,100	199	14,743	737	2.00
3.00	0	0	0	0	0	3.00
4.00	5,468	154,100	44	3,260	163	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	25,368		243	18,003	900	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet A-8-2

Date/Time Prepared:
5/22/2012 11:42 am

	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	14,743	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	3,260	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	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	18,003	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet A-8-2

Date/Time Prepared:
5/22/2012 11:42 am

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	7,711	1.00
2.00	5,157	28,289	2.00
3.00	0	201,731	3.00
4.00	2,208	52,509	4.00
5.00	0	415,990	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	7,365	706,230	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet B
Part I
Date/Time Prepared:
5/22/2012 11:42 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT	1,912,416	1,912,416				1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	524,910		524,910			2.00
4.00 EMPLOYEE BENEFITS	943,360	0	0	943,360		4.00
5.00 ADMINISTRATIVE & GENERAL	1,141,811	88,298	24,236	25,309	1,279,654	5.00
6.00 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 OPERATION OF PLANT	1,961,443	1,098,583	301,534	30,849	3,392,409	7.00
8.00 LAUNDRY & LINEN SERVICE	120,039	24,233	6,651	0	150,923	8.00
9.00 HOUSEKEEPING	733,747	54,559	14,975	0	803,281	9.00
10.00 DIETARY	349,108	14,512	3,983	0	367,603	10.00
11.00 CAFETERIA	0	0	0	0	0	11.00
13.00 NURSING ADMINISTRATION	11,015	0	0	0	11,015	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00 PHARMACY	8,978	29,895	8,205	0	47,078	15.00
16.00 MEDICAL RECORDS & LIBRARY	2,130	12,768	3,505	0	18,403	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1,062,851	68,556	18,817	118,559	1,268,783	30.00
40.00 SUBPROVIDER - I/PF	1,452,923	100,178	27,496	153,330	1,733,927	40.00
41.00 SUBPROVIDER - IRF	1,739,024	92,673	25,436	189,604	2,046,737	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
54.00 RADIOLOGY-DIAGNOSTIC	422,712	0	0	26,413	449,125	54.00
54.01 ULTRA SOUND	0	0	0	0	0	54.01
54.02 CT SCAN	0	0	0	0	0	54.02
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	1,124,579	62,529	17,163	88,575	1,292,846	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	788,842	43,277	11,879	86,838	930,836	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
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	9,583	0	0	0	9,583	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	218,786	0	0	0	218,786	73.00
76.00 MENTAL HEALTH ANCILLARY	922,671	40,803	11,199	101,334	1,076,007	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	1,267,927	126,096	34,610	122,549	1,551,182	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						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	16,718,855	1,856,960	509,689	943,360	16,648,178	118.00
NONREIMBURSABLE COST CENTERS						
190.02 WORKPOWER/CORP HEALTH	0	0	0	0	0	190.02
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 VI STA MEDICAL CENTER EAST	17,670	55,456	15,221	0	88,347	192.01
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)	16,736,525	1,912,416	524,910	943,360	16,736,525	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet B
Part I
Date/Time Prepared:
5/22/2012 11:42 am

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
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
5.00	ADMINISTRATIVE & GENERAL	1,279,654					5.00
6.00	MAINTENANCE & REPAIRS	0	0				6.00
7.00	OPERATION OF PLANT	280,849	0	3,673,258			7.00
8.00	LAUNDRY & LINEN SERVICE	12,495	0	122,687	286,105		8.00
9.00	HOUSEKEEPING	66,503	0	276,225	0	1,146,009	9.00
10.00	DIETARY	30,433	0	73,469	0	25,714	10.00
11.00	CAFETERIA	0	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	912	0	0	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	3,898	0	151,352	0	52,973	15.00
16.00	MEDICAL RECORDS & LIBRARY	1,524	0	64,643	0	22,625	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	105,041	0	347,088	45,519	121,480	30.00
40.00	SUBPROVIDER - I/PF	143,550	0	507,182	66,549	177,512	40.00
41.00	SUBPROVIDER - I/RP	169,447	0	469,187	61,542	164,214	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	RADIOLOGY-DIAGNOSTIC	37,183	0	0	0	0	54.00
54.01	ULTRA SOUND	0	0	0	0	0	54.01
54.02	CT SCAN	0	0	0	0	0	54.02
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	107,033	0	316,574	0	110,800	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	77,063	0	219,105	28,753	76,686	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
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	793	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	18,113	0	0	0	0	73.00
76.00	MENTAL HEALTH ANCILLARY	89,082	0	206,580	0	72,302	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	128,421	0	638,402	83,742	223,437	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							
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,272,340	0	3,392,494	286,105	1,047,743	118.00
NONREIMBURSABLE COST CENTERS							
190.02	WORKPOWER/CORP HEALTH	0	0	0	0	0	190.02
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	VI STA MEDICAL CENTER EAST	7,314	0	280,764	0	98,266	192.01
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)	1,279,654	0	3,673,258	286,105	1,146,009	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet B
Part I
Date/Time Prepared:
5/22/2012 11:42 am

Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	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
5.00 ADMINISTRATIVE & GENERAL						5.00
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY	497,219					10.00
11.00 CAFETERIA	0	0				11.00
13.00 NURSING ADMINISTRATION	0	0	11,927			13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
15.00 PHARMACY	0	0	0	0	255,301	15.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	119,592	0	0	0	0	30.00
40.00 SUBPROVIDER - IPF	194,803	0	0	0	0	40.00
41.00 SUBPROVIDER - IRF	159,130	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01 ULTRA SOUND	0	0	0	0	0	54.01
54.02 CT SCAN	0	0	0	0	0	54.02
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
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
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	255,301	73.00
76.00 MENTAL HEALTH ANCILLARY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	11,927	0	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						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	473,525	0	11,927	0	255,301	118.00
NONREIMBURSABLE COST CENTERS						
190.02 WORKPOWER/CORP HEALTH	0	0	0	0	0	190.02
192.00 PHYSICIANS' PRIVATE OFFICES	23,694	0	0	0	0	192.00
192.01 VISTA MEDICAL CENTER EAST	0	0	0	0	0	192.01
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)	497,219	0	11,927	0	255,301	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet B
Part I
Date/Time Prepared:
5/22/2012 11:42 am

Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	16.00	17.00	24.00	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
5.00 ADMINISTRATIVE & GENERAL						5.00
6.00 MAINTENANCE & REPAIRS						6.00
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	107,195					16.00
17.00 SOCIAL SERVICE	0	0				17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	10,431	0	2,017,934	0	2,017,934	30.00
40.00 SUBPROVIDER - IPF	16,977	0	2,840,500	0	2,840,500	40.00
41.00 SUBPROVIDER - IRF	10,465	0	3,080,722	0	3,080,722	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
54.00 RADIOLOGY-DIAGNOSTIC	9,861	0	496,169	0	496,169	54.00
54.01 ULTRA SOUND	0	0	0	0	0	54.01
54.02 CT SCAN	0	0	0	0	0	54.02
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	13,693	0	1,840,946	0	1,840,946	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	8,235	0	1,340,678	0	1,340,678	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
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	18	0	10,394	0	10,394	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	8,025	0	500,225	0	500,225	73.00
76.00 MENTAL HEALTH ANCILLARY	5,620	0	1,449,591	0	1,449,591	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	23,870	0	2,660,981	0	2,660,981	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	107,195	0	16,238,140	0	16,238,140	118.00
NONREIMBURSABLE COST CENTERS						
190.02 WORKPOWER/CORP HEALTH	0	0	0	0	0	190.02
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	23,694	0	23,694	192.00
192.01 VI STA MEDICAL CENTER EAST	0	0	474,691	0	474,691	192.01
200.00 Cross Foot Adjustments			0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	107,195	0	16,736,525	0	16,736,525	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet B
Part II
Date/Time Prepared:
5/22/2012 11:42 am

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	0	0	0	4.00
5.00	ADMINISTRATIVE & GENERAL	0	88,298	24,236	112,534	5.00
6.00	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	OPERATION OF PLANT	0	1,098,583	301,534	1,400,117	7.00
8.00	LAUNDRY & LINEN SERVICE	0	24,233	6,651	30,884	8.00
9.00	HOUSEKEEPING	0	54,559	14,975	69,534	9.00
10.00	DIETARY	0	14,512	3,983	18,495	10.00
11.00	CAFETERIA	0	0	0	0	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	29,895	8,205	38,100	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	12,768	3,505	16,273	16.00
17.00	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	68,556	18,817	87,373	30.00
40.00	SUBPROVIDER - IPF	0	100,178	27,496	127,674	40.00
41.00	SUBPROVIDER - IRF	0	92,673	25,436	118,109	41.00
42.00	SUBPROVIDER	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	51.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	ULTRA SOUND	0	0	0	0	54.01
54.02	CT SCAN	0	0	0	0	54.02
57.00	CT SCAN	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	LABORATORY	0	62,529	17,163	79,692	60.00
60.01	BLOOD LABORATORY	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	43,277	11,879	55,156	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	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	MENTAL HEALTH ANCILLARY	0	40,803	11,199	52,002	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	90.00
91.00	EMERGENCY	0	126,096	34,610	160,706	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						
109.00	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,856,960	509,689	2,366,649	118.00
NONREIMBURSABLE COST CENTERS						
190.02	WORKPOWER/CORP HEALTH	0	0	0	0	190.02
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	VISTA MEDICAL CENTER EAST	0	55,456	15,221	70,677	192.01
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,912,416	524,910	2,437,326	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet B
Part II
Date/Time Prepared:
5/22/2012 11:42 am

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
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
5.00	ADMINISTRATIVE & GENERAL	112,534					5.00
6.00	MAINTENANCE & REPAIRS	0	0				6.00
7.00	OPERATION OF PLANT	24,693	0	1,424,810			7.00
8.00	LAUNDRY & LINEN SERVICE	1,099	0	47,589	79,572		8.00
9.00	HOUSEKEEPING	5,849	0	107,144	0	182,527	9.00
10.00	DIETARY	2,677	0	28,498	0	4,096	10.00
11.00	CAFETERIA	0	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	80	0	0	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	343	0	58,707	0	8,437	15.00
16.00	MEDICAL RECORDS & LIBRARY	134	0	25,074	0	3,603	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	9,238	0	134,631	12,660	19,348	30.00
40.00	SUBPROVIDER - I/PF	12,625	0	196,730	18,509	28,273	40.00
41.00	SUBPROVIDER - I/RP	14,902	0	181,992	17,116	26,155	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	RADIOLOGY-DIAGNOSTIC	3,270	0	0	0	0	54.00
54.01	ULTRA SOUND	0	0	0	0	0	54.01
54.02	CT SCAN	0	0	0	0	0	54.02
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	9,413	0	122,795	0	17,647	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	6,777	0	84,988	7,997	12,214	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
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	70	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,593	0	0	0	0	73.00
76.00	MENTAL HEALTH ANCILLARY	7,834	0	80,130	0	11,516	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	11,294	0	247,627	23,290	35,587	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							
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	111,891	0	1,315,905	79,572	166,876	118.00
NONREIMBURSABLE COST CENTERS							
190.02	WORKPOWER/CORP HEALTH	0	0	0	0	0	190.02
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	VI STA MEDICAL CENTER EAST	643	0	108,905	0	15,651	192.01
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)	112,534	0	1,424,810	79,572	182,527	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet B
Part II
Date/Time Prepared:
5/22/2012 11:42 am

Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	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
5.00 ADMINISTRATIVE & GENERAL						5.00
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY	53,766					10.00
11.00 CAFETERIA	0	0				11.00
13.00 NURSING ADMINISTRATION	0	0	80			13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
15.00 PHARMACY	0	0	0	0	105,587	15.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	12,932	0	0	0	0	30.00
40.00 SUBPROVIDER - IPF	21,065	0	0	0	0	40.00
41.00 SUBPROVIDER - IRF	17,207	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01 ULTRA SOUND	0	0	0	0	0	54.01
54.02 CT SCAN	0	0	0	0	0	54.02
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
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
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	105,587	73.00
76.00 MENTAL HEALTH ANCILLARY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	80	0	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						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	51,204	0	80	0	105,587	118.00
NONREIMBURSABLE COST CENTERS						
190.02 WORKPOWER/CORP HEALTH	0	0	0	0	0	190.02
192.00 PHYSICIANS' PRIVATE OFFICES	2,562	0	0	0	0	192.00
192.01 VISTA MEDICAL CENTER EAST	0	0	0	0	0	192.01
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)	53,766	0	80	0	105,587	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet B
Part II
Date/Time Prepared:
5/22/2012 11:42 am

Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	16.00	17.00	24.00	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
5.00 ADMINISTRATIVE & GENERAL						5.00
6.00 MAINTENANCE & REPAIRS						6.00
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	45,084					16.00
17.00 SOCIAL SERVICE	0	0				17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	4,391	0	280,573	0	280,573	30.00
40.00 SUBPROVIDER - IPF	7,146	0	412,022	0	412,022	40.00
41.00 SUBPROVIDER - IRF	4,405	0	379,886	0	379,886	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
54.00 RADIOLOGY-DIAGNOSTIC	4,151	0	7,421	0	7,421	54.00
54.01 ULTRA SOUND	0	0	0	0	0	54.01
54.02 CT SCAN	0	0	0	0	0	54.02
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	5,764	0	235,311	0	235,311	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	3,466	0	170,598	0	170,598	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
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	8	0	78	0	78	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	3,378	0	110,558	0	110,558	73.00
76.00 MENTAL HEALTH ANCILLARY	2,365	0	153,847	0	153,847	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	10,010	0	488,594	0	488,594	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						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	45,084	0	2,238,888	0	2,238,888	118.00
NONREIMBURSABLE COST CENTERS						
190.02 WORKPOWER/CORP HEALTH	0	0	0	0	0	190.02
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	2,562	0	2,562	192.00
192.01 VI STA MEDICAL CENTER EAST	0	0	195,876	0	195,876	192.01
200.00 Cross Foot Adjustments			0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	45,084	0	2,437,326	0	2,437,326	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet B-1
Date/Time Prepared:
5/22/2012 11:42 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00 NEW CAP REL COSTS-BLDG & FIXT	230,362						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP		230,362					2.00
4.00 EMPLOYEE BENEFITS	0	0	7,732,498				4.00
5.00 ADMINISTRATIVE & GENERAL	10,636	10,636	207,456	-1,279,654	15,456,871		5.00
6.00 MAINTENANCE & REPAIRS	0	0	0	0	0		6.00
7.00 OPERATION OF PLANT	132,331	132,331	252,859	0	3,392,409		7.00
8.00 LAUNDRY & LINEN SERVICE	2,919	2,919	0	0	150,923		8.00
9.00 HOUSEKEEPING	6,572	6,572	0	0	803,281		9.00
10.00 DIETARY	1,748	1,748	0	0	367,603		10.00
11.00 CAFETERIA	0	0	0	0	0		11.00
13.00 NURSING ADMINISTRATION	0	0	0	0	11,015		13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	0	0		14.00
15.00 PHARMACY	3,601	3,601	0	0	47,078		15.00
16.00 MEDICAL RECORDS & LIBRARY	1,538	1,538	0	0	18,403		16.00
17.00 SOCIAL SERVICE	0	0	0	0	0		17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	8,258	8,258	971,805	0	1,268,783		30.00
40.00 SUBPROVIDER - IPF	12,067	12,067	1,256,813	0	1,733,927		40.00
41.00 SUBPROVIDER - IRF	11,163	11,163	1,554,119	0	2,046,737		41.00
42.00 SUBPROVIDER	0	0	0	0	0		42.00
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	0	0	0	0	0		50.00
51.00 RECOVERY ROOM	0	0	0	0	0		51.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	216,502	0	449,125		54.00
54.01 ULTRA SOUND	0	0	0	0	0		54.01
54.02 CT SCAN	0	0	0	0	0		54.02
57.00 CT SCAN	0	0	0	0	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0		58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0		59.00
60.00 LABORATORY	7,532	7,532	726,034	0	1,292,846		60.00
60.01 BLOOD LABORATORY	0	0	0	0	0		60.01
65.00 RESPIRATORY THERAPY	0	0	0	0	0		65.00
66.00 PHYSICAL THERAPY	5,213	5,213	711,789	0	930,836		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
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	9,583		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	218,786		73.00
76.00 MENTAL HEALTH ANCILLARY	4,915	4,915	830,616	0	1,076,007		76.00
OUTPATIENT SERVICE COST CENTERS							
88.00 RURAL HEALTH CLINIC	0	0	0	0	0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0		89.00
90.00 CLINIC	0	0	0	0	0		90.00
91.00 EMERGENCY	15,189	15,189	1,004,505	0	1,551,182		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							
109.00 PANCREAS ACQUISITION	0	0	0	0	0		109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0		110.00
111.00 ISLET ACQUISITION	0	0	0	0	0		111.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	223,682	223,682	7,732,498	-1,279,654	15,368,524		118.00
NONREIMBURSABLE COST CENTERS							
190.02 WORKPOWER/CORP HEALTH	0	0	0	0	0		190.02
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0		192.00
192.01 VI STA MEDICAL CENTER EAST	6,680	6,680	0	0	88,347		192.01
200.00 Cross Foot Adjustments							200.00
201.00 Negative Cost Centers							201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	1,912,416	524,910	943,360		1,279,654		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	8.301786	2.278631	0.121999		0.082789		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			0		112,534		204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.000000		0.007281		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet B-1
Date/Time Prepared:
5/22/2012 11:42 am

Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
	6.00	7.00	8.00	9.00	10.00	
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
5.00 ADMINISTRATIVE & GENERAL						5.00
6.00 MAINTENANCE & REPAIRS	219,726					6.00
7.00 OPERATION OF PLANT	132,331	87,395				7.00
8.00 LAUNDRY & LINEN SERVICE	2,919	2,919	116,349			8.00
9.00 HOUSEKEEPING	6,572	6,572	0	77,904		9.00
10.00 DIETARY	1,748	1,748	0	1,748	50,428	10.00
11.00 CAFETERIA	0	0	0	0	0	11.00
13.00 NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00 PHARMACY	3,601	3,601	0	3,601	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	1,538	1,538	0	1,538	0	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	8,258	8,258	18,511	8,258	12,129	30.00
40.00 SUBPROVIDER - IPF	12,067	12,067	27,063	12,067	19,757	40.00
41.00 SUBPROVIDER - IRF	11,163	11,163	25,027	11,163	16,139	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01 ULTRA SOUND	0	0	0	0	0	54.01
54.02 CT SCAN	0	0	0	0	0	54.02
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	7,532	7,532	0	7,532	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	5,213	5,213	11,693	5,213	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
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 MENTAL HEALTH ANCILLARY	4,915	4,915	0	4,915	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	15,189	15,189	34,055	15,189	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						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	213,046	80,715	116,349	71,224	48,025	118.00
NONREIMBURSABLE COST CENTERS						
190.02 WORKPOWER/CORP HEALTH	0	0	0	0	0	190.02
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	2,403	192.00
192.01 VI STA MEDICAL CENTER EAST	6,680	6,680	0	6,680	0	192.01
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)	0	3,673,258	286,105	1,146,009	497,219	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.000000	42.030528	2.459024	14.710528	9.859979	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	0	1,424,810	79,572	182,527	53,766	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.000000	16.303107	0.683908	2.342973	1.066193	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet B-1
Date/Time Prepared:
5/22/2012 11:42 am

Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
	11.00	13.00	14.00	15.00	16.00	
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
5.00 ADMINISTRATIVE & GENERAL						5.00
6.00 MAINTENANCE & REPAIRS						6.00
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	11,589					11.00
13.00 NURSING ADMINISTRATION	0	1,004,505				13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	386,647			14.00
15.00 PHARMACY	0	0	0	218,786		15.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	1,582	0	88,285,808	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1,695	0	9,139	0	8,592,152	30.00
40.00 SUBPROVIDER - IPF	2,236	0	15,505	0	13,984,642	40.00
41.00 SUBPROVIDER - IRF	2,516	0	49,565	0	8,620,447	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
54.00 RADIOLOGY-DIAGNOSTIC	210	0	6,545	0	8,123,097	54.00
54.01 ULTRA SOUND	0	0	0	0	0	54.01
54.02 CT SCAN	0	0	0	0	0	54.02
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	1,253	0	214,268	0	11,279,523	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	1,037	0	12,067	0	6,783,473	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
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	14,932	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	218,786	6,610,563	73.00
76.00 MENTAL HEALTH ANCILLARY	1,280	0	2,639	0	4,629,022	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	1,362	1,004,505	75,337	0	19,647,957	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						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	11,589	1,004,505	386,647	218,786	88,285,808	118.00
NONREIMBURSABLE COST CENTERS						
190.02 WORKPOWER/CORP HEALTH	0	0	0	0	0	190.02
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 VI STA MEDICAL CENTER EAST	0	0	0	0	0	192.01
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)	0	11,927	0	255,301	107,195	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.000000	0.011874	0.000000	1.166898	0.001214	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	0	80	0	105,587	45,084	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000080	0.000000	0.482604	0.000511	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet B-1
Date/Time Prepared:
5/22/2012 11:42 am

Cost Center Description	SOCIAL SERVICE		
	(PATIENT DAYS)		
	17.00		
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
5.00 ADMINISTRATIVE & GENERAL			5.00
6.00 MAINTENANCE & REPAIRS			6.00
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
17.00 SOCIAL SERVICE	14,694		17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS	3,711		30.00
40.00 SUBPROVIDER - IPF	6,045		40.00
41.00 SUBPROVIDER - IRF	4,938		41.00
42.00 SUBPROVIDER	0		42.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	0		50.00
51.00 RECOVERY ROOM	0		51.00
54.00 RADIOLOGY-DIAGNOSTIC	0		54.00
54.01 ULTRA SOUND	0		54.01
54.02 CT SCAN	0		54.02
57.00 CT SCAN	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0		58.00
59.00 CARDIAC CATHETERIZATION	0		59.00
60.00 LABORATORY	0		60.00
60.01 BLOOD LABORATORY	0		60.01
65.00 RESPIRATORY THERAPY	0		65.00
66.00 PHYSICAL THERAPY	0		66.00
67.00 OCCUPATIONAL THERAPY	0		67.00
68.00 SPEECH PATHOLOGY	0		68.00
69.00 ELECTROCARDIOLOGY	0		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0		73.00
76.00 MENTAL HEALTH ANCILLARY	0		76.00
OUTPATIENT SERVICE COST CENTERS			
88.00 RURAL HEALTH CLINIC	0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0		89.00
90.00 CLINIC	0		90.00
91.00 EMERGENCY	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
OTHER REIMBURSABLE COST CENTERS			
99.10 CORF	0		99.10
SPECIAL PURPOSE COST CENTERS			
109.00 PANCREAS ACQUISITION	0		109.00
110.00 INTESTINAL ACQUISITION	0		110.00
111.00 ISLET ACQUISITION	0		111.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	14,694		118.00
NONREIMBURSABLE COST CENTERS			
190.02 WORKPOWER/CORP HEALTH	0		190.02
192.00 PHYSICIANS' PRIVATE OFFICES	0		192.00
192.01 VI STA MEDICAL CENTER EAST	0		192.01
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)	0		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.000000		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	0		204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet C
Part I
Date/Time Prepared:
5/22/2012 11:42 am

		Title XVIII		Hospital		PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS		2,017,934	0	2,017,934	30.00
40.00	SUBPROVIDER - IPF		2,840,500	5,157	2,845,657	40.00
41.00	SUBPROVIDER - IRF		3,080,722	0	3,080,722	41.00
42.00	SUBPROVIDER		0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM		0	0	0	50.00
51.00	RECOVERY ROOM		0	0	0	51.00
54.00	RADIOLOGY-DIAGNOSTIC		496,169	0	496,169	54.00
54.01	ULTRA SOUND		0	0	0	54.01
54.02	CT SCAN		0	0	0	54.02
57.00	CT SCAN		0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00
59.00	CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	LABORATORY		1,840,946	0	1,840,946	60.00
60.01	BLOOD LABORATORY		0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	1,340,678	0	1,340,678	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	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		10,394	0	10,394	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS		500,225	0	500,225	73.00
76.00	MENTAL HEALTH ANCILLARY		1,449,591	2,208	1,451,799	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC		0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
90.00	CLINIC		0	0	0	90.00
91.00	EMERGENCY		2,660,981	0	2,660,981	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF		0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION		0	0	0	109.00
110.00	INTESTINAL ACQUISITION		0	0	0	110.00
111.00	ISLET ACQUISITION		0	0	0	111.00
200.00	Subtotal (see instructions)		16,238,140	7,365	16,245,505	200.00
201.00	Less Observation Beds		0	0	0	201.00
202.00	Total (see instructions)		16,238,140	7,365	16,245,505	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet C
Part I
Date/Time Prepared:
5/22/2012 11:42 am

		Title XVIII			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	8,592,152		8,592,152			30.00
40.00	SUBPROVIDER - IPF	13,984,642		13,984,642			40.00
41.00	SUBPROVIDER - IRF	8,620,447		8,620,447			41.00
42.00	SUBPROVIDER	0		0			42.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00
51.00	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
54.00	RADIOLOGY-DIAGNOSTIC	338,550	7,784,547	8,123,097	0.061081	0.000000	54.00
54.01	ULTRA SOUND	0	0	0	0.000000	0.000000	54.01
54.02	CT SCAN	0	0	0	0.000000	0.000000	54.02
57.00	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	LABORATORY	3,178,629	8,100,894	11,279,523	0.163211	0.000000	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000	65.00
66.00	PHYSICAL THERAPY	6,783,473	0	6,783,473	0.197639	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,666	1,266	14,932	0.696089	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	5,110,041	1,500,522	6,610,563	0.075671	0.000000	73.00
76.00	MENTAL HEALTH ANCILLARY	297,074	4,331,948	4,629,022	0.313153	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	EMERGENCY	1,758,158	17,889,799	19,647,957	0.135433	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0	0	0			99.10
SPECIAL PURPOSE COST CENTERS							
109.00	PANCREAS ACQUISITION	0	0	0			109.00
110.00	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	ISLET ACQUISITION	0	0	0			111.00
200.00	Subtotal (see instructions)	48,676,832	39,608,976	88,285,808			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	48,676,832	39,608,976	88,285,808			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140033	Period: From 12/01/2010 To 11/30/2011	Worksheet C Part I Date/Time Prepared: 5/22/2012 11:42 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	ADULTS & PEDIATRICS			30.00
40.00	SUBPROVIDER - IPF			40.00
41.00	SUBPROVIDER - IRF			41.00
42.00	SUBPROVIDER			42.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	0.000000		50.00
51.00	RECOVERY ROOM	0.000000		51.00
54.00	RADIOLOGY-DIAGNOSTIC	0.061081		54.00
54.01	ULTRA SOUND	0.000000		54.01
54.02	CT SCAN	0.000000		54.02
57.00	CT SCAN	0.000000		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	LABORATORY	0.163211		60.00
60.01	BLOOD LABORATORY	0.000000		60.01
65.00	RESPIRATORY THERAPY	0.000000		65.00
66.00	PHYSICAL THERAPY	0.197639		66.00
67.00	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	SPEECH PATHOLOGY	0.000000		68.00
69.00	ELECTROCARDIOLOGY	0.000000		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.696089		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.075671		73.00
76.00	MENTAL HEALTH ANCILLARY	0.313630		76.00
	OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	CLINIC	0.000000		90.00
91.00	EMERGENCY	0.135433		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
	OTHER REIMBURSABLE COST CENTERS			
99.10	CORF			99.10
	SPECIAL PURPOSE COST CENTERS			
109.00	PANCREAS ACQUISITION			109.00
110.00	INTESTINAL ACQUISITION			110.00
111.00	ISLET ACQUISITION			111.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet D
Part I
Date/Time Prepared:
5/22/2012 11:42 am

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	280,573	0	280,573	3,711	75.61	30.00
40.00	SUBPROVIDER - IPF	412,022	0	412,022	6,045	68.16	40.00
41.00	SUBPROVIDER - IRF	379,886	0	379,886	4,938	76.93	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
200.00	Total (lines 30-199)	1,072,481		1,072,481	14,694		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140033	Period: From 12/01/2010 To 11/30/2011	Worksheet D Part I Date/Time Prepared: 5/22/2012 11:42 am
		Title XVIII	Hospital	PPS

Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
	6.00	7.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS	0	0		30.00
40.00 SUBPROVIDER - IPF	2,439	166,242		40.00
41.00 SUBPROVIDER - IRF	3,586	275,871		41.00
42.00 SUBPROVIDER	0	0		42.00
200.00 Total (lines 30-199)	6,025	442,113		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140033	Period: From 12/01/2010 To 11/30/2011	Worksheet D Part II Date/Time Prepared: 5/22/2012 11:42 am
		Title XVIII	Hospital	PPS

Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0.000000	0	0 50.00
51.00	RECOVERY ROOM	0	0	0.000000	0	0 51.00
54.00	RADIOLOGY-DIAGNOSTIC	7,421	8,123,097	0.000914	0	0 54.00
54.01	ULTRA SOUND	0	0	0.000000	0	0 54.01
54.02	CT SCAN	0	0	0.000000	0	0 54.02
57.00	CT SCAN	0	0	0.000000	0	0 57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0 58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0	0 59.00
60.00	LABORATORY	235,311	11,279,523	0.020862	0	0 60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0 60.01
65.00	RESPIRATORY THERAPY	0	0	0.000000	0	0 65.00
66.00	PHYSICAL THERAPY	170,598	6,783,473	0.025149	0	0 66.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0	0 67.00
68.00	SPEECH PATHOLOGY	0	0	0.000000	0	0 68.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0	0 69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	78	14,932	0.005224	0	0 71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0 72.00
73.00	DRUGS CHARGED TO PATIENTS	110,558	6,610,563	0.016724	0	0 73.00
76.00	MENTAL HEALTH ANCILLARY	153,847	4,629,022	0.033235	0	0 76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0	0 88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0 89.00
90.00	CLINIC	0	0	0.000000	0	0 90.00
91.00	EMERGENCY	488,594	19,647,957	0.024867	0	0 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0	0 92.00
200.00	Total (Lines 50-199)	1,166,407	57,088,567		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140033		Period: From 12/01/2010 To 11/30/2011		Worksheet D Part III Date/Time Prepared: 5/22/2012 11:42 am	
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
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
200.00	Total (lines 30-199)	0	0	0			200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140033		Period: From 12/01/2010 To 11/30/2011		Worksheet D Part III Date/Time Prepared: 5/22/2012 11:42 am	
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	3,711	0.00	0	0	30.00	
40.00	SUBPROVIDER - IPF	6,045	0.00	2,439	0	40.00	
41.00	SUBPROVIDER - IRF	4,938	0.00	3,586	0	41.00	
42.00	SUBPROVIDER	0	0.00	0	0	42.00	
200.00	Total (lines 30-199)	14,694		6,025	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet D
Part IV
Date/Time Prepared:
5/22/2012 11:42 am

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	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	0	51.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
54.01	ULTRA SOUND	0	0	0	0	0	0	54.01
54.02	CT SCAN	0	0	0	0	0	0	54.02
57.00	CT SCAN	0	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00	MENTAL HEALTH ANCILLARY	0	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140033	Period: From 12/01/2010 To 11/30/2011	Worksheet D Part IV Date/Time Prepared: 5/22/2012 11:42 am
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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	0	0.000000	0.000000	0	50.00
51.00 RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
54.00 RADIOLOGY-DIAGNOSTIC	0	8,123,097	0.000000	0.000000	0	54.00
54.01 ULTRA SOUND	0	0	0.000000	0.000000	0	54.01
54.02 CT SCAN	0	0	0.000000	0.000000	0	54.02
57.00 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00 LABORATORY	0	11,279,523	0.000000	0.000000	0	60.00
60.01 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00 RESPIRATORY THERAPY	0	0	0.000000	0.000000	0	65.00
66.00 PHYSICAL THERAPY	0	6,783,473	0.000000	0.000000	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,932	0.000000	0.000000	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	6,610,563	0.000000	0.000000	0	73.00
76.00 MENTAL HEALTH ANCILLARY	0	4,629,022	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00 CLINIC	0	0	0.000000	0.000000	0	90.00
91.00 EMERGENCY	0	19,647,957	0.000000	0.000000	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	92.00
200.00 Total (Lines 50-199)	0	57,088,567			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet D
Part IV
Date/Time Prepared:
5/22/2012 11:42 am

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	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	51.00
54.00	RADIOLOGY-DIAGNOSTIC	0	930,601	0	54.00
54.01	ULTRA SOUND	0	0	0	54.01
54.02	CT SCAN	0	0	0	54.02
57.00	CT SCAN	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	LABORATORY	0	202	0	60.00
60.01	BLOOD LABORATORY	0	0	0	60.01
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
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	155,352	0	73.00
76.00	MENTAL HEALTH ANCILLARY	0	607,128	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	CLINIC	0	0	0	90.00
91.00	EMERGENCY	0	1,910,780	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00	Total (Lines 50-199)	0	3,604,063	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140033	Period: From 12/01/2010 To 11/30/2011	Worksheet D Part V Date/Time Prepared: 5/22/2012 11:42 am
		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	3.00				
ANCILLARY SERVICE COST CENTERS								
50.00	OPERATING ROOM	0.000000		0	0	0		50.00
51.00	RECOVERY ROOM	0.000000		0	0	0		51.00
54.00	RADIOLOGY-DIAGNOSTIC	0.061081		930,601	0	0		54.00
54.01	ULTRA SOUND	0.000000		0	0	0		54.01
54.02	CT SCAN	0.000000		0	0	0		54.02
57.00	CT SCAN	0.000000		0	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		0	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0.000000		0	0	0		59.00
60.00	LABORATORY	0.163211		202	0	0		60.00
60.01	BLOOD LABORATORY	0.000000		0	0	0		60.01
65.00	RESPIRATORY THERAPY	0.000000		0	0	0		65.00
66.00	PHYSICAL THERAPY	0.197639		0	0	0		66.00
67.00	OCCUPATIONAL THERAPY	0.000000		0	0	0		67.00
68.00	SPEECH PATHOLOGY	0.000000		0	0	0		68.00
69.00	ELECTROCARDIOLOGY	0.000000		0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.696089		0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000		0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.075671		155,352	0	0		73.00
76.00	MENTAL HEALTH ANCILLARY	0.313153		607,128	0	0		76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	RURAL HEALTH CLINIC	0.000000						88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000						89.00
90.00	CLINIC	0.000000		0	0	0		90.00
91.00	EMERGENCY	0.135433		1,910,780	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		0	0	0		92.00
200.00	Subtotal (see instructions)			3,604,063	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)			3,604,063	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140033	Period: From 12/01/2010 To 11/30/2011	Worksheet D Part V Date/Time Prepared: 5/22/2012 11:42 am
	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	0	0	0		50.00
51.00 RECOVERY ROOM	0	0	0		51.00
54.00 RADIOLOGY-DIAGNOSTIC	56,842	0	0		54.00
54.01 ULTRA SOUND	0	0	0		54.01
54.02 CT SCAN	0	0	0		54.02
57.00 CT SCAN	0	0	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00 LABORATORY	33	0	0		60.00
60.01 BLOOD LABORATORY	0	0	0		60.01
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
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	11,756	0	0		73.00
76.00 MENTAL HEALTH ANCILLARY	190,124	0	0		76.00
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	0	0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00 CLINIC	0	0	0		90.00
91.00 EMERGENCY	258,783	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00 Subtotal (see instructions)	517,538	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)	517,538	0	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140033 Component CCN: 14S033		Period: From 12/01/2010 To 11/30/2011		Worksheet D Part II Date/Time Prepared: 5/22/2012 11:42 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	0.000000	0	0	50.00
51.00	RECOVERY ROOM	0	0	0.000000	0	0	51.00
54.00	RADIOLOGY-DIAGNOSTIC	7,421	8,123,097	0.000914	69,861	64	54.00
54.01	ULTRA SOUND	0	0	0.000000	0	0	54.01
54.02	CT SCAN	0	0	0.000000	0	0	54.02
57.00	CT SCAN	0	0	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	LABORATORY	235,311	11,279,523	0.020862	683,111	14,251	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	0	0	0.000000	0	0	65.00
66.00	PHYSICAL THERAPY	170,598	6,783,473	0.025149	3,994	100	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	78	14,932	0.005224	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	110,558	6,610,563	0.016724	850,080	14,217	73.00
76.00	MENTAL HEALTH ANCILLARY	153,847	4,629,022	0.033235	72,335	2,404	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	CLINIC	0	0	0.000000	0	0	90.00
91.00	EMERGENCY	488,594	19,647,957	0.024867	399,005	9,922	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0	0	92.00
200.00	Total (Lines 50-199)	1,166,407	57,088,567		2,078,386	40,958	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140033 Component CCN: 14S033	Period: From 12/01/2010 To 11/30/2011	Worksheet D Part IV Date/Time Prepared: 5/22/2012 11:42 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01 ULTRA SOUND	0	0	0	0	0	54.01
54.02 CT SCAN	0	0	0	0	0	54.02
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
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
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 MENTAL HEALTH ANCILLARY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00
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: 140033 Component CCN: 14S033	Period: From 12/01/2010 To 11/30/2011	Worksheet D Part IV Date/Time Prepared: 5/22/2012 11:42 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0.000000	0.000000	0	50.00
51.00 RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
54.00 RADIOLOGY-DIAGNOSTIC	0	8,123,097	0.000000	0.000000	69,861	54.00
54.01 ULTRA SOUND	0	0	0.000000	0.000000	0	54.01
54.02 CT SCAN	0	0	0.000000	0.000000	0	54.02
57.00 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00 LABORATORY	0	11,279,523	0.000000	0.000000	683,111	60.00
60.01 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00 RESPIRATORY THERAPY	0	0	0.000000	0.000000	0	65.00
66.00 PHYSICAL THERAPY	0	6,783,473	0.000000	0.000000	3,994	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,932	0.000000	0.000000	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	6,610,563	0.000000	0.000000	850,080	73.00
76.00 MENTAL HEALTH ANCILLARY	0	4,629,022	0.000000	0.000000	72,335	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER CLINIC	0	0	0.000000	0.000000	0	89.00
90.00 CLINIC	0	0	0.000000	0.000000	0	90.00
91.00 EMERGENCY	0	19,647,957	0.000000	0.000000	399,005	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	92.00
200.00 Total (Lines 50-199)	0	57,088,567			2,078,386	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140033 Component CCN: 14S033	Period: From 12/01/2010 To 11/30/2011	Worksheet D Part IV Date/Time Prepared: 5/22/2012 11:42 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	51.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01 ULTRA SOUND	0	0	0	54.01
54.02 CT SCAN	0	0	0	54.02
57.00 CT SCAN	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 LABORATORY	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	60.01
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
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00 MENTAL HEALTH ANCILLARY	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00 CLINIC	0	0	0	90.00
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 INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 140033	Period: From 12/01/2010 To 11/30/2011	Worksheet D Part II Date/Time Prepared: 5/22/2012 11:42 am
	Component CCN: 14T033		

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	0.000000	0	0	50.00
51.00	RECOVERY ROOM	0	0	0.000000	0	0	51.00
54.00	RADIOLOGY-DIAGNOSTIC	7,421	8,123,097	0.000914	105,865	97	54.00
54.01	ULTRA SOUND	0	0	0.000000	0	0	54.01
54.02	CT SCAN	0	0	0.000000	0	0	54.02
57.00	CT SCAN	0	0	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	LABORATORY	235,311	11,279,523	0.020862	752,712	15,703	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	0	0	0.000000	0	0	65.00
66.00	PHYSICAL THERAPY	170,598	6,783,473	0.025149	4,864,869	122,347	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	78	14,932	0.005224	9,347	49	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	110,558	6,610,563	0.016724	1,967,178	32,899	73.00
76.00	MENTAL HEALTH ANCILLARY	153,847	4,629,022	0.033235	7,204	239	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	CLINIC	0	0	0.000000	0	0	90.00
91.00	EMERGENCY	488,594	19,647,957	0.024867	220,954	5,494	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0	0	92.00
200.00	Total (Lines 50-199)	1,166,407	57,088,567		7,928,129	176,828	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140033 Component CCN: 14T033	Period: From 12/01/2010 To 11/30/2011	Worksheet D Part IV Date/Time Prepared: 5/22/2012 11:42 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01 ULTRA SOUND	0	0	0	0	0	54.01
54.02 CT SCAN	0	0	0	0	0	54.02
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
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
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 MENTAL HEALTH ANCILLARY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00
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: 140033 Component CCN: 14T033	Period: From 12/01/2010 To 11/30/2011	Worksheet D Part IV Date/Time Prepared: 5/22/2012 11:42 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0.000000	0.000000	0	50.00
51.00 RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
54.00 RADIOLOGY-DIAGNOSTIC	0	8,123,097	0.000000	0.000000	105,865	54.00
54.01 ULTRA SOUND	0	0	0.000000	0.000000	0	54.01
54.02 CT SCAN	0	0	0.000000	0.000000	0	54.02
57.00 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00 LABORATORY	0	11,279,523	0.000000	0.000000	752,712	60.00
60.01 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00 RESPIRATORY THERAPY	0	0	0.000000	0.000000	0	65.00
66.00 PHYSICAL THERAPY	0	6,783,473	0.000000	0.000000	4,864,869	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,932	0.000000	0.000000	9,347	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	6,610,563	0.000000	0.000000	1,967,178	73.00
76.00 MENTAL HEALTH ANCILLARY	0	4,629,022	0.000000	0.000000	7,204	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER CLINIC	0	0	0.000000	0.000000	0	89.00
90.00 CLINIC	0	0	0.000000	0.000000	0	90.00
91.00 EMERGENCY	0	19,647,957	0.000000	0.000000	220,954	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	92.00
200.00 Total (Lines 50-199)	0	57,088,567			7,928,129	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140033 Component CCN: 14T033	Period: From 12/01/2010 To 11/30/2011	Worksheet D Part IV Date/Time Prepared: 5/22/2012 11:42 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	51.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01 ULTRA SOUND	0	0	0	54.01
54.02 CT SCAN	0	0	0	54.02
57.00 CT SCAN	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 LABORATORY	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	60.01
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
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00 MENTAL HEALTH ANCILLARY	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00 CLINIC	0	0	0	90.00
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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140033	Period: From 12/01/2010 To 11/30/2011	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/22/2012 11:42 am
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)		3,711	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,711	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)		3,711	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)		0	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)		2,017,934	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)		2,017,934	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		8,592,152	28.00
29.00	Private room charges (excluding swing-bed charges)		36,148	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		8,556,004	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.234858	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)		2,305.58	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)		2,017,934	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)		543.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	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)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140033	Period: From 12/01/2010 To 11/30/2011	Worksheet D-1 Date/Time Prepared: 5/22/2012 11:42 am
Title XVIII			Hospital	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					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 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					0 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140033		Period: From 12/01/2010 To 11/30/2011		Worksheet D-1 Date/Time Prepared: 5/22/2012 11:42 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	280,573	2,017,934	0.139040	0	0	90.00
91.00	Nursing School cost	0	2,017,934	0.000000	0	0	91.00
92.00	Allied health cost	0	2,017,934	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,017,934	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140033	Period: From 12/01/2010 To 11/30/2011	Worksheet D-1
		Component CCN: 14S033		Date/Time Prepared: 5/22/2012 11:42 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,045	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,045	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)		6,045	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)		2,439	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)		2,845,657	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)		2,845,657	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		13,984,642	28.00
29.00	Private room charges (excluding swing-bed charges)		97,742	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		13,886,900	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.203484	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)		2,297.25	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)		2,845,657	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)		470.75	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,148,159	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)		1,148,159	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140033	Period: From 12/01/2010 To 11/30/2011	Worksheet D-1			
		Component CCN: 14S033		Date/Time Prepared: 5/22/2012 11:42 am			
		Title XVIII	Subprovider - IPF	PPS			
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)					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	SURGICAL INTENSIVE CARE UNIT					46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00	
	Cost Center Description						
					1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					257,597	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,405,756	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)					166,242	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					40,958	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					207,200	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,198,556	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)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140033	Period: From 12/01/2010 To 11/30/2011	Worksheet D-1
		Component CCN: 14S033		Date/Time Prepared: 5/22/2012 11:42 am
		Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	412,022	2,845,657	0.144790	0	0	90.00
91.00 Nursing School cost	0	2,845,657	0.000000	0	0	91.00
92.00 Allied health cost	0	2,845,657	0.000000	0	0	92.00
93.00 All other Medical Education	0	2,845,657	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140033	Period: From 12/01/2010 To 11/30/2011	Worksheet D-1
		Component CCN: 14T033		Date/Time Prepared: 5/22/2012 11:42 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,938	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,938	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)		4,938	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)		3,586	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)		3,080,722	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)		3,080,722	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		8,620,447	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		8,620,447	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.357374	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)		1,745.74	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)		3,080,722	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)		623.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,237,234	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)		2,237,234	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140033	Period: From 12/01/2010 To 11/30/2011	Worksheet D-1	
		Component CCN: 14T033		Date/Time Prepared: 5/22/2012 11:42 am	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				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	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
Cost Center Description					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				1,278,352
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				3,515,586
PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				275,871
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				176,828
52.00	Total Program excludable cost (sum of lines 50 and 51)				452,699
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				3,062,887
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)				0
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140033 Component CCN: 14T033		Period: From 12/01/2010 To 11/30/2011		Worksheet D-1 Date/Time Prepared: 5/22/2012 11:42 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	379,886	3,080,722	0.123311	0	0	90.00
91.00	Nursing School cost	0	3,080,722	0.000000	0	0	91.00
92.00	Allied health cost	0	3,080,722	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,080,722	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140033	Period: From 12/01/2010 To 11/30/2011	Worksheet D-3 Date/Time Prepared: 5/22/2012 11:42 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		0		30.00
40.00	SUBPROVIDER - IPF		0		40.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000	0	0	50.00
51.00	RECOVERY ROOM	0.000000	0	0	51.00
54.00	RADIOLOGY-DIAGNOSTIC	0.061081	0	0	54.00
54.01	ULTRA SOUND	0.000000	0	0	54.01
54.02	CT SCAN	0.000000	0	0	54.02
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.163211	0	0	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	0.000000	0	0	65.00
66.00	PHYSICAL THERAPY	0.197639	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.696089	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.075671	0	0	73.00
76.00	MENTAL HEALTH ANCILLARY	0.313630	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	CLINIC	0.000000	0	0	90.00
91.00	EMERGENCY	0.135433	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		0	0	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)		0	0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140033	Period: From 12/01/2010 To 11/30/2011	Worksheet D-3	
		Component CCN: 14S033		Date/Time Prepared: 5/22/2012 11:42 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		0		30.00
40.00	SUBPROVIDER - IPF		5,614,898		40.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000	0	0	50.00
51.00	RECOVERY ROOM	0.000000	0	0	51.00
54.00	RADIOLOGY-DIAGNOSTIC	0.061081	69,861	4,267	54.00
54.01	ULTRA SOUND	0.000000	0	0	54.01
54.02	CT SCAN	0.000000	0	0	54.02
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.163211	683,111	111,491	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	0.000000	0	0	65.00
66.00	PHYSICAL THERAPY	0.197639	3,994	789	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.696089	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.075671	850,080	64,326	73.00
76.00	MENTAL HEALTH ANCILLARY	0.313630	72,335	22,686	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	CLINIC	0.000000	0	0	90.00
91.00	EMERGENCY	0.135433	399,005	54,038	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		2,078,386	257,597	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)		2,078,386		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140033	Period: From 12/01/2010 To 11/30/2011	Worksheet D-3	
		Component CCN: 14T033		Date/Time Prepared: 5/22/2012 11:42 am	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		0		30.00
40.00	SUBPROVIDER - IPF		0		40.00
41.00	SUBPROVIDER - IRF		6,245,085		41.00
42.00	SUBPROVIDER		0		42.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000	0	0	50.00
51.00	RECOVERY ROOM	0.000000	0	0	51.00
54.00	RADIOLOGY-DIAGNOSTIC	0.061081	105,865	6,466	54.00
54.01	ULTRA SOUND	0.000000	0	0	54.01
54.02	CT SCAN	0.000000	0	0	54.02
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.163211	752,712	122,851	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	0.000000	0	0	65.00
66.00	PHYSICAL THERAPY	0.197639	4,864,869	961,488	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.696089	9,347	6,506	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.075671	1,967,178	148,858	73.00
76.00	MENTAL HEALTH ANCILLARY	0.313630	7,204	2,259	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	CLINIC	0.000000	0	0	90.00
91.00	EMERGENCY	0.135433	220,954	29,924	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		7,928,129	1,278,352	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)			0	201.00
202.00	Net Charges (line 200 minus line 201)		7,928,129		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140033	Period: From 12/01/2010 To 11/30/2011	Worksheet E Part A Date/Time Prepared: 5/22/2012 11:42 am
		Title XVIII	Hospital	PPS
			before 1/1	on/after 1/1
			1.00	1.01
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
2.00	Outlier payments for discharges. (see instructions)		0	2.00
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		16.00	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.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	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)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	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.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	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		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	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)		0	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)		0	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)		0	49.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140033	Period: From 12/01/2010 To 11/30/2011	Worksheet E Part A Date/Time Prepared: 5/22/2012 11:42 am
		Title XVIII	Hospital	PPS
			before 1/1	on/after 1/1
			1.00	1.01
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		0	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).		0	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
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)		0	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		0	61.00
62.00	Deductibles billed to program beneficiaries		0	62.00
63.00	Coinsurance billed to program beneficiaries		0	63.00
64.00	Allowable bad debts (see instructions)		0	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		0	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		0	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		0	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)		0	71.00
72.00	Interim payments		0	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)		0	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: 140033	Period: From 12/01/2010 To 11/30/2011	Worksheet E Part B Date/Time Prepared: 5/22/2012 11:42 am
		Title XVII	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)		517,538	2.00
3.00	PPS payments		451,081	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from 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)		451,081	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		109,570	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)		341,511	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		341,511	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		341,511	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)		48,373	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		33,861	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		43,977	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		375,372	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)		375,372	40.00
41.00	Interim payments		385,811	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)		-10,439	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		19,095	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140033	Period: From 12/01/2010 To 11/30/2011	Worksheet E Part B Date/Time Prepared: 5/22/2012 11:42 am
		Component CCN: 14S033	Title VIII	Subprovider - IPF
		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)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from 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)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		0	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	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)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		0	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)		0	40.00
41.00	Interim payments		0	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)		0	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140033	Period: From 12/01/2010 To 11/30/2011	Worksheet E Part B Date/Time Prepared: 5/22/2012 11:42 am
		Component CCN: 14T033	Title VIII	Subprovider - IRF
		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)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from 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)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		0	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	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)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		0	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)		0	40.00
41.00	Interim payments		0	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)		0	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: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet E-1
Part I
Date/Time Prepared:
5/22/2012 11:42 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		0		375,611		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		0	06/24/2011	10,200		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
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)		0		10,200		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)		0		385,811		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		10,439		6.02
7.00	Total Medicare program liability (see instructions)		0		375,372		7.00
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140033
Component CCN: 14S033

Period:
From 12/01/2010
To 11/30/2011

Worksheet E-1
Part I
Date/Time Prepared:
5/22/2012 11:42 am

Title XVIII

Subprovider -
IPF

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				0	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		1,783,234		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	06/24/2011	21,900		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
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)		21,900		0	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)		1,805,134		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		15,398		0	6.02
7.00	Total Medicare program liability (see instructions)		1,789,736		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140033
Component CCN: 14T033

Period:
From 12/01/2010
To 11/30/2011

Worksheet E-1
Part I
Date/Time Prepared:
5/22/2012 11:42 am

Title XVIII

Subprovider -
IRF

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				0	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		4,213,950		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		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
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)		0		0	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)		4,213,950		0	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		10,483		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,224,433		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140033	Period: From 12/01/2010 To 11/30/2011	Worksheet E-3 Part II Date/Time Prepared: 5/22/2012 11:42 am
		Component CCN: 14S033		
		Title XVII I	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			1,908,848 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			297 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			16.561644 9.00
10.00	Medical Education Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$.			0.000000 10.00
11.00	Medical Education Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			1,909,145 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition			0 14.00
15.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 15.00
16.00	Subtotal (see instructions)			1,909,145 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			1,909,145 18.00
19.00	Deductibles			214,472 19.00
20.00	Subtotal (line 18 minus line 19)			1,694,673 20.00
21.00	Coinsurance			17,239 21.00
22.00	Subtotal (line 20 minus line 21)			1,677,434 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			160,432 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			112,302 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			139,955 25.00
26.00	Subtotal (sum of lines 22 and 24)			1,789,736 26.00
27.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			1,789,736 31.00
32.00	Interim payments			1,805,134 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus the sum lines 32 and 33)			-15,398 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			118,703 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140033	Period: From 12/01/2010 To 11/30/2011	Worksheet E-3 Part III Date/Time Prepared: 5/22/2012 11:42 am
		Component CCN: 14T033	Title XVIII	Subprovider - IRF
				PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)		4,133,681	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0564	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		202,526	3.00
4.00	Outlier Payments		10,626	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)		0.00	5.00
6.00	New Teaching program adjustment. (see instructions)		0.00	6.00
7.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)		0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)		0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)		0.00	9.00
10.00	Average Daily Census (see instructions)		13.528767	10.00
11.00	Medical Education Adjustment Factor $\{((1 + (\text{line 9}/\text{line 10})) \text{ raised to the power of } .6876 - 1)\}$.		0.000000	11.00
12.00	Medical Education Adjustment (line 1 multiplied by line 11).		0	12.00
13.00	Total PPS Payment (sum of lines 1, 3, 4 and 12)		4,346,833	13.00
14.00	Nursing and Allied Health Managed Care payment (see instruction)		0	14.00
15.00	Organ acquisition		0	15.00
16.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		0	16.00
17.00	Subtotal (see instructions)		4,346,833	17.00
18.00	Primary payer payments		0	18.00
19.00	Subtotal (line 17 less line 18).		4,346,833	19.00
20.00	Deductibles		20,280	20.00
21.00	Subtotal (line 19 minus line 20)		4,326,553	21.00
22.00	Coinurance		15,565	22.00
23.00	Subtotal (line 21 minus line 22)		4,310,988	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		3,620	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		2,534	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		2,547	26.00
27.00	Subtotal (sum of lines 23 and 25)		4,313,522	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	28.00
29.00	Other pass through costs (see instructions)		0	29.00
30.00	Outlier payments reconciliation		0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		-89,089	31.00
31.99	Recovery of Accelerated Depreciation		0	31.99
32.00	Total amount payable to the provider (see instructions)		4,224,433	32.00
33.00	Interim payments		4,213,950	33.00
34.00	Tentative settlement (for contractor use only)		0	34.00
35.00	Balance due provider/program (line 32 minus the sum lines 33 and 34)		10,483	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		31,554	36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

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

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet G
Date/Time Prepared:
5/22/2012 11:42 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	1,790	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	5,846,698	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,704,945	0	0	0	6.00
7.00	Inventory	203,213	0	0	0	7.00
8.00	Prepaid expenses	22,753	0	0	0	8.00
9.00	Other current assets	1,155	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	3,370,664	0	0	0	11.00
FIXED ASSETS						
12.00	Land	4,217,077	0	0	0	12.00
13.00	Land improvements	4,286,407	0	0	0	13.00
14.00	Accumulated depreciation	-1,257,231	0	0	0	14.00
15.00	Buildings	13,165,611	0	0	0	15.00
16.00	Accumulated depreciation	-1,889,624	0	0	0	16.00
17.00	Leasehold improvements	1,473,091	0	0	0	17.00
18.00	Accumulated depreciation	-387,046	0	0	0	18.00
19.00	Fixed equipment	664,589	0	0	0	19.00
20.00	Accumulated depreciation	-95,667	0	0	0	20.00
21.00	Automobiles and trucks	22,569	0	0	0	21.00
22.00	Accumulated depreciation	-4,987	0	0	0	22.00
23.00	Major movable equipment	2,046,184	0	0	0	23.00
24.00	Accumulated depreciation	-1,302,374	0	0	0	24.00
25.00	Minor equipment depreciable	1,375,845	0	0	0	25.00
26.00	Accumulated depreciation	-875,418	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)	21,439,026	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	-543,592	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	-543,592	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	24,266,098	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,841,980	0	0	0	37.00
38.00	Salaries, wages, and fees payable	820,509	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	829,947	0	0	0	43.00
44.00	Other current liabilities	243,783	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,736,219	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)	3,736,219	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	20,529,879				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)	20,529,879	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	24,266,098	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet G-1

Date/Time Prepared:
5/22/2012 11:42 am

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
		1.00	Fund balances at beginning of period		18,407,601		
2.00	Net income (loss) (From Wkst. G-3, line 29)		2,122,278			2.00	
3.00	Total (sum of line 1 and line 2)		20,529,879		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)		20,529,879		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)		20,529,879		0	19.00	

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet G-2 Parts

Date/Time Prepared:
5/22/2012 11:42 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	8,592,152		8,592,152	1.00
2.00	SUBPROVIDER - IPF	13,984,642		13,984,642	2.00
3.00	SUBPROVIDER - IRF	8,620,447		8,620,447	3.00
4.00	SUBPROVIDER	0		0	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)	31,197,241		31,197,241	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				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	31,197,241		31,197,241	17.00
18.00	Ancillary services	17,479,591		17,479,591	18.00
19.00	Outpatient services	0	39,608,976	39,608,976	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)	48,676,832	39,608,976	88,285,808	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		25,110,015		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)		25,110,015		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140033

Period:
From 12/01/2010
To 11/30/2011

Worksheet G-3

Date/Time Prepared:
5/22/2012 11:42 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	88,285,808	1.00
2.00	Less contractual allowances and discounts on patients' accounts	61,184,306	2.00
3.00	Net patient revenues (line 1 minus line 2)	27,101,502	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	25,110,015	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,991,487	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)	130,791	24.00
25.00	Total other income (sum of lines 6-24)	130,791	25.00
26.00	Total (line 5 plus line 25)	2,122,278	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,122,278	29.00