This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Falure 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: 150037	Period: From 01/01/2012 To 12/31/2012	Worksheet S Parts I-III Date/Time Prepared: 5/24/2013 6:27 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/24/2013 Time: 6:27 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HANCOCK REGIONAL HOSPITAL (150037) for the cost reporting period beginning 01/01/2012 and ending 12/31/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-44,568	-77,171	92,906	-535,853	1.00
2.00	Subprovider - IPF	0	337	0		0	2.00
3.00	Subprovider - IRF	0	2,273	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		1,847		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	-41,958	-75,324	92,906	-535,853	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.

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FORM APPROVED
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 150037	Period: From 01/01/2012 To 12/31/2012	Worksheet S Parts I-III Date/Time Prepared: 5/24/2013 6:27 pm

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Encryption Information

ECR: Date: 5/24/2013 Time: 6:27 pm
2ueeo1SoDdAH0h5tpBG048VbDMtS20
FUCmx0wJs4BVocIGbLXz10CHAX21:U
KqHo1uW1MO0L7VnN

PI: Date: 5/24/2013 Time: 6:27 pm
7EyxftcQsB6U858gbdE1Udm2Tto900
2A71y0eA4ffxwvpf:tcSRNtV6SpZ1y
67B50yw2Uv0eIq.a

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

_____
Title

_____
Date

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-44,568	-77,171	92,906	-535,853	1.00
2.00	Subprovider - IPF	0	337	0		0	2.00
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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		1,847		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	-41,958	-75,324	92,906	-535,853	200.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2013 6:25 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: .10 NORTH STATE STREET	PO Box:			1.00
2.00	City: GREENFIELD	State: IN	Zip Code: 46140-	County: HANCOCK	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	HANCOCK REGIONAL HOSPITAL	150037	26900	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	HANCOCK REGIONAL GERO PSYCH UNIT	15S037	26900	4	12/01/1996	N	P	N	4.00
5.00	Subprovider - IRF	HANCOCK REGIONAL HOSPITAL REHAB	15T037	26900	5	01/01/2005	N	P	N	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	HANCOCK REGIONAL HHA	157092	26900		10/14/1983	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	HANCOCK REGIONAL HOSPICE	151547	26900		02/02/1996				14.00
15.00	Hospital-Based Health Clinic - RHC	KNIGHTSTOWN RURAL HEALTH	153987	26900		09/22/1998	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2012	12/31/2012	20.00
21.00	Type of Control (see instructions)	9		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.	Y	N	22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	268	0	0	0	1,054	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	8	0	0	0	0	25.00

		Urban/Rural S 1.00	Date of Geogr 2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150037	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/24/2013 6:25 pm

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.			39.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete 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)	Y			60.00

		Y/N	IME Average	Direct GME Average	
		1.00	2.00	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 in column 1. If yes, complete lines 64-67. (see instructions)	N			63.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2013 6:25 pm

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

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all 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	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

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		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	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	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	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	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 and "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)(ii)? Enter "Y" for yes and "N" for no.		86.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\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	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2013 6:25 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	747,560	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	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)	N		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:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	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, line 74, 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	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150037	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/24/2013 6:25 pm

							1.00	
	Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						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.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						1.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part II Date/Time Prepared: 5/24/2013 6:25 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	04/16/2013	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	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

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	04/24/2013	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN:150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part II Date/Time Prepared: 5/24/2013 6:25 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	

	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	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.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TINA	SEVERS	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946	TSEVERS@BLUEANDCO.COM	43.00

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	04/24/2013			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HFS Supplemental Information	Provider CCN:150037	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part IX Date/Time Prepared: 5/24/2013 6:25 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-3 Part I Date/Time Prepared: 5/24/2013 6:25 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	43	15,738	0.00	0	1.00
2.00	HMO						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		43	15,738	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	24	8,784	0.00	0	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)		67	24,522	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	10	3,660		0	16.00
17.00	SUBPROVIDER - IRF	41.00	5	1,830		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	7	2,562			24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		89				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

	Component	I/P Days / O/P Visits / Trips Title XVIII	Title XIX	Total All Patients	Full Time Equivalents Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	1,492	266	3,697			1.00
2.00	HMO	717	1,032				2.00
3.00	HMO IPF Subprovider	7	0				3.00
4.00	HMO IRF Subprovider	11	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,492	266	3,697			7.00
8.00	INTENSIVE CARE UNIT	2,416	0	4,792			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)	3,908	266	8,489	0.00	570.19	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,706	0	2,744	0.00	16.82	16.00
17.00	SUBPROVIDER - IRF	934	0	1,211	0.00	9.84	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	8,651	0	23,767	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	1,304	0.00	0.00	24.00
25.00	CMHC - CMHC						25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-3 Part I Date/Time Prepared: 5/24/2013 6:25 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
26.00	RURAL HEALTH CLINIC	336	0	1,618	0.00	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	596.85	27.00
28.00	Observation Bed Days		0	2,299			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			96			30.00
31.00	Employee discount days - IRF			22			31.00
32.00	Labor & delivery days (see instructions)		24	54			32.00
33.00	LTCH non-covered days	0					33.00

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)		0	1,244	79	2,692	1.00
2.00	HMO			228			2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,244	79	2,692	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	241	0	251	16.00
17.00	SUBPROVIDER - IRF	0.00	0	83	0	108	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-3 Part II Date/Time Prepared: 5/24/2013 6:25 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	37,840,887	0	37,840,887	1,241,463.00	30.48	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		168,197	0	168,197	5,453.00	30.84	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		6,697,563	94,079	6,791,642	230,074.00	29.52	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		762,925	0	762,925	11,161.00	68.36	11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		9,619,968	0	9,619,968			17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV line 25		0	0	0			18.00
19.00	Excluded areas		2,098,482	0	2,098,482			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		52,149	0	52,149			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits	4.00	304,470	0	304,470	9,060.00	33.61	26.00
27.00	Administrative & General	5.00	6,838,417	-94,079	6,744,338	200,781.00	33.59	27.00
28.00	Administrative & General under contract (see inst.)		758,209	0	758,209	4,648.00	163.13	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	805,695	0	805,695	29,839.00	27.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	810,512	0	810,512	58,520.00	13.85	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,057,426	-708,925	348,501	24,440.00	14.26	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	708,925	708,925	41,122.00	17.24	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	813,489	0	813,489	19,416.00	41.90	38.00
39.00	Central Services and Supply	14.00	63,193	0	63,193	3,981.00	15.87	39.00
40.00	Pharmacy	15.00	1,290,992	-59,744	1,231,248	33,743.00	36.49	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150037

Period:
From 01/01/2012
To 12/31/2012

Worksheet S-3
Part II
Date/Time Prepared:
5/24/2013 6:25 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	615,952	0	615,952	28,162.00	21.87	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150037

Period: From 01/01/2012 To 12/31/2012

Worksheet S-3 Part III Date/Time Prepared: 5/24/2013 6:25 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		38,430,899	0	38,430,899	1,240,658.00	30.98	1.00
2.00	Excluded area salaries (see instructions)		6,697,563	94,079	6,791,642	230,074.00	29.52	2.00
3.00	Subtotal salaries (line 1 minus line 2)		31,733,336	-94,079	31,639,257	1,010,584.00	31.31	3.00
4.00	Subtotal other wages & related costs (see inst.)		762,925	0	762,925	11,161.00	68.36	4.00
5.00	Subtotal wage-related costs (see inst.)		9,619,968	0	9,619,968	0.00	30.41	5.00
6.00	Total (sum of lines 3 thru 5)		42,116,229	-94,079	42,022,150	1,021,745.00	41.13	6.00
7.00	Total overhead cost (see instructions)		13,358,355	-153,823	13,204,532	453,712.00	29.10	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 150037	Period: From 01/01/2012 To 12/31/2012	Worksheet S-3 Part IV Date/Time Prepared: 5/24/2013 6:25 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	628,226	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	6,543	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)	7,737,635	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	253,998	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	173,440	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)	58,175	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	94,437	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,645,899	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	97,866	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	11,798	22.00
23.00	Tuition Reimbursement	50,939	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	11,758,956	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: 150037	Period: From 01/01/2012 To 12/31/2012	Worksheet S-3 Part V Date/Time Prepared: 5/24/2013 6:25 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	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	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA

Provider CCN: 150037
Component CCN: 157092

Period: From 01/01/2012 To 12/31/2012

Worksheet S-4
Date/Time Prepared: 5/24/2013 6:25 pm

		Home Health Agency I	PPS
		1.00	
0.00	County		0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	416.00	0.00	0.00	0.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent) Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	0.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		0.00	0.00	0.00	5.00
6.00	Direct Nursing Service		0.00	0.00	0.00	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		3			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		99915			20.00
20.01			26900			20.01
20.02			11300			20.02

		Full Episodes Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	2,552	0	119	16	2,687	21.00
22.00	Skilled Nursing Visit Charges	462,731	0	21,750	2,900	487,381	22.00
23.00	Physical Therapy Visits	2,438	0	43	25	2,506	23.00
24.00	Physical Therapy Visit Charges	470,596	0	8,310	4,831	483,737	24.00
25.00	Occupational Therapy Visits	1,376	0	8	15	1,399	25.00
26.00	Occupational Therapy Visit Charges	265,599	0	1,546	2,899	270,044	26.00
27.00	Speech Pathology Visits	57	0	1	0	58	27.00
28.00	Speech Pathology Visit Charges	11,015	0	193	0	11,208	28.00
29.00	Medical Social Service Visits	68	0	3	0	71	29.00
30.00	Medical Social Service Visit Charges	13,351	0	587	0	13,938	30.00
31.00	Home Health Aide Visits	1,903	0	6	21	1,930	31.00
32.00	Home Health Aide Visit Charges	151,289	0	477	1,670	153,436	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	8,394	0	180	77	8,651	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,374,581	0	32,863	12,300	1,419,744	35.00
36.00	Total Number of Episodes (standard/non outlier)	478		69	6	553	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	14,399	0	170	142	14,711	38.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER
STATISTICAL DATA

Provider CCN: 150037
Component CCN: 153987

Period: From 01/01/2012 To 12/31/2012

Worksheet S-8

Date/Time Prepared: 5/24/2013 6:25 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	437 N. MCCULLUM	1.00

		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	KNIGHTSTOWN	IN		2.00
				1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	68,816	12/31/2011	4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00
		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	16:00	08:00	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 104-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number			14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		0	0	0	0	15.00

		County		
		4.00		
2.00	City, State, Zip Code, County			2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	16:00	08:00	16:00	08:00	16:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN:150037 Component CCN:153987	Period: From 01/01/2012 To 12/31/2012	Worksheet S-8 Date/Time Prepared: 5/24/2013 6:25 pm
		Rural Health Clinic (RHC) I	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	14:00				11.00

HOSPITAL IDENTIFICATION DATA	Provider CCN:150037 Component CCN:151547	Period: From 01/01/2012 To 12/31/2012	Worksheet S-9 Parts I & II Date/Time Prepared: 5/24/2013 6:25 pm
		Hospice I	

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Routine Home Care	5,698	355	2,147	10	570	6,623	2.00
3.00	Inpatient Respite Care	149	0	0	0	0	149	3.00
4.00	General Inpatient Care	502	25	0	0	70	597	4.00
5.00	Total Hospice Days	6,349	380	2,147	10	640	7,369	5.00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving Hospice Care	208	9	20	2	22	239	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00				7.00
8.00	Average Length of Stay (line 5/line 6)	30.52	42.22	107.35	5.00	29.09	30.83	8.00
9.00	Unduplicated Census Count	188	9	18	8	22	219	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-10 | Date/Time Prepared: 5/24/2013 6:25 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.362638	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,287,749	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	16,115,139	6.00
7.00	Medicaid cost (line 1 times line 6)	5,843,962	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)	4,556,213	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)	4,556,213	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	4,655,172	0	4,655,172	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,688,142	0	1,688,142	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,688,142	0	1,688,142	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?		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)	9,855,324	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	53,268	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	9,802,056	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	3,554,598	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	5,242,740	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	9,798,953	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A | Date/Time Prepared: 5/24/2013 6:25 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		5,972,118	5,972,118	0	5,972,118	1.00
4.00	00400	EMPLOYEE BENEFITS	304,470	9,465,578	9,770,048	0	9,770,048	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,838,417	14,283,785	21,122,202	-581,421	20,540,781	5.00
7.00	00700	OPERATION OF PLANT	805,695	3,750,813	4,556,508	3,047	4,559,555	7.00
9.00	00900	HOUSEKEEPING	810,512	652,210	1,462,722	0	1,462,722	9.00
10.00	01000	DIETARY	1,057,426	970,668	2,028,094	-1,291,159	736,935	10.00
11.00	01100	CAFETERIA	0	0	0	1,291,159	1,291,159	11.00
13.00	01300	NURSING ADMINISTRATION	813,489	110,296	923,785	0	923,785	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	63,193	43,475	106,668	0	106,668	14.00
15.00	01500	PHARMACY	1,290,992	2,553,532	3,844,524	-65,584	3,778,940	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	615,952	283,730	899,682	9,900	909,582	16.00
23.00	02300	PARAMED ED PRGM	66,230	12,502	78,732	0	78,732	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,848,168	620,371	3,468,539	0	3,468,539	30.00
31.00	03100	INTENSIVE CARE UNIT	2,869,128	591,943	3,461,071	0	3,461,071	31.00
40.00	04000	SUBPROVIDER - IPF	997,177	225,349	1,222,526	0	1,222,526	40.00
41.00	04100	SUBPROVIDER - IRF	579,083	141,885	720,968	0	720,968	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,126,395	2,576,670	4,703,065	0	4,703,065	50.00
51.00	05100	RECOVERY ROOM	298,768	40,230	338,998	0	338,998	51.00
53.00	05300	ANESTHESIOLOGY	0	135,225	135,225	0	135,225	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,473,043	1,906,343	4,379,386	0	4,379,386	54.00
60.00	06000	LABORATORY	1,588,480	2,441,998	4,030,478	57,106	4,087,584	60.00
65.00	06500	RESPIRATORY THERAPY	1,090,563	285,897	1,376,460	6,469	1,382,929	65.00
66.00	06600	PHYSICAL THERAPY	991,575	227,561	1,219,136	0	1,219,136	66.00
67.00	06700	OCCUPATIONAL THERAPY	290,619	31,707	322,326	0	322,326	67.00
68.00	06800	SPEECH PATHOLOGY	146,787	28,646	175,433	0	175,433	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	437,306	444,369	881,675	18,216	899,891	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,680,999	3,680,999	0	3,680,999	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,254,498	1,254,498	0	1,254,498	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	48,324	35,878	84,202	0	84,202	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	168,197	87,441	255,638	0	255,638	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	187,483	955,778	1,143,261	0	1,143,261	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	48,002	48,950	96,952	0	96,952	90.04
90.05	09005	PRIME TIME	581,563	150,467	732,030	0	732,030	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	93,336	54,908	148,244	0	148,244	90.06
91.00	09100	EMERGENCY	2,255,441	495,944	2,751,385	0	2,751,385	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,618,690	447,632	2,066,322	0	2,066,322	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	792,107	775,110	1,567,217	0	1,567,217	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	35,196,611	55,784,506	90,981,117	-552,267	90,428,850	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	424,799	424,799	-29,154	395,645	190.01
190.02	19002	PHYSICIAN BUILDING	74,344	181,297	255,641	0	255,641	190.02
190.03	19003	PRIVATE DUTY	335,170	205,126	540,296	0	540,296	190.03
190.04	19004	MARKETING	0	0	0	581,421	581,421	190.04
190.05	19005	WATER LAB	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	108,554	102,517	211,071	0	211,071	190.06
190.07	19007	ASC	0	2,645	2,645	0	2,645	190.07
190.08	19008	ANDERSON WOMEN'S CLINIC	206,532	65,671	272,203	0	272,203	190.08
190.09	19009	HANCOCK OB	1,120,406	1,752,959	2,873,365	0	2,873,365	190.09
190.10	19010	HANCOCK WELLNESS	799,270	810,538	1,609,808	0	1,609,808	190.10
190.11	19011	MORRISTOWN CLINIC	0	2,367	2,367	0	2,367	190.11
190.12	19012	O3PUREMED	0	15,576	15,576	0	15,576	190.12
200.00		TOTAL (SUM OF LINES 118-199)	37,840,887	59,348,001	97,188,888	0	97,188,888	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A | Date/Time Prepared: 5/24/2013 6:25 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-1,591,817	4,380,301	1.00
4.00	00400	EMPLOYEE BENEFITS	-2,463,648	7,306,400	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-6,865,251	13,675,530	5.00
7.00	00700	OPERATION OF PLANT	-150,080	4,409,475	7.00
9.00	00900	HOUSEKEEPING	-25,168	1,437,554	9.00
10.00	01000	DIETARY	-387,354	349,581	10.00
11.00	01100	CAFETERIA	-61,274	1,229,885	11.00
13.00	01300	NURSING ADMINISTRATION	-13,844	909,941	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-42,071	64,597	14.00
15.00	01500	PHARMACY	-499,032	3,279,908	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-72,365	837,217	16.00
23.00	02300	PARAMED ED PRGM	-60,120	18,612	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-2,392	3,466,147	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,461,071	31.00
40.00	04000	SUBPROVIDER - IPF	-67,001	1,155,525	40.00
41.00	04100	SUBPROVIDER - IRF	-72,000	648,968	41.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-994,194	3,708,871	50.00
51.00	05100	RECOVERY ROOM	0	338,998	51.00
53.00	05300	ANESTHESIOLOGY	-135,032	193	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-636,270	3,743,116	54.00
60.00	06000	LABORATORY	-218,387	3,869,197	60.00
65.00	06500	RESPIRATORY THERAPY	-259,261	1,123,668	65.00
66.00	06600	PHYSICAL THERAPY	-5,368	1,213,768	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	322,326	67.00
68.00	06800	SPEECH PATHOLOGY	-1,650	173,783	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	-128	899,763	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-1	3,680,998	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,254,498	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020	CARDIAC	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	0	84,202	76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	-14,280	241,358	88.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	WOUND CLINIC	-127,699	1,015,562	90.01
90.02	09002	DIABETES CLINIC	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	90.03
90.04	09004	ANDIS CLINIC	-41,453	55,499	90.04
90.05	09005	PRIME TIME	-15,176	716,854	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	148,244	90.06
91.00	09100	EMERGENCY	-17,813	2,733,572	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	-25	2,066,297	101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE	-3,887	1,563,330	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-14,844,041	75,584,809	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	395,645	190.01
190.02	19002	PHYSICIAN BUILDING	0	255,641	190.02
190.03	19003	PRIVATE DUTY	0	540,296	190.03
190.04	19004	MARKETING	0	581,421	190.04
190.05	19005	WATER LAB	0	0	190.05
190.06	19006	FOUNDATION	0	211,071	190.06
190.07	19007	ASC	0	2,645	190.07
190.08	19008	ANDERSON WOMEN'S CLINIC	0	272,203	190.08
190.09	19009	HANCOCK OB	0	2,873,365	190.09
190.10	19010	HANCOCK WELLNESS	0	1,609,808	190.10
190.11	19011	MORRISTOWN CLINIC	0	2,367	190.11
190.12	19012	O3PUREMED	0	15,576	190.12
200.00		TOTAL (SUM OF LINES 118-199)	-14,844,041	82,344,847	200.00

COST CENTERS USED IN COST REPORT | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet Non-CMS W | Date/Time Prepared: 5/24/2013 6:25 pm

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	NEW CAP REL COSTS-BLDG & FIXT	00100		1.00
4.00	EMPLOYEE BENEFITS	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
23.00	PARAMED ED PRGM	02300		23.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
40.00	SUBPROVIDER - IPF	04000		40.00
41.00	SUBPROVIDER - IRF	04100		41.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
68.01	OCCUPATIONAL HEALTH	06801		68.01
69.00	ELECTROCARDIOLOGY	06900		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.00	CARDIAC	03020		76.00
76.01	CARDIAC REHABILITATION	03022		76.01
	OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC	08800		88.00
90.00	CLINIC	09000		90.00
90.01	WOUND CLINIC	09001		90.01
90.02	DIABETES CLINIC	09002		90.02
90.03	ASTHMA CLINIC	09003		90.03
90.04	ANDIS CLINIC	09004		90.04
90.05	PRIME TIME	09005		90.05
90.06	SHELBYVILLE WOUND CLINIC	09006		90.06
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
	OTHER REIMBURSABLE COST CENTERS			
101.00	HOME HEALTH AGENCY	10100		101.00
	SPECIAL PURPOSE COST CENTERS			
116.00	HOSPICE	11600		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
190.01	PROFESSIONAL BUILDING	19001		190.01
190.02	PHYSICIAN BUILDING	19002		190.02
190.03	PRIVATE DUTY	19003		190.03
190.04	MARKETING	19004		190.04
190.05	WATER LAB	19005		190.05
190.06	FOUNDATION	19006		190.06
190.07	ASC	19007		190.07
190.08	ANDERSON WOMEN'S CLINIC	19008		190.08
190.09	HANCOCK OB	19009		190.09
190.10	HANCOCK WELLNESS	19010		190.10
190.11	MORRISTOWN CLINIC	19011		190.11
190.12	O3PUREMED	19012		190.12
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-6 | Date/Time Prepared: 5/24/2013 6:25 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	708,925	582,234	1.00
	TOTALS		708,925	582,234	
	B - PLANT RECLASS				
1.00	OPERATION OF PLANT	7.00	0	3,047	1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	9,900	2.00
3.00	ELECTROCARDIOLOGY	69.00	0	9,738	3.00
4.00	RESPIRATORY THERAPY	65.00	0	6,469	4.00
	TOTALS		0	29,154	
	C - MARKETING RECLASS				
1.00	MARKETING	190.04	94,079	487,342	1.00
	TOTALS		94,079	487,342	
	D - OUTPATIENT PROCEDURE RECLASS				
1.00	LABORATORY	60.00	52,021	5,085	1.00
2.00	ELECTROCARDIOLOGY	69.00	7,723	755	2.00
	TOTALS		59,744	5,840	
500.00	Grand Total: Increases		862,748	1,104,570	500.00

RECLASSIFICATIONS | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-6 | Date/Time Prepared: 5/24/2013 6:25 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAFETERIA RECLASS					
1.00	DIETARY	10.00	708,925	582,234	0	1.00
	TOTALS		708,925	582,234		
	B - PLANT RECLASS					
1.00	PROFESSIONAL BUILDING	190.01	0	29,154	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
	TOTALS		0	29,154		
	C - MARKETING RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	94,079	487,342	0	1.00
	TOTALS		94,079	487,342		
	D - OUTPATIENT PROCEDURE RECLASS					
1.00	PHARMACY	15.00	59,744	5,840	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		59,744	5,840		
500.00	Grand Total: Decreases		862,748	1,104,570		500.00

RECLASSIFICATIONS

Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 5/24/2013 6:25 pm

	Increases			Decreases			
	Cost Center	Line #	Salary	Cost Center	Line #	Salary	
	2.00	3.00	4.00	6.00	7.00	8.00	
	A - CAFETERIA RECLASS						
1.00	CAFETERIA	11.00	708,925	DIETARY	10.00	708,925	1.00
	TOTALS		708,925	TOTALS		708,925	
	B - PLANT RECLASS						
1.00	OPERATION OF PLANT	7.00	0	PROFESSIONAL BUILDING	190.01	0	1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0		0.00	0	2.00
3.00	ELECTROCARDIOLOGY	69.00	0		0.00	0	3.00
4.00	RESPIRATORY THERAPY	65.00	0		0.00	0	4.00
	TOTALS		0	TOTALS		0	
	C - MARKETING RECLASS						
1.00	MARKETING	190.04	94,079	ADMINISTRATIVE & GENERAL	5.00	94,079	1.00
	TOTALS		94,079	TOTALS		94,079	
	D - OUTPATIENT PROCEDURE RECLASS						
1.00	LABORATORY	60.00	52,021	PHARMACY	15.00	59,744	1.00
2.00	ELECTROCARDIOLOGY	69.00	7,723		0.00	0	2.00
	TOTALS		59,744	TOTALS		59,744	
500.00	Grand Total: Increases		862,748	Grand Total: Decreases		862,748	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-7 Part I Date/Time Prepared: 5/24/2013 6:25 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	270,285	0	0	0	0	1.00
2.00	Land Improvements	5,382,451	644	0	644	0	2.00
3.00	Buildings and Fixtures	96,998,351	805,957	0	805,957	6,212,281	3.00
4.00	Building Improvements	235,570	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	45,700,307	6,359,409	0	6,359,409	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	148,586,964	7,166,010	0	7,166,010	6,212,281	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	148,586,964	7,166,010	0	7,166,010	6,212,281	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	270,285	0	1.00
2.00	Land Improvements	5,383,095	0	2.00
3.00	Buildings and Fixtures	91,592,027	0	3.00
4.00	Building Improvements	235,570	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	52,059,716	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	149,540,693	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	149,540,693	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-7 Part II Date/Time Prepared: 5/24/2013 6:25 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	4,191,980	0	1,547,490	197,200	35,448	1.00
3.00	Total (sum of lines 1-2)	4,191,980	0	1,547,490	197,200	35,448	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	5,972,118		1.00
3.00	Total (sum of lines 1-2)	0	5,972,118		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-7 Part III Date/Time Prepared: 5/24/2013 6:25 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	91,592,027	0	91,592,027	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	91,592,027	0	91,592,027	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	3,251,106	-648,610	1.00
3.00	Total (sum of lines 1-2)	0	0	0	3,251,106	-648,610	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,545,157	197,200	35,448	0	4,380,301	1.00
3.00	Total (sum of lines 1-2)	1,545,157	197,200	35,448	0	4,380,301	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-8 | Date/Time Prepared: 5/24/2013 6:25 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,061,584			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-8 | Date/Time Prepared: 5/24/2013 6:25 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	HRH MMO RENTAL INCOME	B	-642,329	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.00
33.01	HRH OTHER REVENUE SALES TAX	B	38,564	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	HRH OTHER REVENUE MISCELLANEOUS REV	B	-289	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	HRH OTHER REVNUE CHARGE CARD OTHER	B	-71	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	HRH GREENFIELD PAR EDUCATION SVC REV	B	-5,063	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	HRH HOME MED EQUIP HME-OTC SALES	B	-65,049	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	HRH MED STAFF SVC QA APPL FEES	B	-2,370	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	HRH MED STAFF DUES	B	-18,600	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	HRH PAT FIN SVC BUS SVC COPY FEE	B	-2,125	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	HRH PAT FIN SVC EXP REIMB	B	-48,368	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	HRH INFO SVCS MISC REV	B	-76,077	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	HRH ACCOUNTING MISC REV	B	-8,973	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	HRH EXEC ADMIN MISC REVENUE	B	-1,000	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	HRH PURCHASING MISC REVENUE	B	-15	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	HRH PURCHASING REBATES/REFUNDS	B	-9,357	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	HRH COMMUNICATIONS MISC REVENUE	B	-12,063	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	HRH COMMUNICATION PHONE LEASE REV	B	-170,391	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	HRH COMM ED EDUCATION SVC REV	B	-11,157	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	HRH COMM EDUCATION CAR SEAT STATE FU	B	-1,400	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	HRH TOBACCO AWARENESS ED SVC REV	B	-45	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	HRH WILLIAMS PROPERTY RENTAL INCOME	B	-4,980	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	HRH GAIN/LOSS INVENTORY	B	-51,946	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	HRH GAIN/LOSS GROSS VARIANCE INV	B	9,240	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23	HRH PLANT OFFSITE SERVICES	B	-86,461	OPERATION OF PLANT	7.00	0	33.23
33.24	HRH OFFSITE SERVICES	B	-17,518	HOUSEKEEPING	9.00	0	33.24
33.25	HRH NUTRITIONAL SER REBATES/REFUNDS	B	-7,482	DIETARY	10.00	0	33.25
33.26	HRH OTHER REVENUE REBATES/REFUNDS	B	-34,978	CENTRAL SERVICES & SUPPLY	14.00	0	33.26
33.27	HRH OTHER REVENUE DISCOUNTS EARNED	B	-7,093	CENTRAL SERVICES & SUPPLY	14.00	0	33.27
33.28	HRH PHARMACY MISC REV	B	-1,484	PHARMACY	15.00	0	33.28
33.29	HRH PHARMACY REBATES/REFUNDS	B	-2,069	PHARMACY	15.00	0	33.29
33.30	HRH ASSOC PHARM RETAIL PHARMACY REV	B	-495,479	PHARMACY	15.00	0	33.30
33.31	HRH HEALTH INFO SER MEDICAL RECORDS	B	-72,365	MEDICAL RECORDS & LIBRARY	16.00	0	33.31
33.32	HRH ANDIS UNIT REBATES/REFUNDS	B	-1,922	ADULTS & PEDIATRICS	30.00	0	33.32
33.33	HRH HAN GEN SURG PHYS OTHER REVENUE	B	-2,301,178	OPERATING ROOM	50.00	0	33.33
33.34	HRH HAN GEN SURG CONTRACTUAL PHYS OT	B	1,505,674	OPERATING ROOM	50.00	0	33.34
33.35	HRH RADIOLOGY REV COMMUNITY BENEFITS	B	49	RADIOLOGY-DIAGNOSTIC	54.00	0	33.35
33.36	HRH DIAG IMAGING HEARTBEATS REVENUE	B	-5,239	RADIOLOGY-DIAGNOSTIC	54.00	0	33.36
33.37	HRH PIC AHN EXP REIMBURSEMENT	B	-447,395	RADIOLOGY-DIAGNOSTIC	54.00	0	33.37
33.38	HRH MMO RADIOLOGY HEARTBEATS REV	B	-2,398	RADIOLOGY-DIAGNOSTIC	54.00	0	33.38
33.39	HRH MMO EXPENSE REIMBURSEMENT	B	-181,287	RADIOLOGY-DIAGNOSTIC	54.00	0	33.39
33.40	HRH LAB WATER TESTING	B	-51,090	LABORATORY	60.00	0	33.40
33.41	HRH LAB HEARTBEATS REVENUE	B	-42,297	LABORATORY	60.00	0	33.41

ADJUSTMENTS TO EXPENSES | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-8 | Date/Time Prepared: 5/24/2013 6:25 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.42	HRH SLEEP STUDY CLINIC MANAGEMENT	B	-85,100	RESPIRATORY THERAPY	65.00	0	33.42
33.43	HRH SLEEP STUDY SLEEP STUDY FEES	B	-152,161	RESPIRATORY THERAPY	65.00	0	33.43
33.44	HRH MMO-PT MISC REVENUE	B	-45	PHYSICAL THERAPY	66.00	0	33.44
33.45	HRH WOUND/SKIN CLIN LEASED EMPLOYEE	B	-63,149	WOUND CLINIC	90.01	0	33.45
33.46	HRH ANDIS WOMEN'S CENTER CLINIC MGT	B	-41,453	ANDIS CLINIC	90.04	0	33.46
33.47	HRH ER REBATES/REFUNDS	B	-313	EMERGENCY	91.00	0	33.47
33.48	HRH HOSPICE CHARITABLE TRUST	B	-3,887	HOSPICE	116.00	0	33.48
33.49	MOW	A	-379,872	DIETARY	10.00	0	33.49
33.50	CAFETERIA GUEST MEALS	A	-61,274	CAFETERIA	11.00	0	33.50
33.51	ADVERTISING FEE	A	-416	ADMINISTRATIVE & GENERAL	5.00	0	33.51
33.52	ADVERTISING FEE	A	-458	PHYSICAL THERAPY	66.00	0	33.52
33.53	LIFELINE OTHER EXPENSE	A	-18,781	ADMINISTRATIVE & GENERAL	5.00	0	33.53
33.54	IHA LOBBYING EXPENSE	A	-2,058	ADMINISTRATIVE & GENERAL	5.00	0	33.54
33.55	AHA LOBBYING EXPENSE	A	-5,323	ADMINISTRATIVE & GENERAL	5.00	0	33.55
33.56	PHY OFFICE BLDG	A	-942,354	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.56
33.57	PHY OFFICE BLDG	A	-63,619	OPERATION OF PLANT	7.00	0	33.57
33.58	INTEREST REVENUE	B	-2,333	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.58
33.59	RENTAL PROPERTIES EXPENSE	A	-114,356	ADMINISTRATIVE & GENERAL	5.00	0	33.59
33.60	RENTAL PROPERTIES EXPENSE	A	-6,281	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.60
33.61	RENTAL PROPERTIES EXPENSE	A	-1	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.61
33.62	TELEPHONE SERVICES	A	-33,293	ADMINISTRATIVE & GENERAL	5.00	0	33.62
33.63	1987 USEFUL LIFE ADJ	A	1,480	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.63
33.64	XRAY SCHOOL TUITION REVENUE	B	-60,120	PARAMED ED PRGM	23.00	0	33.64
33.65	HRH CLINICAL EDUC AHA COURSE REV	B	-13,529	NURSING ADMINISTRATION	13.00	0	33.65
33.66	HRH CLINICAL EDUC ED SVC REVENUE	B	-315	NURSING ADMINISTRATION	13.00	0	33.66
33.67	HRH ANDIS UNIT MISC REVENUE	B	-470	ADULTS & PEDIATRICS	30.00	0	33.67
33.68	HRH CARDIO SVC MISC REV	B	-128	ELECTROCARDIOLOGY	69.00	0	33.68
33.69	HRH NEW PAL PT MISC REV	B	-2,895	PHYSICAL THERAPY	66.00	0	33.69
33.70	HRH HOME HEALTH MIS REV	B	-25	HOME HEALTH AGENCY	101.00	0	33.70
33.71	HRH HOUSEKEEPING OFFSITE SERVICES	B	-7,650	HOUSEKEEPING	9.00	0	33.71
33.72	HRH TRAIN & DEVELOP AHA COURSE REV	B	-12	ADMINISTRATIVE & GENERAL	5.00	0	33.72
33.73	HRH COMM ED MISC REVENUE	B	-420	ADMINISTRATIVE & GENERAL	5.00	0	33.73
33.74	HAF EXPENSE	A	-5,747,849	ADMINISTRATIVE & GENERAL	5.00	0	33.74
33.75	PHYSICIAN RECRUITMENT FEES	A	-169,692	ADMINISTRATIVE & GENERAL	5.00	0	33.75
33.76	DONATIONS & SPONSORSHIPS	A	-4,781	ADMINISTRATIVE & GENERAL	5.00	0	33.76
33.77	SELF INSURED CLAIMS PAID	A	-2,463,648	EMPLOYEE BENEFITS	4.00	0	33.77
33.78			0		0.00	0	33.78
33.79			0		0.00	0	33.79
33.80			0		0.00	0	33.80
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-14,844,041				50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-8-2 | Date/Time Prepared: 5/24/2013 6:25 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	326,735	326,735	0	0	0	1.00
2.00	40.00	SUBPROVIDER - IPF	67,001	67,001	0	0	0	2.00
3.00	41.00	SUBPROVIDER - IRF	72,000	72,000	0	0	0	3.00
4.00	50.00	OPERATING ROOM	198,690	198,690	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	135,032	135,032	0	0	0	5.00
6.00	60.00	LABORATORY	125,000	125,000	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	22,000	22,000	0	0	0	7.00
8.00	66.00	PHYSICAL THERAPY	1,970	1,970	0	0	0	8.00
9.00	68.00	SPEECH PATHOLOGY	1,650	1,650	0	0	0	9.00
10.00	88.00	RURAL HEALTH CLINIC	14,280	14,280	0	0	0	10.00
11.00	90.01	WOUND CLINIC	64,550	64,550	0	0	0	11.00
12.00	90.05	PRIME TIME	15,176	15,176	0	0	0	12.00
13.00	91.00	EMERGENCY	17,500	17,500	0	0	0	13.00
200.00			1,061,584	1,061,584	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	8.00
9.00	68.00	SPEECH PATHOLOGY	0	0	0	0	0	9.00
10.00	88.00	RURAL HEALTH CLINIC	0	0	0	0	0	10.00
11.00	90.01	WOUND CLINIC	0	0	0	0	0	11.00
12.00	90.05	PRIME TIME	0	0	0	0	0	12.00
13.00	91.00	EMERGENCY	0	0	0	0	0	13.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	326,735		1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	67,001		2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	72,000		3.00
4.00	50.00	OPERATING ROOM	0	0	0	198,690		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	135,032		5.00
6.00	60.00	LABORATORY	0	0	0	125,000		6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	22,000		7.00
8.00	66.00	PHYSICAL THERAPY	0	0	0	1,970		8.00
9.00	68.00	SPEECH PATHOLOGY	0	0	0	1,650		9.00
10.00	88.00	RURAL HEALTH CLINIC	0	0	0	14,280		10.00
11.00	90.01	WOUND CLINIC	0	0	0	64,550		11.00
12.00	90.05	PRIME TIME	0	0	0	15,176		12.00
13.00	91.00	EMERGENCY	0	0	0	17,500		13.00
200.00			0	0	0	1,061,584		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part I Date/Time Prepared: 5/24/2013 6:25 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	4,380,301	4,380,301				1.00
4.00	00400	EMPLOYEE BENEFITS	7,306,400	14,219	7,320,619			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,675,530	330,074	1,315,335	15,320,939	15,320,939	5.00
7.00	00700	OPERATION OF PLANT	4,409,475	1,130,244	157,132	5,696,851	1,302,249	7.00
9.00	00900	HOUSEKEEPING	1,437,554	27,982	158,072	1,623,608	371,139	9.00
10.00	01000	DIETARY	349,581	47,437	67,967	464,985	106,290	10.00
11.00	01100	CAFETERIA	1,229,885	80,438	138,260	1,448,583	331,130	11.00
13.00	01300	NURSING ADMINISTRATION	909,941	0	158,652	1,068,593	244,269	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	64,597	0	12,324	76,921	17,583	14.00
15.00	01500	PHARMACY	3,279,908	64,177	240,127	3,584,212	819,311	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	837,217	38,226	120,127	995,570	227,576	16.00
23.00	02300	PARAMED ED PRGM	18,612	14,599	12,917	46,128	10,544	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,466,147	337,548	555,470	4,359,165	996,457	30.00
31.00	03100	INTENSIVE CARE UNIT	3,461,071	259,076	559,557	4,279,704	978,293	31.00
40.00	04000	SUBPROVIDER - IPF	1,155,525	69,261	194,476	1,419,262	324,428	40.00
41.00	04100	SUBPROVIDER - IRF	648,968	47,687	112,937	809,592	185,064	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,708,871	256,078	414,704	4,379,653	1,001,140	50.00
51.00	05100	RECOVERY ROOM	338,998	23,029	58,268	420,295	96,075	51.00
53.00	05300	ANESTHESIOLOGY	193	0	0	193	44	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,743,116	160,442	482,310	4,385,868	1,002,561	54.00
60.00	06000	LABORATORY	3,869,197	69,022	319,942	4,258,161	973,369	60.00
65.00	06500	RESPIRATORY THERAPY	1,123,668	25,115	212,689	1,361,472	311,218	65.00
66.00	06600	PHYSICAL THERAPY	1,213,768	47,220	193,384	1,454,372	332,453	66.00
67.00	06700	OCCUPATIONAL THERAPY	322,326	0	56,679	379,005	86,636	67.00
68.00	06800	SPEECH PATHOLOGY	173,783	5,453	28,627	207,863	47,515	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	899,763	75,518	86,793	1,062,074	242,778	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,680,998	0	0	3,680,998	841,436	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,254,498	0	0	1,254,498	286,764	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	84,202	0	9,424	93,626	21,402	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	241,358	0	32,803	274,161	62,670	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	1,015,562	31,448	36,564	1,083,574	247,693	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	55,499	0	9,362	64,861	14,827	90.04
90.05	09005	PRIME TIME	716,854	0	113,420	830,274	189,792	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	148,244	0	18,203	166,447	38,048	90.06
91.00	09100	EMERGENCY	2,733,572	234,417	439,872	3,407,861	779,000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,066,297	0	315,688	2,381,985	544,496	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	1,563,330	100,371	154,482	1,818,183	415,617	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	75,584,809	3,489,081	6,786,567	74,159,537	13,449,867	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	395,645	615,438	0	1,011,083	231,122	190.01
190.02	19002	PHYSICIAN BUILDING	255,641	0	14,499	270,140	61,751	190.02
190.03	19003	PRIVATE DUTY	540,296	0	65,367	605,663	138,448	190.03
190.04	19004	MARKETING	581,421	4,790	18,348	604,559	138,196	190.04
190.05	19005	WATER LAB	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	211,071	0	21,171	232,242	53,088	190.06
190.07	19007	ASC	2,645	252,417	0	255,062	58,304	190.07
190.08	19008	ANDERSON WOMEN'S CLINIC	272,203	18,575	40,279	331,057	75,676	190.08
190.09	19009	HANCOCK OB	2,873,365	0	218,509	3,091,874	706,768	190.09
190.10	19010	HANCOCK WELLNESS	1,609,808	0	155,879	1,765,687	403,617	190.10
190.11	19011	MORRISTOWN CLINIC	2,367	0	0	2,367	541	190.11
190.12	19012	O3PUREMED	15,576	0	0	15,576	3,561	190.12
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	82,344,847	4,380,301	7,320,619	82,344,847	15,320,939	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part I Date/Time Prepared: 5/24/2013 6:25 pm

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	6,999,100					7.00
9.00	00900	HOUSEKEEPING	67,401	2,062,148				9.00
10.00	01000	DIETARY	114,262	32,723	718,260			10.00
11.00	01100	CAFETERIA	193,752	53,922	0	2,027,387		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	48,688	1,361,550	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	81,794	0	9,983	7,752	14.00
15.00	01500	PHARMACY	154,583	59,664	0	84,700	65,769	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	92,074	71,767	0	70,620	0	16.00
23.00	02300	PARAMED ED PRGM	35,166	82,669	0	4,702	3,651	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	813,050	548,476	175,641	204,361	158,686	30.00
31.00	03100	INTENSIVE CARE UNIT	624,034	113,076	261,625	235,095	182,551	31.00
40.00	04000	SUBPROVIDER - IPF	166,828	90,496	146,749	87,844	68,211	40.00
41.00	04100	SUBPROVIDER - IRF	114,864	31,327	64,861	51,509	39,997	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	616,813	219,551	0	33,083	25,689	50.00
51.00	05100	RECOVERY ROOM	55,470	80,844	0	18,780	14,582	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	386,456	80,369	0	201,893	156,770	54.00
60.00	06000	LABORATORY	166,252	76,693	0	169,074	131,285	60.00
65.00	06500	RESPIRATORY THERAPY	60,493	58,739	0	174,475	135,479	65.00
66.00	06600	PHYSICAL THERAPY	113,739	68,266	0	71,828	55,774	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	23,727	0	67.00
68.00	06800	SPEECH PATHOLOGY	13,135	0	0	9,251	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	181,899	133,106	0	37,820	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	0	0	0	6,241	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	75,748	0	0	7,538	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	0	4,188	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
91.00	09100	EMERGENCY	564,640	117,602	0	150,412	116,794	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	61,064	0	134,225	104,226	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	241,764	0	69,384	67,355	52,301	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,852,423	2,062,148	718,260	1,907,392	1,319,517	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	1,482,401	0	0	0	0	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	9,817	0	190.02
190.03	19003	PRIVATE DUTY	0	0	0	54,132	42,033	190.03
190.04	19004	MARKETING	11,539	0	0	6,908	0	190.04
190.05	19005	WATER LAB	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	0	0	0	9,404	0	190.06
190.07	19007	ASC	607,995	0	0	0	0	190.07
190.08	19008	ANDERSON WOMEN'S CLINIC	44,742	0	0	18,933	0	190.08
190.09	19009	HANCOCK OB	0	0	0	20,801	0	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	0	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
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)	6,999,100	2,062,148	718,260	2,027,387	1,361,550	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part I Date/Time Prepared: 5/24/2013 6:25 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
			14.00	15.00	16.00	23.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	194,033					14.00
15.00	01500	PHARMACY	1,073	4,769,312				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,457,607			16.00
23.00	02300	PARAMED ED PRGM	0	0	0	182,860		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,449	0	336,569	0	7,595,854	30.00
31.00	03100	INTENSIVE CARE UNIT	5,504	0	42,025	0	6,721,907	31.00
40.00	04000	SUBPROVIDER - IPF	515	0	34,652	0	2,338,985	40.00
41.00	04100	SUBPROVIDER - IRF	398	0	206,070	0	1,503,682	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,111	0	442,370	0	6,723,410	50.00
51.00	05100	RECOVERY ROOM	218	0	0	0	686,264	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	237	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,596	0	50,504	182,860	6,448,877	54.00
60.00	06000	LABORATORY	35,522	0	112,067	0	5,922,423	60.00
65.00	06500	RESPIRATORY THERAPY	620	0	0	0	2,102,496	65.00
66.00	06600	PHYSICAL THERAPY	49	0	0	0	2,096,481	66.00
67.00	06700	OCCUPATIONAL THERAPY	30	0	0	0	489,398	67.00
68.00	06800	SPEECH PATHOLOGY	191	0	0	0	277,955	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	984	0	57,508	0	1,716,169	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	4,522,434	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	130,063	0	0	0	1,671,325	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,769,312	2,580	0	4,771,892	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	22	0	0	0	121,291	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	47	0	0	0	336,878	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	534	0	0	0	1,415,087	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	18	0	0	0	83,894	90.04
90.05	09005	PRIME TIME	364	0	0	0	1,020,430	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	101	0	0	0	204,596	90.06
91.00	09100	EMERGENCY	4,583	0	172,893	0	5,313,785	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	430	0	369	0	3,226,795	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	2,296	0	0	0	2,666,900	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	193,718	4,769,312	1,457,607	182,860	69,979,445	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0	0	2,724,606	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	341,708	190.02
190.03	19003	PRIVATE DUTY	225	0	0	0	840,501	190.03
190.04	19004	MARKETING	0	0	0	0	761,202	190.04
190.05	19005	WATER LAB	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	0	0	0	0	294,734	190.06
190.07	19007	ASC	7	0	0	0	921,368	190.07
190.08	19008	ANDERSON WOMEN'S CLINIC	83	0	0	0	470,491	190.08
190.09	19009	HANCOCK OB	0	0	0	0	3,819,443	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	0	2,169,304	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	2,908	190.11
190.12	19012	O3PUREMED	0	0	0	0	19,137	190.12
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	194,033	4,769,312	1,457,607	182,860	82,344,847	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part I Date/Time Prepared: 5/24/2013 6:25 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
23.00	02300	PARAMED ED PRGM				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	7,595,854		30.00
31.00	03100	INTENSIVE CARE UNIT	0	6,721,907		31.00
40.00	04000	SUBPROVIDER - IPF	0	2,338,985		40.00
41.00	04100	SUBPROVIDER - IRF	0	1,503,682		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	6,723,410		50.00
51.00	05100	RECOVERY ROOM	0	686,264		51.00
53.00	05300	ANESTHESIOLOGY	0	237		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,448,877		54.00
60.00	06000	LABORATORY	0	5,922,423		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,102,496		65.00
66.00	06600	PHYSICAL THERAPY	0	2,096,481		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	489,398		67.00
68.00	06800	SPEECH PATHOLOGY	0	277,955		68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	1,716,169		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,522,434		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,671,325		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,771,892		73.00
76.00	03020	CARDIAC	0	0		76.00
76.01	03022	CARDIAC REHABILITATION	0	121,291		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	336,878		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	1,415,087		90.01
90.02	09002	DIABETES CLINIC	0	0		90.02
90.03	09003	ASTHMA CLINIC	0	0		90.03
90.04	09004	ANDIS CLINIC	0	83,894		90.04
90.05	09005	PRIME TIME	0	1,020,430		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	204,596		90.06
91.00	09100	EMERGENCY	0	5,313,785		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	3,226,795		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	2,666,900		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	69,979,445		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	2,724,606		190.01
190.02	19002	PHYSICIAN BUILDING	0	341,708		190.02
190.03	19003	PRIVATE DUTY	0	840,501		190.03
190.04	19004	MARKETING	0	761,202		190.04
190.05	19005	WATER LAB	0	0		190.05
190.06	19006	FOUNDATION	0	294,734		190.06
190.07	19007	ASC	0	921,368		190.07
190.08	19008	ANDERSON WOMEN'S CLINIC	0	470,491		190.08
190.09	19009	HANCOCK OB	0	3,819,443		190.09
190.10	19010	HANCOCK WELLNESS	0	2,169,304		190.10
190.11	19011	MORRISTOWN CLINIC	0	2,908		190.11
190.12	19012	O3PUREMED	0	19,137		190.12
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	82,344,847		202.00

COST ALLOCATION STATISTICS | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet Non-CMS W | Date/Time Prepared: 5/24/2013 6:25 pm

	Cost Center Description	Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	NEW CAP REL COSTS-BLDG & FIXT	1		1.00
4.00	EMPLOYEE BENEFITS	S		4.00
5.00	ADMINISTRATIVE & GENERAL	-3		5.00
7.00	OPERATION OF PLANT	4		7.00
9.00	HOUSEKEEPING	5		9.00
10.00	DIETARY	6		10.00
11.00	CAFETERIA	7		11.00
13.00	NURSING ADMINISTRATION	2		13.00
14.00	CENTRAL SERVICES & SUPPLY	9		14.00
15.00	PHARMACY	10		15.00
16.00	MEDICAL RECORDS & LIBRARY	11		16.00
23.00	PARAMED ED PRGM	12		23.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part II Date/Time Prepared: 5/24/2013 6:25 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS	0	14,219	14,219	14,219		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	330,074	330,074	2,552	332,626	5.00
7.00	00700	OPERATION OF PLANT	0	1,130,244	1,130,244	305	28,258	7.00
9.00	00900	HOUSEKEEPING	0	27,982	27,982	307	8,058	9.00
10.00	01000	DIETARY	0	47,437	47,437	132	2,308	10.00
11.00	01100	CAFETERIA	0	80,438	80,438	269	7,189	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	308	5,303	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	24	382	14.00
15.00	01500	PHARMACY	0	64,177	64,177	467	17,788	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	38,226	38,226	233	4,941	16.00
23.00	02300	PARAMED ED PRGM	0	14,599	14,599	25	229	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	337,548	337,548	1,079	21,635	30.00
31.00	03100	INTENSIVE CARE UNIT	0	259,076	259,076	1,087	21,240	31.00
40.00	04000	SUBPROVIDER - IPF	0	69,261	69,261	378	7,044	40.00
41.00	04100	SUBPROVIDER - IRF	0	47,687	47,687	219	4,018	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	256,078	256,078	806	21,736	50.00
51.00	05100	RECOVERY ROOM	0	23,029	23,029	113	2,086	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	1	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	160,442	160,442	937	21,767	54.00
60.00	06000	LABORATORY	0	69,022	69,022	622	21,133	60.00
65.00	06500	RESPIRATORY THERAPY	0	25,115	25,115	413	6,757	65.00
66.00	06600	PHYSICAL THERAPY	0	47,220	47,220	376	7,218	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	110	1,881	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,453	5,453	56	1,032	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	75,518	75,518	169	5,271	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	18,269	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	6,226	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	0	0	0	18	465	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	64	1,361	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	31,448	31,448	71	5,378	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	0	18	322	90.04
90.05	09005	PRIME TIME	0	0	0	220	4,121	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	35	826	90.06
91.00	09100	EMERGENCY	0	234,417	234,417	855	16,913	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	613	11,822	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	100,371	100,371	300	9,024	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,489,081	3,489,081	13,181	292,002	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	615,438	615,438	0	5,018	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	28	1,341	190.02
190.03	19003	PRIVATE DUTY	0	0	0	127	3,006	190.03
190.04	19004	MARKETING	0	4,790	4,790	36	3,000	190.04
190.05	19005	WATER LAB	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	0	0	0	41	1,153	190.06
190.07	19007	ASC	0	252,417	252,417	0	1,266	190.07
190.08	19008	ANDERSON WOMEN'S CLINIC	0	18,575	18,575	78	1,643	190.08
190.09	19009	HANCOCK OB	0	0	0	425	15,345	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	303	8,763	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	12	190.11
190.12	19012	O3PUREMED	0	0	0	0	77	190.12
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	4,380,301	4,380,301	14,219	332,626	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part II Date/Time Prepared: 5/24/2013 6:25 pm

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	1,158,807					7.00
9.00	00900	HOUSEKEEPING	11,159	47,506				9.00
10.00	01000	DIETARY	18,918	754	69,549			10.00
11.00	01100	CAFETERIA	32,078	1,242	0	121,216		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	2,911	8,522	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,884	0	597	49	14.00
15.00	01500	PHARMACY	25,593	1,374	0	5,064	412	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,244	1,653	0	4,222	0	16.00
23.00	02300	PARAMED ED PRGM	5,822	1,904	0	281	23	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	134,613	12,637	17,007	12,219	993	30.00
31.00	03100	INTENSIVE CARE UNIT	103,318	2,605	25,334	14,055	1,143	31.00
40.00	04000	SUBPROVIDER - IPF	27,621	2,085	14,210	5,252	427	40.00
41.00	04100	SUBPROVIDER - IRF	19,018	722	6,280	3,080	250	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	102,123	5,058	0	1,978	161	50.00
51.00	05100	RECOVERY ROOM	9,184	1,862	0	1,123	91	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	63,984	1,851	0	12,071	981	54.00
60.00	06000	LABORATORY	27,526	1,767	0	10,109	822	60.00
65.00	06500	RESPIRATORY THERAPY	10,016	1,353	0	10,432	848	65.00
66.00	06600	PHYSICAL THERAPY	18,831	1,573	0	4,295	349	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,419	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,175	0	0	553	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	30,116	3,066	0	2,261	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	0	0	0	373	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	12,541	0	0	451	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	0	250	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
91.00	09100	EMERGENCY	93,485	2,709	0	8,993	731	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,407	0	8,025	652	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	40,028	0	6,718	4,027	327	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	803,393	47,506	69,549	114,041	8,259	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	245,433	0	0	0	0	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	587	0	190.02
190.03	19003	PRIVATE DUTY	0	0	0	3,237	263	190.03
190.04	19004	MARKETING	1,910	0	0	413	0	190.04
190.05	19005	WATER LAB	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	0	0	0	562	0	190.06
190.07	19007	ASC	100,663	0	0	0	0	190.07
190.08	19008	ANDERSON WOMEN'S CLINIC	7,408	0	0	1,132	0	190.08
190.09	19009	HANCOCK OB	0	0	0	1,244	0	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	0	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,158,807	47,506	69,549	121,216	8,522	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part II Date/Time Prepared: 5/24/2013 6:25 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
			14.00	15.00	16.00	23.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,936					14.00
15.00	01500	PHARMACY	16	114,891				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	64,519			16.00
23.00	02300	PARAMED ED PRGM	0	0	0	22,883		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	52	0	14,898		552,681	30.00
31.00	03100	INTENSIVE CARE UNIT	83	0	1,860		429,801	31.00
40.00	04000	SUBPROVIDER - IPF	8	0	1,534		127,820	40.00
41.00	04100	SUBPROVIDER - IRF	6	0	9,121		90,401	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	77	0	19,582		407,599	50.00
51.00	05100	RECOVERY ROOM	3	0	0		37,491	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		1	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24	0	2,235		264,292	54.00
60.00	06000	LABORATORY	538	0	4,960		136,499	60.00
65.00	06500	RESPIRATORY THERAPY	9	0	0		54,943	65.00
66.00	06600	PHYSICAL THERAPY	1	0	0		79,863	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		3,410	67.00
68.00	06800	SPEECH PATHOLOGY	3	0	0		9,272	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0		0	68.01
69.00	06900	ELECTROCARDIOLOGY	15	0	2,546		118,962	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		18,269	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,969	0	0		8,195	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	114,891	114		115,005	73.00
76.00	03020	CARDIAC	0	0	0		0	76.00
76.01	03022	CARDIAC REHABILITATION	0	0	0		856	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1	0	0		1,426	88.00
90.00	09000	CLINIC	0	0	0		0	90.00
90.01	09001	WOUND CLINIC	8	0	0		49,897	90.01
90.02	09002	DIABETES CLINIC	0	0	0		0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0		0	90.03
90.04	09004	ANDIS CLINIC	0	0	0		590	90.04
90.05	09005	PRIME TIME	6	0	0		4,347	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	2	0	0		863	90.06
91.00	09100	EMERGENCY	69	0	7,653		365,825	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	7	0	16		22,542	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	35	0	0		160,830	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,932	114,891	64,519	0	3,061,680	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0		865,889	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0		1,956	190.02
190.03	19003	PRIVATE DUTY	3	0	0		6,636	190.03
190.04	19004	MARKETING	0	0	0		10,149	190.04
190.05	19005	WATER LAB	0	0	0		0	190.05
190.06	19006	FOUNDATION	0	0	0		1,756	190.06
190.07	19007	ASC	0	0	0		354,346	190.07
190.08	19008	ANDERSON WOMEN'S CLINIC	1	0	0		28,837	190.08
190.09	19009	HANCOCK OB	0	0	0		17,014	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0		9,066	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0		12	190.11
190.12	19012	O3PUREMED	0	0	0		77	190.12
200.00		Cross Foot Adjustments				22,883	22,883	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,936	114,891	64,519	22,883	4,380,301	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part II Date/Time Prepared: 5/24/2013 6:25 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
23.00	02300	PARAMED ED PRGM				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	552,681		30.00
31.00	03100	INTENSIVE CARE UNIT	0	429,801		31.00
40.00	04000	SUBPROVIDER - IPF	0	127,820		40.00
41.00	04100	SUBPROVIDER - IRF	0	90,401		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	407,599		50.00
51.00	05100	RECOVERY ROOM	0	37,491		51.00
53.00	05300	ANESTHESIOLOGY	0	1		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	264,292		54.00
60.00	06000	LABORATORY	0	136,499		60.00
65.00	06500	RESPIRATORY THERAPY	0	54,943		65.00
66.00	06600	PHYSICAL THERAPY	0	79,863		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,410		67.00
68.00	06800	SPEECH PATHOLOGY	0	9,272		68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	118,962		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	18,269		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	8,195		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	115,005		73.00
76.00	03020	CARDIAC	0	0		76.00
76.01	03022	CARDIAC REHABILITATION	0	856		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	1,426		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	49,897		90.01
90.02	09002	DIABETES CLINIC	0	0		90.02
90.03	09003	ASTHMA CLINIC	0	0		90.03
90.04	09004	ANDIS CLINIC	0	590		90.04
90.05	09005	PRIME TIME	0	4,347		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	863		90.06
91.00	09100	EMERGENCY	0	365,825		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	22,542		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	160,830		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,061,680		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	865,889		190.01
190.02	19002	PHYSICIAN BUILDING	0	1,956		190.02
190.03	19003	PRIVATE DUTY	0	6,636		190.03
190.04	19004	MARKETING	0	10,149		190.04
190.05	19005	WATER LAB	0	0		190.05
190.06	19006	FOUNDATION	0	1,756		190.06
190.07	19007	ASC	0	354,346		190.07
190.08	19008	ANDERSON WOMEN'S CLINIC	0	28,837		190.08
190.09	19009	HANCOCK OB	0	17,014		190.09
190.10	19010	HANCOCK WELLNESS	0	9,066		190.10
190.11	19011	MORRISTOWN CLINIC	0	12		190.11
190.12	19012	O3PUREMED	0	77		190.12
200.00		Cross Foot Adjustments	0	22,883		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	4,380,301		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B-1 | Date/Time Prepared: 5/24/2013 6:25 pm

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	403,242					1.00
4.00	00400	EMPLOYEE BENEFITS	1,309	37,536,417				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	30,386	6,744,338	-15,320,939	67,023,908		5.00
7.00	00700	OPERATION OF PLANT	104,048	805,695	0	5,696,851	267,499	7.00
9.00	00900	HOUSEKEEPING	2,576	810,512	0	1,623,608	2,576	9.00
10.00	01000	DIETARY	4,367	348,501	0	464,985	4,367	10.00
11.00	01100	CAFETERIA	7,405	708,925	0	1,448,583	7,405	11.00
13.00	01300	NURSING ADMINISTRATION	0	813,489	0	1,068,593	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	63,193	0	76,921	0	14.00
15.00	01500	PHARMACY	5,908	1,231,248	0	3,584,212	5,908	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,519	615,952	0	995,570	3,519	16.00
23.00	02300	PARAMED ED PRGM	1,344	66,230	0	46,128	1,344	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	31,074	2,848,168	0	4,359,165	31,074	30.00
31.00	03100	INTENSIVE CARE UNIT	23,850	2,869,128	0	4,279,704	23,850	31.00
40.00	04000	SUBPROVIDER - IPF	6,376	997,177	0	1,419,262	6,376	40.00
41.00	04100	SUBPROVIDER - IRF	4,390	579,083	0	809,592	4,390	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,574	2,126,395	0	4,379,653	23,574	50.00
51.00	05100	RECOVERY ROOM	2,120	298,768	0	420,295	2,120	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	193	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,770	2,473,043	0	4,385,868	14,770	54.00
60.00	06000	LABORATORY	6,354	1,640,501	0	4,258,161	6,354	60.00
65.00	06500	RESPIRATORY THERAPY	2,312	1,090,563	0	1,361,472	2,312	65.00
66.00	06600	PHYSICAL THERAPY	4,347	991,575	0	1,454,372	4,347	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	290,619	0	379,005	0	67.00
68.00	06800	SPEECH PATHOLOGY	502	146,787	0	207,863	502	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	6,952	445,029	0	1,062,074	6,952	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,680,998	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,254,498	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	0	48,324	0	93,626	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	168,197	0	274,161	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	2,895	187,483	0	1,083,574	2,895	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	48,002	0	64,861	0	90.04
90.05	09005	PRIME TIME	0	581,563	0	830,274	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	93,336	0	166,447	0	90.06
91.00	09100	EMERGENCY	21,580	2,255,441	0	3,407,861	21,580	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,618,690	0	2,381,985	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	9,240	792,107	0	1,818,183	9,240	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	321,198	34,798,062	-15,320,939	58,838,598	185,455	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	56,656	0	0	1,011,083	56,656	190.01
190.02	19002	PHYSICIAN BUILDING	0	74,344	0	270,140	0	190.02
190.03	19003	PRIVATE DUTY	0	335,170	0	605,663	0	190.03
190.04	19004	MARKETING	441	94,079	0	604,559	441	190.04
190.05	19005	WATER LAB	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	0	108,554	0	232,242	0	190.06
190.07	19007	ASC	23,237	0	0	255,062	23,237	190.07
190.08	19008	ANDERSON WOMEN'S CLINIC	1,710	206,532	0	331,057	1,710	190.08
190.09	19009	HANCOCK OB	0	1,120,406	0	3,091,874	0	190.09
190.10	19010	HANCOCK WELLNESS	0	799,270	0	1,765,687	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	2,367	0	190.11
190.12	19012	O3PUREMED	0	0	0	15,576	0	190.12
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)	4,380,301	7,320,619		15,320,939	6,999,100	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.862710	0.195027		0.228589	26.164958	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B-1 | Date/Time Prepared: 5/24/2013 6:25 pm

	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	4.00	5A	5.00	7.00	
204.00	Cost to be allocated (per Wkst. B, Part II)		14,219		332,626	1,158,807	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0.000379		0.004963	4.332005	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B-1 | Date/Time Prepared: 5/24/2013 6:25 pm

		Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
9.00	00900	HOUSEKEEPING	412,334					9.00
10.00	01000	DIETARY	6,543	13,499				10.00
11.00	01100	CAFETERIA	10,782	0	808,491			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	19,416	699,250		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,355	0	3,981	3,981	5,491,522	14.00
15.00	01500	PHARMACY	11,930	0	33,777	33,777	30,379	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,350	0	28,162	0	0	16.00
23.00	02300	PARAMED ED PRGM	16,530	0	1,875	1,875	6	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	109,670	3,301	81,496	81,496	97,610	30.00
31.00	03100	INTENSIVE CARE UNIT	22,610	4,917	93,753	93,753	155,766	31.00
40.00	04000	SUBPROVIDER - IPF	18,095	2,758	35,031	35,031	14,581	40.00
41.00	04100	SUBPROVIDER - IRF	6,264	1,219	20,541	20,541	11,258	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	43,900	0	13,193	13,193	144,656	50.00
51.00	05100	RECOVERY ROOM	16,165	0	7,489	7,489	6,162	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,070	0	80,512	80,512	45,182	54.00
60.00	06000	LABORATORY	15,335	0	67,424	67,424	1,005,344	60.00
65.00	06500	RESPIRATORY THERAPY	11,745	0	69,578	69,578	17,534	65.00
66.00	06600	PHYSICAL THERAPY	13,650	0	28,644	28,644	1,392	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	9,462	0	850	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	3,689	0	5,409	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	26,615	0	15,082	0	27,856	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	3,680,999	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	0	0	2,489	0	624	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	1,324	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	3,006	0	15,118	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	1,670	0	518	90.04
90.05	09005	PRIME TIME	0	0	0	0	10,304	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	2,866	90.06
91.00	09100	EMERGENCY	23,515	0	59,982	59,982	129,721	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	12,210	0	53,527	53,527	12,175	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	1,304	26,860	26,860	64,980	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	412,334	13,499	760,639	677,663	5,482,614	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0	0	0	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	3,915	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	21,587	21,587	6,357	190.03
190.04	19004	MARKETING	0	0	2,755	0	0	190.04
190.05	19005	WATER LAB	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	0	0	3,750	0	0	190.06
190.07	19007	ASC	0	0	0	0	195	190.07
190.08	19008	ANDERSON WOMEN'S CLINIC	0	0	7,550	0	2,356	190.08
190.09	19009	HANCOCK OB	0	0	8,295	0	0	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	0	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	0	190.12
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)	2,062,148	718,260	2,027,387	1,361,550	194,033	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.001159	53.208386	2.507619	1.947158	0.035333	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B-1 | Date/Time Prepared: 5/24/2013 6:25 pm

	Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	47,506	69,549	121,216	8,522	2,936	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.115212	5.152159	0.149929	0.012187	0.000535	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B-1 | Date/Time Prepared: 5/24/2013 6:25 pm

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	PARAMED ED PRGM (ASSIGNED TIME)		
			15.00	16.00	23.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,954			16.00
23.00	02300	PARAMED ED PRGM	0	0	100		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	913	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	114	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	94	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	559	0		41.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,200	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	137	100		54.00
60.00	06000	LABORATORY	0	304	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	156	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100	7	0		73.00
76.00	03020	CARDIAC	0	0	0		76.00
76.01	03022	CARDIAC REHABILITATION	0	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	WOUND CLINIC	0	0	0		90.01
90.02	09002	DIABETES CLINIC	0	0	0		90.02
90.03	09003	ASTHMA CLINIC	0	0	0		90.03
90.04	09004	ANDIS CLINIC	0	0	0		90.04
90.05	09005	PRIME TIME	0	0	0		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0		90.06
91.00	09100	EMERGENCY	0	469	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	1	0		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	3,954	100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0		190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0		190.02
190.03	19003	PRIVATE DUTY	0	0	0		190.03
190.04	19004	MARKETING	0	0	0		190.04
190.05	19005	WATER LAB	0	0	0		190.05
190.06	19006	FOUNDATION	0	0	0		190.06
190.07	19007	ASC	0	0	0		190.07
190.08	19008	ANDERSON WOMEN'S CLINIC	0	0	0		190.08
190.09	19009	HANCOCK OB	0	0	0		190.09
190.10	19010	HANCOCK WELLNESS	0	0	0		190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0		190.11
190.12	19012	O3PUREMED	0	0	0		190.12
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)	4,769,312	1,457,607	182,860		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	47,693.120000	368.641123	1,828.600000		203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B-1 | Date/Time Prepared: 5/24/2013 6:25 pm

	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	PARAMED ED PRGM (ASSIGNED TIME)			
		15.00	16.00	23.00			
204.00	Cost to be allocated (per Wkst. B, Part II)	114,891	64,519	22,883			204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1,148.910000	16.317400	228.830000			205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet C Part I Date/Time Prepared: 5/24/2013 6:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs: Total Costs	Costs: RCE Disallowance	Costs: Total Costs	Charges: Inpatient	
			1.00	2.00	3.00	4.00	5.00	6.00	
		INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,595,854		7,595,854	0	7,595,854	4,604,056	30.00
31.00	03100	INTENSIVE CARE UNIT	6,721,907		6,721,907	0	6,721,907	6,072,174	31.00
40.00	04000	SUBPROVIDER - IPF	2,338,985		2,338,985	0	2,338,985	3,043,918	40.00
41.00	04100	SUBPROVIDER - IRF	1,503,682		1,503,682	0	1,503,682	1,310,717	41.00
		ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,723,410		6,723,410	0	6,723,410	5,773,749	50.00
51.00	05100	RECOVERY ROOM	686,264		686,264	0	686,264	871,483	51.00
53.00	05300	ANESTHESIOLOGY	237		237	0	237	11,423	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,448,877		6,448,877	0	6,448,877	4,268,911	54.00
60.00	06000	LABORATORY	5,922,423		5,922,423	0	5,922,423	5,807,361	60.00
65.00	06500	RESPIRATORY THERAPY	2,102,496	0	2,102,496	0	2,102,496	2,461,923	65.00
66.00	06600	PHYSICAL THERAPY	2,096,481	0	2,096,481	0	2,096,481	1,267,643	66.00
67.00	06700	OCCUPATIONAL THERAPY	489,398	0	489,398	0	489,398	959,120	67.00
68.00	06800	SPEECH PATHOLOGY	277,955	0	277,955	0	277,955	170,603	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	1,716,169		1,716,169	0	1,716,169	2,969,157	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,522,434		4,522,434	0	4,522,434	2,325,754	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,671,325		1,671,325	0	1,671,325	4,425,400	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,771,892		4,771,892	0	4,771,892	10,195,294	73.00
76.00	03020	CARDIAC	0		0	0	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	121,291		121,291	0	121,291	203	76.01
		OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	336,878		336,878	0	336,878	0	88.00
90.00	09000	CLINIC	0		0	0	0	0	90.00
90.01	09001	WOUND CLINIC	1,415,087		1,415,087	0	1,415,087	36,017	90.01
90.02	09002	DIABETES CLINIC	0		0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0		0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	83,894		83,894	0	83,894	0	90.04
90.05	09005	PRIME TIME	1,020,430		1,020,430	0	1,020,430	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	204,596		204,596	0	204,596	0	90.06
91.00	09100	EMERGENCY	5,313,785		5,313,785	0	5,313,785	2,504,068	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,912,419		2,912,419		2,912,419	0	92.00
		OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	3,226,795		3,226,795		3,226,795	0	101.00
		SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	2,666,900		2,666,900		2,666,900	1,407,981	116.00
200.00		Subtotal (see instructions)	72,891,864	0	72,891,864	0	72,891,864	60,486,955	200.00
201.00		Less Observation Beds	2,912,419		2,912,419		2,912,419		201.00
202.00		Total (see instructions)	69,979,445	0	69,979,445	0	69,979,445	60,486,955	202.00

		Cost Center Description	Charges: Outpatient	Charges: Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio		
			7.00	8.00	9.00	10.00	11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		4,604,056					30.00
31.00	03100	INTENSIVE CARE UNIT		6,072,174					31.00
40.00	04000	SUBPROVIDER - IPF		3,043,918					40.00
41.00	04100	SUBPROVIDER - IRF		1,310,717					41.00
		ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,534,885	16,308,634	0.412261	0.000000	0.412261		50.00
51.00	05100	RECOVERY ROOM	937,972	1,809,455	0.379266	0.000000	0.379266		51.00
53.00	05300	ANESTHESIOLOGY	847	12,270	0.019315	0.000000	0.019315		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,163,900	41,432,811	0.155647	0.000000	0.155647		54.00
60.00	06000	LABORATORY	26,104,683	31,912,044	0.185586	0.000000	0.185586		60.00
65.00	06500	RESPIRATORY THERAPY	4,216,591	6,678,514	0.314815	0.000000	0.314815		65.00
66.00	06600	PHYSICAL THERAPY	2,873,159	4,140,802	0.506298	0.000000	0.506298		66.00
67.00	06700	OCCUPATIONAL THERAPY	510,730	1,469,850	0.332958	0.000000	0.332958		67.00
68.00	06800	SPEECH PATHOLOGY	380,898	551,501	0.503997	0.000000	0.503997		68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0.000000	0.000000	0.000000		68.01
69.00	06900	ELECTROCARDIOLOGY	7,498,568	10,467,725	0.163949	0.000000	0.163949		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,100,338	5,426,092	0.833461	0.000000	0.833461		71.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet C Part I Date/Time Prepared: 5/24/2013 6:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Outpatient	Charges Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio		
			7.00	8.00	9.00	10.00	11.00		
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	831,855	5,257,255	0.317908	0.000000	0.317908		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,295,773	19,491,067	0.244825	0.000000	0.244825		73.00
76.00	03020	CARDIAC	0	0	0.000000	0.000000	0.000000		76.00
76.01	03022	CARDIAC REHABILITATION	229,765	229,968	0.527426	0.000000	0.527426		76.01
		OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	339,004	339,004					88.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0.000000		90.00
90.01	09001	WOUND CLINIC	5,710,220	5,746,237	0.246263	0.000000	0.246263		90.01
90.02	09002	DIABETES CLINIC	0	0	0.000000	0.000000	0.000000		90.02
90.03	09003	ASTHMA CLINIC	0	0	0.000000	0.000000	0.000000		90.03
90.04	09004	ANDIS CLINIC	598,179	598,179	0.140249	0.000000	0.140249		90.04
90.05	09005	PRIME TIME	2,002,174	2,002,174	0.509661	0.000000	0.509661		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0.000000	0.000000	0.000000		90.06
91.00	09100	EMERGENCY	15,680,009	18,184,077	0.292222	0.000000	0.292222		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,142,208	2,142,208	1.359541	0.000000	1.359541		92.00
		OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	2,334,494	2,334,494					101.00
		SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	1,407,981					116.00
200.00		Subtotal (see instructions)	132,486,252	192,973,207					200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	132,486,252	192,973,207					202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet C Part I Date/Time Prepared: 5/24/2013 6:25 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs: Total Costs	Costs: RCE Disallowance	Costs: Total Costs	Charges: Inpatient	
			1.00	2.00	3.00	4.00	5.00	6.00	
		INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,595,854		7,595,854	0	0	4,604,056	30.00
31.00	03100	INTENSIVE CARE UNIT	6,721,907		6,721,907	0	0	6,072,174	31.00
40.00	04000	SUBPROVIDER - IPF	2,338,985		2,338,985	0	0	3,043,918	40.00
41.00	04100	SUBPROVIDER - IRF	1,503,682		1,503,682	0	0	1,310,717	41.00
		ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,723,410		6,723,410	0	0	5,773,749	50.00
51.00	05100	RECOVERY ROOM	686,264		686,264	0	0	871,483	51.00
53.00	05300	ANESTHESIOLOGY	237		237	0	0	11,423	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,448,877		6,448,877	0	0	4,268,911	54.00
60.00	06000	LABORATORY	5,922,423		5,922,423	0	0	5,807,361	60.00
65.00	06500	RESPIRATORY THERAPY	2,102,496	0	2,102,496	0	0	2,461,923	65.00
66.00	06600	PHYSICAL THERAPY	2,096,481	0	2,096,481	0	0	1,267,643	66.00
67.00	06700	OCCUPATIONAL THERAPY	489,398	0	489,398	0	0	959,120	67.00
68.00	06800	SPEECH PATHOLOGY	277,955	0	277,955	0	0	170,603	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	1,716,169		1,716,169	0	0	2,969,157	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,522,434		4,522,434	0	0	2,325,754	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,671,325		1,671,325	0	0	4,425,400	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,771,892		4,771,892	0	0	10,195,294	73.00
76.00	03020	CARDIAC	0		0	0	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	121,291		121,291	0	0	203	76.01
		OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	336,878		336,878	0	0	0	88.00
90.00	09000	CLINIC	0		0	0	0	0	90.00
90.01	09001	WOUND CLINIC	1,415,087		1,415,087	0	0	36,017	90.01
90.02	09002	DIABETES CLINIC	0		0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0		0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	83,894		83,894	0	0	0	90.04
90.05	09005	PRIME TIME	1,020,430		1,020,430	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	204,596		204,596	0	0	0	90.06
91.00	09100	EMERGENCY	5,313,785		5,313,785	0	0	2,504,068	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,912,419		2,912,419		0	0	92.00
		OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	3,226,795		3,226,795		0	0	101.00
		SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	2,666,900		2,666,900		0	1,407,981	116.00
200.00		Subtotal (see instructions)	72,891,864	0	72,891,864	0	0	60,486,955	200.00
201.00		Less Observation Beds	2,912,419		2,912,419		0		201.00
202.00		Total (see instructions)	69,979,445	0	69,979,445	0	0	60,486,955	202.00

		Cost Center Description	Charges: Outpatient	Charges: Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio		
			7.00	8.00	9.00	10.00	11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		4,604,056					30.00
31.00	03100	INTENSIVE CARE UNIT		6,072,174					31.00
40.00	04000	SUBPROVIDER - IPF		3,043,918					40.00
41.00	04100	SUBPROVIDER - IRF		1,310,717					41.00
		ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,534,885	16,308,634	0.412261	0.000000	0.000000		50.00
51.00	05100	RECOVERY ROOM	937,972	1,809,455	0.379266	0.000000	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	847	12,270	0.019315	0.000000	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,163,900	41,432,811	0.155647	0.000000	0.000000		54.00
60.00	06000	LABORATORY	26,104,683	31,912,044	0.185586	0.000000	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	4,216,591	6,678,514	0.314815	0.000000	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	2,873,159	4,140,802	0.506298	0.000000	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	510,730	1,469,850	0.332958	0.000000	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	380,898	551,501	0.503997	0.000000	0.000000		68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0.000000	0.000000	0.000000		68.01
69.00	06900	ELECTROCARDIOLOGY	7,498,568	10,467,725	0.163949	0.000000	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,100,338	5,426,092	0.833461	0.000000	0.000000		71.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet C Part I Date/Time Prepared: 5/24/2013 6:25 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Outpatient	Charges Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio		
			7.00	8.00	9.00	10.00	11.00		
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	831,855	5,257,255	0.317908	0.000000	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,295,773	19,491,067	0.244825	0.000000	0.000000		73.00
76.00	03020	CARDIAC	0	0	0.000000	0.000000	0.000000		76.00
76.01	03022	CARDIAC REHABILITATION	229,765	229,968	0.527426	0.000000	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	339,004	339,004	0.993729	0.000000	0.000000		88.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0.000000		90.00
90.01	09001	WOUND CLINIC	5,710,220	5,746,237	0.246263	0.000000	0.000000		90.01
90.02	09002	DIABETES CLINIC	0	0	0.000000	0.000000	0.000000		90.02
90.03	09003	ASTHMA CLINIC	0	0	0.000000	0.000000	0.000000		90.03
90.04	09004	ANDIS CLINIC	598,179	598,179	0.140249	0.000000	0.000000		90.04
90.05	09005	PRIME TIME	2,002,174	2,002,174	0.509661	0.000000	0.000000		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0.000000	0.000000	0.000000		90.06
91.00	09100	EMERGENCY	15,680,009	18,184,077	0.292222	0.000000	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,142,208	2,142,208	1.359541	0.000000	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	2,334,494	2,334,494					101.00
		SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	1,407,981					116.00
200.00		Subtotal (see instructions)	132,486,252	192,973,207					200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	132,486,252	192,973,207					202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part I Date/Time Prepared: 5/24/2013 6:25 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	552,681	0	552,681	5,996	92.17	30.00
31.00	INTENSIVE CARE UNIT	429,801		429,801	4,792	89.69	31.00
40.00	SUBPROVIDER - IPF	127,820	0	127,820	2,744	46.58	40.00
41.00	SUBPROVIDER - IRF	90,401	0	90,401	1,211	74.65	41.00
200.00	Total (lines 30-199)	1,200,703		1,200,703	14,743		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	1,492	137,518	30.00
31.00	INTENSIVE CARE UNIT	2,416	216,691	31.00
40.00	SUBPROVIDER - IPF	2,706	126,045	40.00
41.00	SUBPROVIDER - IRF	934	69,723	41.00
200.00	Total (lines 30-199)	7,548	549,977	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part II Date/Time Prepared: 5/24/2013 6:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	407,599	16,308,634	0.024993	2,788,794	69,700	50.00
51.00	05100	RECOVERY ROOM	37,491	1,809,455	0.020719	377,497	7,821	51.00
53.00	05300	ANESTHESIOLOGY	1	12,270	0.000081	1,675	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	264,292	41,432,811	0.006379	2,300,453	14,675	54.00
60.00	06000	LABORATORY	136,499	31,912,044	0.004277	3,262,808	13,955	60.00
65.00	06500	RESPIRATORY THERAPY	54,943	6,678,514	0.008227	1,592,056	13,098	65.00
66.00	06600	PHYSICAL THERAPY	79,863	4,140,802	0.019287	412,932	7,964	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,410	1,469,850	0.002320	240,050	557	67.00
68.00	06800	SPEECH PATHOLOGY	9,272	551,501	0.016812	58,314	980	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	118,962	10,467,725	0.011365	1,640,213	18,641	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,269	5,426,092	0.003367	1,056,118	3,556	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,195	5,257,255	0.001559	2,179,002	3,397	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	115,005	19,491,067	0.005900	4,860,780	28,679	73.00
76.00	03020	CARDIAC	0	0	0.000000	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	856	229,968	0.003722	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,426	339,004	0.004206	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	49,897	5,746,237	0.008683	19,087	166	90.01
90.02	09002	DIABETES CLINIC	0	0	0.000000	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	590	598,179	0.000986	0	0	90.04
90.05	09005	PRIME TIME	4,347	2,002,174	0.002171	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	863	0	0.000000	0	0	90.06
91.00	09100	EMERGENCY	365,825	18,184,077	0.020118	1,474,278	29,660	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	211,911	2,142,208	0.098922	0	0	92.00
200.00		Total (lines 50-199)	1,889,516	174,199,867		22,264,057	212,849	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150037

Period: From 01/01/2012 To 12/31/2012

Worksheet D Part III Date/Time Prepared: 5/24/2013 6:25 pm

Title XVIII Hospital PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,996	0.00	1,492	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,792	0.00	2,416	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	2,744	0.00	2,706	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	1,211	0.00	934	0	0	41.00
200.00		Total (lines 30-199)	14,743		7,548	0	0	200.00

		Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost	
			12.00	13.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
200.00		Total (lines 30-199)	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV Date/Time Prepared: 5/24/2013 6:25 pm

		Cost Center Description	Title XVIII Non Physician Anesthetist Cost	Title XVIII Nursing School	Title XVIII Allied Health	Hospital All Other Medical Education Cost	PPS Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	182,860	0	182,860	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	0	0	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	0	0	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	182,860	0	182,860	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV Date/Time Prepared: 5/24/2013 6:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	16,308,634	0.000000	0.000000	2,788,794	50.00
51.00	05100	RECOVERY ROOM	0	1,809,455	0.000000	0.000000	377,497	51.00
53.00	05300	ANESTHESIOLOGY	0	12,270	0.000000	0.000000	1,675	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	182,860	41,432,811	0.004413	0.004413	2,300,453	54.00
60.00	06000	LABORATORY	0	31,912,044	0.000000	0.000000	3,262,808	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,678,514	0.000000	0.000000	1,592,056	65.00
66.00	06600	PHYSICAL THERAPY	0	4,140,802	0.000000	0.000000	412,932	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,469,850	0.000000	0.000000	240,050	67.00
68.00	06800	SPEECH PATHOLOGY	0	551,501	0.000000	0.000000	58,314	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0.000000	0.000000	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	10,467,725	0.000000	0.000000	1,640,213	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,426,092	0.000000	0.000000	1,056,118	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	5,257,255	0.000000	0.000000	2,179,002	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,491,067	0.000000	0.000000	4,860,780	73.00
76.00	03020	CARDIAC	0	0	0.000000	0.000000	0	76.00
76.01	03022	CARDIAC REHABILITATION	0	229,968	0.000000	0.000000	0	76.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	339,004	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	WOUND CLINIC	0	5,746,237	0.000000	0.000000	19,087	90.01
90.02	09002	DIABETES CLINIC	0	0	0.000000	0.000000	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0.000000	0.000000	0	90.03
90.04	09004	ANDIS CLINIC	0	598,179	0.000000	0.000000	0	90.04
90.05	09005	PRIME TIME	0	2,002,174	0.000000	0.000000	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0.000000	0.000000	0	90.06
91.00	09100	EMERGENCY	0	18,184,077	0.000000	0.000000	1,474,278	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,142,208	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	182,860	174,199,867			22,264,057	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV Date/Time Prepared: 5/24/2013 6:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	2,765,545	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	253,099	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	87	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,152	10,806,990	47,691	0	0	54.00
60.00	06000	LABORATORY	0	781,517	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,250,372	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	4,685	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,692	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	70,124	0	0	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	3,099,185	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	987,977	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	239,597	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,036,555	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	0	0	0	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	2,751,296	0	0	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	2,285	0	0	0	90.04
90.05	09005	PRIME TIME	0	67,511	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
91.00	09100	EMERGENCY	0	3,493,771	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	905,643	0	0	0	92.00
200.00		Total (lines 50-199)	10,152	30,519,931	47,691	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV Date/Time Prepared: 5/24/2013 6:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			23.00	24.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	CARDIAC	0	0		76.00
76.01	03022	CARDIAC REHABILITATION	0	0		76.01
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	0		90.01
90.02	09002	DIABETES CLINIC	0	0		90.02
90.03	09003	ASTHMA CLINIC	0	0		90.03
90.04	09004	ANDIS CLINIC	0	0		90.04
90.05	09005	PRIME TIME	0	0		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0		90.06
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part V Date/Time Prepared: 5/24/2013 6:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.412261	2,765,545	0	0	1,140,126	50.00
51.00	05100	RECOVERY ROOM	0.379266	253,099	0	0	95,992	51.00
53.00	05300	ANESTHESIOLOGY	0.019315	87	0	0	2	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.155647	10,806,990	0	849	1,682,076	54.00
60.00	06000	LABORATORY	0.185586	781,517	0	0	145,039	60.00
65.00	06500	RESPIRATORY THERAPY	0.314815	1,250,372	0	0	393,636	65.00
66.00	06600	PHYSICAL THERAPY	0.506298	4,685	0	0	2,372	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.332958	3,692	0	0	1,229	67.00
68.00	06800	SPEECH PATHOLOGY	0.503997	70,124	0	0	35,342	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.163949	3,099,185	0	324	508,108	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.833461	987,977	0	0	823,440	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.317908	239,597	0	0	76,170	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.244825	3,036,555	0	14,914	743,425	73.00
76.00	03020	CARDIAC	0.000000	0	0	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	0.527426	0	0	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.246263	2,751,296	0	2,257	677,542	90.01
90.02	09002	DIABETES CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0.140249	2,285	0	0	320	90.04
90.05	09005	PRIME TIME	0.509661	67,511	0	0	34,408	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.000000	0	0	0	0	90.06
91.00	09100	EMERGENCY	0.292222	3,493,771	0	0	1,020,957	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.359541	905,643	0	0	1,231,259	92.00
200.00		Subtotal (see instructions)		30,519,931	0	18,344	8,611,443	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		30,519,931	0	18,344	8,611,443	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part V Date/Time Prepared: 5/24/2013 6:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	132		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	53		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,651		73.00
76.00	03020	CARDIAC	0	0		76.00
76.01	03022	CARDIAC REHABILITATION	0	0		76.01
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	556		90.01
90.02	09002	DIABETES CLINIC	0	0		90.02
90.03	09003	ASTHMA CLINIC	0	0		90.03
90.04	09004	ANDIS CLINIC	0	0		90.04
90.05	09005	PRIME TIME	0	0		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0		90.06
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	4,392		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	4,392		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150037
Component CCN: 15S037

Period: From 01/01/2012 To 12/31/2012

Worksheet D Part II
Date/Time Prepared: 5/24/2013 6:25 pm

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	05000	OPERATING ROOM	407,599	16,308,634	0.024993	26,948	674	50.00
51.00	05100	RECOVERY ROOM	37,491	1,809,455	0.020719	2,331	48	51.00
53.00	05300	ANESTHESIOLOGY	1	12,270	0.000081	81	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	264,292	41,432,811	0.006379	76,450	488	54.00
60.00	06000	LABORATORY	136,499	31,912,044	0.004277	336,840	1,441	60.00
65.00	06500	RESPIRATORY THERAPY	54,943	6,678,514	0.008227	109,126	898	65.00
66.00	06600	PHYSICAL THERAPY	79,863	4,140,802	0.019287	121,281	2,339	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,410	1,469,850	0.002320	107,060	248	67.00
68.00	06800	SPEECH PATHOLOGY	9,272	551,501	0.016812	8,021	135	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	118,962	10,467,725	0.011365	7,661	87	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,269	5,426,092	0.003367	28,352	95	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,195	5,257,255	0.001559	1,588	2	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	115,005	19,491,067	0.005900	520,487	3,071	73.00
76.00	03020	CARDIAC	0	0	0.000000	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	856	229,968	0.003722	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,426	339,004	0.004206	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	49,897	5,746,237	0.008683	2,259	20	90.01
90.02	09002	DIABETES CLINIC	0	0	0.000000	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	590	598,179	0.000986	0	0	90.04
90.05	09005	PRIME TIME	4,347	2,002,174	0.002171	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	863	0	0.000000	0	0	90.06
91.00	09100	EMERGENCY	365,825	18,184,077	0.020118	38,398	772	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,142,208	0.000000	0	0	92.00
200.00		Total (lines 50-199)	1,677,605	174,199,867		1,386,883	10,318	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150037
Component CCN: 15S037

Period:
From 01/01/2012
To 12/31/2012

Worksheet D
Part IV
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		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	182,860	0	182,860	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	0	0	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	0	0	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	182,860	0	182,860	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150037
Component CCN: 15S037

Period: From 01/01/2012 To 12/31/2012

Worksheet D Part IV
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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	05000	OPERATING ROOM	0	16,308,634	0.000000	0.000000	26,948	50.00
51.00	05100	RECOVERY ROOM	0	1,809,455	0.000000	0.000000	2,331	51.00
53.00	05300	ANESTHESIOLOGY	0	12,270	0.000000	0.000000	81	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	182,860	41,432,811	0.004413	0.004413	76,450	54.00
60.00	06000	LABORATORY	0	31,912,044	0.000000	0.000000	336,840	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,678,514	0.000000	0.000000	109,126	65.00
66.00	06600	PHYSICAL THERAPY	0	4,140,802	0.000000	0.000000	121,281	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,469,850	0.000000	0.000000	107,060	67.00
68.00	06800	SPEECH PATHOLOGY	0	551,501	0.000000	0.000000	8,021	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0.000000	0.000000	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	10,467,725	0.000000	0.000000	7,661	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,426,092	0.000000	0.000000	28,352	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	5,257,255	0.000000	0.000000	1,588	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,491,067	0.000000	0.000000	520,487	73.00
76.00	03020	CARDIAC	0	0	0.000000	0.000000	0	76.00
76.01	03022	CARDIAC REHABILITATION	0	229,968	0.000000	0.000000	0	76.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	339,004	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	WOUND CLINIC	0	5,746,237	0.000000	0.000000	2,259	90.01
90.02	09002	DIABETES CLINIC	0	0	0.000000	0.000000	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0.000000	0.000000	0	90.03
90.04	09004	ANDIS CLINIC	0	598,179	0.000000	0.000000	0	90.04
90.05	09005	PRIME TIME	0	2,002,174	0.000000	0.000000	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0.000000	0.000000	0	90.06
91.00	09100	EMERGENCY	0	18,184,077	0.000000	0.000000	38,398	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,142,208	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	182,860	174,199,867			1,386,883	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150037
Component CCN: 15S037

Period:
From 01/01/2012
To 12/31/2012

Worksheet D
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Date/Time Prepared:
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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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	337	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	0	0	0	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	0	0	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	0	0	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	337	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150037
Component CCN: 15S037

Period: From 01/01/2012 To 12/31/2012

Worksheet D Part IV
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		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
			23.00	24.00	
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020	CARDIAC	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	90.01
90.02	09002	DIABETES CLINIC	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	90.04
90.05	09005	PRIME TIME	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	90.06
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150037
Component CCN: 15T037

Period: From 01/01/2012 To 12/31/2012

Worksheet D Part II
Date/Time Prepared: 5/24/2013 6:25 pm

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		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	407,599	16,308,634	0.024993	11,346	284	50.00
51.00	05100	RECOVERY ROOM	37,491	1,809,455	0.020719	2,547	53	51.00
53.00	05300	ANESTHESIOLOGY	1	12,270	0.000081	13	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	264,292	41,432,811	0.006379	87,262	557	54.00
60.00	06000	LABORATORY	136,499	31,912,044	0.004277	109,750	469	60.00
65.00	06500	RESPIRATORY THERAPY	54,943	6,678,514	0.008227	57,049	469	65.00
66.00	06600	PHYSICAL THERAPY	79,863	4,140,802	0.019287	392,390	7,568	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,410	1,469,850	0.002320	379,254	880	67.00
68.00	06800	SPEECH PATHOLOGY	9,272	551,501	0.016812	65,971	1,109	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	118,962	10,467,725	0.011365	3,979	45	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,269	5,426,092	0.003367	34,519	116	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,195	5,257,255	0.001559	397	1	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	115,005	19,491,067	0.005900	239,129	1,411	73.00
76.00	03020	CARDIAC	0	0	0.000000	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	856	229,968	0.003722	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,426	339,004	0.004206	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	49,897	5,746,237	0.008683	416	4	90.01
90.02	09002	DIABETES CLINIC	0	0	0.000000	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	590	598,179	0.000986	0	0	90.04
90.05	09005	PRIME TIME	4,347	2,002,174	0.002171	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	863	0	0.000000	0	0	90.06
91.00	09100	EMERGENCY	365,825	18,184,077	0.020118	3,138	63	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,142,208	0.000000	0	0	92.00
200.00		Total (lines 50-199)	1,677,605	174,199,867		1,387,160	13,029	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150037
Component CCN: 15T037

Period:
From 01/01/2012
To 12/31/2012

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		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	182,860	0	182,860	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	0	0	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	0	0	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	182,860	0	182,860	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150037
Component CCN: 15T037

Period: From 01/01/2012 To 12/31/2012

Worksheet D Part IV
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		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	16,308,634	0.000000	0.000000	11,346	50.00
51.00	05100	RECOVERY ROOM	0	1,809,455	0.000000	0.000000	2,547	51.00
53.00	05300	ANESTHESIOLOGY	0	12,270	0.000000	0.000000	13	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	182,860	41,432,811	0.004413	0.004413	87,262	54.00
60.00	06000	LABORATORY	0	31,912,044	0.000000	0.000000	109,750	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,678,514	0.000000	0.000000	57,049	65.00
66.00	06600	PHYSICAL THERAPY	0	4,140,802	0.000000	0.000000	392,390	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,469,850	0.000000	0.000000	379,254	67.00
68.00	06800	SPEECH PATHOLOGY	0	551,501	0.000000	0.000000	65,971	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0.000000	0.000000	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	10,467,725	0.000000	0.000000	3,979	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,426,092	0.000000	0.000000	34,519	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	5,257,255	0.000000	0.000000	397	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,491,067	0.000000	0.000000	239,129	73.00
76.00	03020	CARDIAC	0	0	0.000000	0.000000	0	76.00
76.01	03022	CARDIAC REHABILITATION	0	229,968	0.000000	0.000000	0	76.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	339,004	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	WOUND CLINIC	0	5,746,237	0.000000	0.000000	416	90.01
90.02	09002	DIABETES CLINIC	0	0	0.000000	0.000000	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0.000000	0.000000	0	90.03
90.04	09004	ANDIS CLINIC	0	598,179	0.000000	0.000000	0	90.04
90.05	09005	PRIME TIME	0	2,002,174	0.000000	0.000000	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0.000000	0.000000	0	90.06
91.00	09100	EMERGENCY	0	18,184,077	0.000000	0.000000	3,138	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,142,208	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	182,860	174,199,867			1,387,160	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150037
Component CCN: 15T037

Period:
From 01/01/2012
To 12/31/2012

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		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	385	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	0	0	0	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	0	0	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	0	0	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	385	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150037
Component CCN: 15T037

Period: From 01/01/2012 To 12/31/2012

Worksheet D Part IV
Date/Time Prepared: 5/24/2013 6:25 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
			23.00	24.00	
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020	CARDIAC	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	90.01
90.02	09002	DIABETES CLINIC	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	90.04
90.05	09005	PRIME TIME	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	90.06
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Total (lines 50-199)	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/24/2013 6:25 pm

	Cost Center Description	Title XVIII	Hospital	PPS	
				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			5,996	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			5,996	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			3,697	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)			1,492	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)			7,595,854	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)			7,595,854	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)			4,700,611	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			4,700,611	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			1.615929	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)			1,271.47	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)			7,595,854	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,266.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,890,095	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)			1,890,095	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/24/2013 6:25 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	6,721,907	4,792	1,402.74	2,416	3,389,020	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)	6,543,514	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	11,822,629	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)	354,209	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	223,001	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	577,210	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	11,245,419	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)	2,299	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,266.82	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,912,419	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150037

Period: From 01/01/2012 To 12/31/2012

Worksheet D-1

Date/Time Prepared: 5/24/2013 6:25 pm

Title XVIII Hospital PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	552,681	7,595,854	0.072761	2,912,419	211,911	90.00
91.00	Nursing School cost	0	7,595,854	0.000000	2,912,419	0	91.00
92.00	Allied health cost	0	7,595,854	0.000000	2,912,419	0	92.00
93.00	All other Medical Education	0	7,595,854	0.000000	2,912,419	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN:150037 Component CCN:15S037	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 5/24/2013 6:25 pm
	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)	2,744	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,744	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,744	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)	2,706	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)	2,338,985	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)	2,338,985	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	6,073,066	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	6,073,066	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.385141	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)	2,213.22	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)	2,338,985	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)	852.40	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,306,594	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)	2,306,594	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150037
Component CCN: 15S037

Period: From 01/01/2012 To 12/31/2012

Worksheet D-1
Date/Time Prepared: 5/24/2013 6:25 pm

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	0	0	0.00	0	0	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)	386,452	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,693,046	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)	126,045	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	10,655	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	136,700	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,556,346	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:150037 Component CCN:15S037	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 5/24/2013 6:25 pm
	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	127,820	2,338,985	0.054648	0	0	90.00
91.00	Nursing School cost	0	2,338,985	0.000000	0	0	91.00
92.00	Allied health cost	0	2,338,985	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,338,985	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN:150037 Component CCN:15T037	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 5/24/2013 6:25 pm
	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)	1,211	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,211	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,211	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)	934	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)	1,503,682	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)	1,503,682	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	1,647,348	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,647,348	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.912790	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)	1,360.32	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)	1,503,682	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,241.69	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,159,738	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)	1,159,738	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150037 Component CCN: 15T037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 Date/Time Prepared: 5/24/2013 6:25 pm

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	0	0	0.00	0	0	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)	504,857	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,664,595	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)	69,723	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	13,414	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	83,137	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,581,458	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:150037 Component CCN:15T037	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 5/24/2013 6:25 pm
	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	90,401	1,503,682	0.060120	0	0	90.00
91.00	Nursing School cost	0	1,503,682	0.000000	0	0	91.00
92.00	Allied health cost	0	1,503,682	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,503,682	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/24/2013 6:25 pm

	Cost Center Description	Title XIX Hospital Cost 1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,996	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,996	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,697	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)	266	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)	7,595,854	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)	7,595,854	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	5,762,746	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	5,762,746	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.318096	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)	1,558.76	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)	7,595,854	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,266.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	336,974	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)	336,974	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/24/2013 6:25 pm

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		Title XIX			Hospital	Cost	
		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	6,721,907	4,792	1,402.74	0	0	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)	360,282	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	697,256	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)	2,299	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,266.82	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,912,419	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150037

Period: From 01/01/2012 To 12/31/2012

Worksheet D-1

Date/Time Prepared: 5/24/2013 6:25 pm

Title XIX Hospital Cost

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-3 | Date/Time Prepared: 5/24/2013 6:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		956,377		30.00
31.00	03100	INTENSIVE CARE UNIT		3,598,184		31.00
40.00	04000	SUBPROVIDER - IPF		21,908		40.00
41.00	04100	SUBPROVIDER - IRF		6,242		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.412261	2,788,794	1,149,711	50.00
51.00	05100	RECOVERY ROOM	0.379266	377,497	143,172	51.00
53.00	05300	ANESTHESIOLOGY	0.019315	1,675	32	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.155647	2,300,453	358,059	54.00
60.00	06000	LABORATORY	0.185586	3,262,808	605,531	60.00
65.00	06500	RESPIRATORY THERAPY	0.314815	1,592,056	501,203	65.00
66.00	06600	PHYSICAL THERAPY	0.506298	412,932	209,067	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.332958	240,050	79,927	67.00
68.00	06800	SPEECH PATHOLOGY	0.503997	58,314	29,390	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.163949	1,640,213	268,911	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.833461	1,056,118	880,233	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.317908	2,179,002	692,722	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.244825	4,860,780	1,190,040	73.00
76.00	03020	CARDIAC	0.000000	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	0.527426	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.246263	19,087	4,700	90.01
90.02	09002	DIABETES CLINIC	0.000000	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	0.140249	0	0	90.04
90.05	09005	PRIME TIME	0.509661	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.000000	0	0	90.06
91.00	09100	EMERGENCY	0.292222	1,474,278	430,816	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.359541	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		22,264,057	6,543,514	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)		22,264,057		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150037
Component CCN: 15S037

Period: From 01/01/2012 To 12/31/2012

Worksheet D-3
Date/Time Prepared: 5/24/2013 6:25 pm

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	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		3,021,159		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.412261	26,948	11,110	50.00
51.00	05100	RECOVERY ROOM	0.379266	2,331	884	51.00
53.00	05300	ANESTHESIOLOGY	0.019315	81	2	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.155647	76,450	11,899	54.00
60.00	06000	LABORATORY	0.185586	336,840	62,513	60.00
65.00	06500	RESPIRATORY THERAPY	0.314815	109,126	34,355	65.00
66.00	06600	PHYSICAL THERAPY	0.506298	121,281	61,404	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.332958	107,060	35,646	67.00
68.00	06800	SPEECH PATHOLOGY	0.503997	8,021	4,043	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.163949	7,661	1,256	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.833461	28,352	23,630	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.317908	1,588	505	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.244825	520,487	127,428	73.00
76.00	03020	CARDIAC	0.000000	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	0.527426	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.246263	2,259	556	90.01
90.02	09002	DIABETES CLINIC	0.000000	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	0.140249	0	0	90.04
90.05	09005	PRIME TIME	0.509661	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.000000	0	0	90.06
91.00	09100	EMERGENCY	0.292222	38,398	11,221	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.359541	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,386,883	386,452	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)		1,386,883		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150037
Component CCN: 15T037

Period: From 01/01/2012 To 12/31/2012

Worksheet D-3
Date/Time Prepared: 5/24/2013 6:25 pm

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	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		1,033,133		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.412261	11,346	4,678	50.00
51.00	05100	RECOVERY ROOM	0.379266	2,547	966	51.00
53.00	05300	ANESTHESIOLOGY	0.019315	13	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.155647	87,262	13,582	54.00
60.00	06000	LABORATORY	0.185586	109,750	20,368	60.00
65.00	06500	RESPIRATORY THERAPY	0.314815	57,049	17,960	65.00
66.00	06600	PHYSICAL THERAPY	0.506298	392,390	198,666	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.332958	379,254	126,276	67.00
68.00	06800	SPEECH PATHOLOGY	0.503997	65,971	33,249	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.163949	3,979	652	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.833461	34,519	28,770	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.317908	397	126	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.244825	239,129	58,545	73.00
76.00	03020	CARDIAC	0.000000	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	0.527426	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.246263	416	102	90.01
90.02	09002	DIABETES CLINIC	0.000000	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	0.140249	0	0	90.04
90.05	09005	PRIME TIME	0.509661	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.000000	0	0	90.06
91.00	09100	EMERGENCY	0.292222	3,138	917	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.359541	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,387,160	504,857	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)		1,387,160		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-3 | Date/Time Prepared: 5/24/2013 6:25 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		510,975		30.00
31.00	03100	INTENSIVE CARE UNIT		112,152		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		63		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.412261	215,886	89,001	50.00
51.00	05100	RECOVERY ROOM	0.379266	29,967	11,365	51.00
53.00	05300	ANESTHESIOLOGY	0.019315	1,180	23	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.155647	88,274	13,740	54.00
60.00	06000	LABORATORY	0.185586	144,009	26,726	60.00
65.00	06500	RESPIRATORY THERAPY	0.314815	45,757	14,405	65.00
66.00	06600	PHYSICAL THERAPY	0.506298	5,959	3,017	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.332958	1,619	539	67.00
68.00	06800	SPEECH PATHOLOGY	0.503997	720	363	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.163949	27,973	4,586	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.833461	103,990	86,672	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.317908	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.244825	389,372	95,328	73.00
76.00	03020	CARDIAC	0.000000	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	0.527426	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.993729	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.246263	0	0	90.01
90.02	09002	DIABETES CLINIC	0.000000	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	0.140249	0	0	90.04
90.05	09005	PRIME TIME	0.509661	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.000000	0	0	90.06
91.00	09100	EMERGENCY	0.292222	49,677	14,517	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.359541	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,104,383	360,282	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)		1,104,383		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150037	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part A Date/Time Prepared: 5/24/2013 6:25 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS		
1.00	DRG Amounts Other than Outlier Payments	8,832,062	1.00
2.00	Outlier payments for discharges. (see instructions)	125,161	2.00
2.01	Outlier reconciliation amount	0	2.01
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)	60.72	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	Adjusment 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)	2.86	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)	15.30	31.00
32.00	Sum of lines 30 and 31	18.16	32.00
33.00	Allowable disproportionate share percentage (see instructions)	4.56	33.00
34.00	Disproportionate share adjustment (see instructions)	402,742	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 an 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 an 685. (see instructions)	0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)	0	46.00
47.00	Subtotal (see instructions)	9,359,965	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)	9,359,965	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)	712,343	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150037	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part A Date/Time Prepared: 5/24/2013 6:25 pm
	Title XVIII	Hospital	PPS

		1.00	
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).	0	57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)	10,152	58.00
59.00	Total (sum of amounts on lines 49 through 58)	10,082,460	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	10,082,460	61.00
62.00	Deductibles billed to program beneficiaries	1,075,996	62.00
63.00	Coinsurance billed to program beneficiaries	6,358	63.00
64.00	Allowable bad debts (see instructions)	23,879	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	16,715	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	23,879	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	9,016,821	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 (Sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.93	HVBP incentive payment (see instructions)	-1,004	70.93
70.94	Hospital readmissions reduction adjustment (see instructions)	0	70.94
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)	9,015,817	71.00
72.00	Interim payments	9,060,385	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)	-44,568	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	100,000	75.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)	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

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/24/2013 6:25 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00	8,832,062	0	0	8,832,062	1.00
2.00	Outlier payments for discharges (see instructions)	2.00	125,161	0	0	125,161	2.00
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	Amount from Worksheet E Part A, line 27 (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0456	0.0456	0.0456	0.0456	10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	402,742	0	0	402,742	11.00
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	9,359,965	0	0	9,359,965	13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	49.00	9,359,965	0	0	9,359,965	15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50.00	712,343	0	0	712,343	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	0	10,072,308	19.00
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	708,639	0	0	708,639	20.00
21.00	Capital DRG outlier payments	2.00	3,704	0	0	3,704	21.00
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	22.00
23.00	Indirect medical education adjustment (line 20 times line 22)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	24.00
25.00	Disproportionate share adjustment (line 20 times line 24)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	12.00	712,343	0	0	712,343	26.00
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	
27.00	Low volume adjustment factor				0.000000	0.013393	27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.96			0		28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.97				134,898	29.00

LOW VOLUME CALCULATION EXHIBIT 4	Provider CCN:150037	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/24/2013 6:25 pm
	Title XVIII	Hospital	PPS

		Total (Col 2 through 4)		
		5.00		
1.00	DRG amounts other than outlier payments	8,832,062		1.00
2.00	Outlier payments for discharges (see instructions)	125,161		2.00
3.00	Operating outlier reconciliation	0		3.00
4.00	Managed care simulated payments	0		4.00
	Indirect Medical Education Adjustment			
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)			5.00
6.00	IME payment adjustment (see instructions)	0		6.00
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA			
7.00	Amount from Worksheet E Part A, line 27 (see instructions)			7.00
8.00	IME adjustment (see instructions)	0		8.00
9.00	Total IME payment (sum of lines 6 and 8)	0		9.00
	Disproportionate Share Adjustment			
10.00	Allowable disproportionate share percentage (see instructions)			10.00
11.00	Disproportionate share adjustment (see instructions)	402,742		11.00
	Additional payment for high percentage of ESRD beneficiary discharges			
12.00	Total ESRD additional payment (see instructions)	0		12.00
13.00	Subtotal (see instructions)	9,359,965		13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	9,359,965		15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	712,343		16.00
17.00	Special add-on payments for new technologies	0		17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	0		18.00
19.00	SUBTOTAL	10,072,308		19.00
		5.00		
20.00	Capital DRG other than outlier	708,639		20.00
21.00	Capital DRG outlier payments	3,704		21.00
22.00	Indirect medical education percentage (see instructions)			22.00
23.00	Indirect medical education adjustment (line 20 times line 22)	0		23.00
24.00	Allowable disproportionate share percentage (see instructions)			24.00
25.00	Disproportionate share adjustment (line 20 times line 24)	0		25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	712,343		26.00
		5.00		
27.00	Low volume adjustment factor			27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	0		28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	134,898		29.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150037	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/24/2013 6:25 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,392	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	8,563,752	2.00
3.00	PPS payments	5,921,032	3.00
4.00	Outlier payment (see instructions)	45,822	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	47,691	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,392	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	18,344	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)	18,344	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	18,344	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	13,952	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)	4,392	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)	6,014,545	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)	1,497,733	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)	4,521,204	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)	4,521,204	30.00
31.00	Primary payer payments	827	31.00
32.00	Subtotal (line 30 minus line 31)	4,520,377	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)	52,218	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	36,553	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	52,218	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	4,556,930	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-5	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.98	AB Re-billing demo amount (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	4,556,935	40.00
41.00	Interim payments	4,634,106	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)	-77,171	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
		Overrides	
		1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet E-1 Part I Date/Time Prepared: 5/24/2013 6:25 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		8,931,618		4,470,718	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	12/31/2012	128,767	12/31/2012	163,388	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)		128,767		163,388	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)		9,060,385		4,634,106	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		44,568		77,171	6.02
7.00	Total Medicare program liability (see instructions)		9,015,817		4,556,935	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:150037 Component CCN:15S037	Period: From 01/01/2012 To 12/31/2012	Worksheet E-1 Part I Date/Time Prepared: 5/24/2013 6:25 pm
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		2,163,985		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		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		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)		2,163,985		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		337		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,164,322		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:150037 Component CCN:15T037	Period: From 01/01/2012 To 12/31/2012	Worksheet E-1 Part I Date/Time Prepared: 5/24/2013 6:25 pm
	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		1,244,888		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		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		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)		1,244,888		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		2,273		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,247,161		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 FOR HIT	Provider CCN: 150037	Period: From 01/01/2012 To 12/31/2012	Worksheet E-1 Part II Date/Time Prepared: 5/24/2013 6:25 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	2,692	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	3,908	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	717	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	8,489	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	192,973,207	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	4,655,172	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	1,288,903	8.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	1,195,997	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)	92,906	32.00
		Overrides	
		1.00	
	CONTRACTOR OVERRIDES		
108.00	Override of HIT payment	0	108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN:150037 Component CCN:15S037	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part II Date/Time Prepared: 5/24/2013 6:25 pm
	Title XVIII	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)	2,361,477	1.00
2.00	Net IPF PPS Outlier Payments	3,990	2.00
3.00	Net IPF PPS ECT Payments	0	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
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
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)	7.497268	9.00
10.00	Medical Education Adjustment Factor {((1 + (line 8/line 9)) 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)	2,365,467	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)	2,365,467	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	2,365,467	18.00
19.00	Deductibles	182,504	19.00
20.00	Subtotal (line 18 minus line 19)	2,182,963	20.00
21.00	Coinsurance	18,978	21.00
22.00	Subtotal (line 20 minus line 21)	2,163,985	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	2,163,985	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)	337	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)	2,164,322	31.00
32.00	Interim payments	2,163,985	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)	337	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	3,990	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:150037 Component CCN:15T037	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part III Date/Time Prepared: 5/24/2013 6:25 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	1,145,933	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0258	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	16,922	3.00
4.00	Outlier Payments	106,174	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
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
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)	3.308743	10.00
11.00	Medical Education Adjustment Factor {((1 + (line 9/line 10)) 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)	1,269,029	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)	1,269,029	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	1,269,029	19.00
20.00	Deductibles	20,808	20.00
21.00	Subtotal (line 19 minus line 20)	1,248,221	21.00
22.00	Coinsurance	1,445	22.00
23.00	Subtotal (line 21 minus line 22)	1,246,776	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	1,246,776	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)	385	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	1,247,161	32.00
33.00	Interim payments	1,244,888	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)	2,273	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part III, line 4	106,174	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: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet E-3 Part VII Date/Time Prepared: 5/24/2013 6:25 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	697,256		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	697,256	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	697,256	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	623,190		8.00
9.00	Ancillary service charges	1,104,383	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,727,573	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,727,573	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,030,317	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	697,256	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	697,256	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	697,256	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	697,256	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	697,256	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	697,256	0	40.00
41.00	Interim payments	1,233,109	0	41.00
42.00	Balance due provider/program (line 40 minus 41)	-535,853	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	0	0	43.00

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

Provider CCN: 150037

Period: From 01/01/2012 To 12/31/2012

Worksheet G

Date/Time Prepared: 5/24/2013 6:25 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	17,646,194	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	8,324,758	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	5,564,321	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	47,481,543	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)	79,016,816	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	5,760,136	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	95,698,691	0	0	0	15.00
16.00	Accumulated depreciation	-98,256,792	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	55,725,447	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	58,927,482	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	7,387,726	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	7,387,726	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	145,332,024	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,242,461	0	0	0	37.00
38.00	Salaries, wages, and fees payable	6,411,168	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,000,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,754,474	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	16,408,103	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	28,245,000	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	28,245,000	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	44,653,103	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	100,678,921				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)	100,678,921	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	145,332,024	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet G-1 | Date/Time Prepared: 5/24/2013 6:25 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		92,664,591		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		8,014,330				2.00
3.00	Total (sum of line 1 and line 2)		100,678,921		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		100,678,921		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		100,678,921		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/24/2013 6:25 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,604,056		4,604,056	1.00
2.00	SUBPROVIDER - IPF	3,043,918		3,043,918	2.00
3.00	SUBPROVIDER - IRF	1,310,717		1,310,717	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	8,958,691		8,958,691	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	6,072,174		6,072,174	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)	6,072,174		6,072,174	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	15,030,865		15,030,865	17.00
18.00	Ancillary services	41,508,024	103,679,964	145,187,988	18.00
19.00	Outpatient services	2,540,085	26,951,003	29,491,088	19.00
20.00	RURAL HEALTH CLINIC	0	2,142,208	2,142,208	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,334,494	2,334,494	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	1,407,981	0	1,407,981	26.00
27.00	PROF FEES, SELF INS, AFS VARIANCE	911,029	3,584,799	4,495,828	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	61,397,984	138,692,468	200,090,452	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		97,188,888		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)		97,188,888		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet G-3 | Date/Time Prepared: 5/24/2013 6:25 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	200,090,452	1.00
2.00	Less contractual allowances and discounts on patients' accounts	112,101,710	2.00
3.00	Net patient revenues (line 1 minus line 2)	87,988,742	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	97,188,888	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-9,200,146	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	MISCLASSIFICATION OF INC, OTHER OP	17,214,476	24.00
25.00	Total other income (sum of lines 6-24)	17,214,476	25.00
26.00	Total (line 5 plus line 25)	8,014,330	26.00
27.00		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)	8,014,330	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 150037
HHA CCN: 157092

Period: From 01/01/2012 To 12/31/2012

Worksheet H
Date/Time Prepared: 5/24/2013 6:25 pm

Home Health Agency I — PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	460,178	0	113,742	0	333,865	907,785	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	428,940	0	0	0	0	428,940	6.00
7.00	Physical Therapy	351,045	0	0	0	0	351,045	7.00
8.00	Occupational Therapy	147,781	0	0	0	0	147,781	8.00
9.00	Speech Pathology	6,179	0	0	0	0	6,179	9.00
10.00	Medical Social Services	29,100	0	0	0	0	29,100	10.00
11.00	Home Health Aide	195,467	0	0	0	0	195,467	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,618,690	0	113,742	0	333,865	2,066,297	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	907,785	0	907,785			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	428,940	0	428,940			6.00
7.00	Physical Therapy	0	351,045	0	351,045			7.00
8.00	Occupational Therapy	0	147,781	0	147,781			8.00
9.00	Speech Pathology	0	6,179	0	6,179			9.00
10.00	Medical Social Services	0	29,100	0	29,100			10.00
11.00	Home Health Aide	0	195,467	0	195,467			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	0	2,066,297	0	2,066,297			24.00

Column, 6 line 24 should agree with the Worksheet A, column 7, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 150037
HHA CCN: 157092

Period: From 01/01/2012 To 12/31/2012

Worksheet H-1 Part I
Date/Time Prepared: 5/24/2013 6:25 pm

Home Health Agency I | PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	907,785	0	0	0	0	907,785	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	428,940	0	0	0	0	428,940	6.00
7.00	Physical Therapy	351,045	0	0	0	0	351,045	7.00
8.00	Occupational Therapy	147,781	0	0	0	0	147,781	8.00
9.00	Speech Pathology	6,179	0	0	0	0	6,179	9.00
10.00	Medical Social Services	29,100	0	0	0	0	29,100	10.00
11.00	Home Health Aide	195,467	0	0	0	0	195,467	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	2,066,297	0	0	0	0	2,066,297	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	907,785		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	336,108	765,048	6.00
7.00	Physical Therapy	275,071	626,116	7.00
8.00	Occupational Therapy	115,798	263,579	8.00
9.00	Speech Pathology	4,842	11,021	9.00
10.00	Medical Social Services	22,802	51,902	10.00
11.00	Home Health Aide	153,164	348,631	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
24.00	Total (sum of lines 1-23)		2,066,297	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 150037
HHA CCN: 157092

Period:
From 01/01/2012
To 12/31/2012

Worksheet H-1
Part II
Date/Time Prepared:
5/24/2013 6:25 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-907,785	1,158,512	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	428,940	6.00
7.00	Physical Therapy	0	0	0	0	0	351,045	7.00
8.00	Occupational Therapy	0	0	0	0	0	147,781	8.00
9.00	Speech Pathology	0	0	0	0	0	6,179	9.00
10.00	Medical Social Services	0	0	0	0	0	29,100	10.00
11.00	Home Health Aide	0	0	0	0	0	195,467	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-907,785	1,158,512	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		907,785	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.783578	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150037
HHA CCN: 157092

Period:
From 01/01/2012
To 12/31/2012

Worksheet H-2
Part I
Date/Time Prepared:
5/24/2013 6:25 pm

Home Health Agency I

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		0	1.00	4.00	4A	5.00	7.00	
1.00	Administrative and General	0	0	315,688	315,688	72,163	0	1.00
2.00	Skilled Nursing Care	765,048	0	0	765,048	174,883	0	2.00
3.00	Physical Therapy	626,116	0	0	626,116	143,123	0	3.00
4.00	Occupational Therapy	263,579	0	0	263,579	60,251	0	4.00
5.00	Speech Pathology	11,021	0	0	11,021	2,519	0	5.00
6.00	Medical Social Services	51,902	0	0	51,902	11,864	0	6.00
7.00	Home Health Aide	348,631	0	0	348,631	79,693	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	2,066,297	0	315,688	2,381,985	544,496	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.000000			21.00

	Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	61,064	0	134,225	104,226	430	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	61,064	0	134,225	104,226	430	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150037
HHA CCN: 157092

Period:
From 01/01/2012
To 12/31/2012

Worksheet H-2
Part I
Date/Time Prepared:
5/24/2013 6:25 pm

Home Health Agency I | PPS

	Cost Center Description	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		16.00	23.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	369	0	688,165	0	688,165		1.00
2.00	Skilled Nursing Care	0	0	939,931	0	939,931	254,795	2.00
3.00	Physical Therapy	0	0	769,239	0	769,239	208,523	3.00
4.00	Occupational Therapy	0	0	323,830	0	323,830	87,783	4.00
5.00	Speech Pathology	0	0	13,540	0	13,540	3,670	5.00
6.00	Medical Social Services	0	0	63,766	0	63,766	17,285	6.00
7.00	Home Health Aide	0	0	428,324	0	428,324	116,109	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	369	0	3,226,795	0	3,226,795	688,165	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						0.271077	21.00

	Cost Center Description	Total HHA Costs	
		28.00	
1.00	Administrative and General		1.00
2.00	Skilled Nursing Care	1,194,726	2.00
3.00	Physical Therapy	977,762	3.00
4.00	Occupational Therapy	411,613	4.00
5.00	Speech Pathology	17,210	5.00
6.00	Medical Social Services	81,051	6.00
7.00	Home Health Aide	544,433	7.00
8.00	Supplies (see instructions)	0	8.00
9.00	Drugs	0	9.00
10.00	DME	0	10.00
11.00	Home Dialysis Aide Services	0	11.00
12.00	Respiratory Therapy	0	12.00
13.00	Private Duty Nursing	0	13.00
14.00	Clinic	0	14.00
15.00	Health Promotion Activities	0	15.00
16.00	Day Care Program	0	16.00
17.00	Home Delivered Meals Program	0	17.00
18.00	Homemaker Service	0	18.00
19.00	All Others (specify)	0	19.00
20.00	Total (sum of lines 1-19) (2)	3,226,795	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150037
HHA CCN: 157092

Period: From 01/01/2012 To 12/31/2012

Worksheet H-2 Part II
Date/Time Prepared: 5/24/2013 6:25 pm

Home Health Agency I

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	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	HOUSEKEEPING (HOURS OF SERVICE)	
		1.00	4.00	5A	5.00	7.00	9.00	
1.00	Administrative and General	0	1,618,690	0	315,688	0	12,210	1.00
2.00	Skilled Nursing Care	0	0	0	765,048	0	0	2.00
3.00	Physical Therapy	0	0	0	626,116	0	0	3.00
4.00	Occupational Therapy	0	0	0	263,579	0	0	4.00
5.00	Speech Pathology	0	0	0	11,021	0	0	5.00
6.00	Medical Social Services	0	0	0	51,902	0	0	6.00
7.00	Home Health Aide	0	0	0	348,631	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	1,618,690		2,381,985	0	12,210	20.00
21.00	Total cost to be allocated	0	315,688		544,496	0	61,064	21.00
22.00	Unit cost multiplier	0.000000	0.195027		0.228589	0.000000	5.001147	22.00

	Cost Center Description	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		10.00	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	53,527	53,527	12,175	0	1	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	53,527	53,527	12,175	0	1	20.00
21.00	Total cost to be allocated	0	134,225	104,226	430	0	369	21.00
22.00	Unit cost multiplier	0.000000	2.507613	1.947167	0.035318	0.000000	369.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 150037 HHA CCN: 157092	Period: From 01/01/2012 To 12/31/2012	Worksheet H-2 Part II Date/Time Prepared: 5/24/2013 6:25 pm
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	Cost Center Description	PARAMED ED PRGM (ASSIGNED TIME)				
		23.00				
1.00	Administrative and General	0				1.00
2.00	Skilled Nursing Care	0				2.00
3.00	Physical Therapy	0				3.00
4.00	Occupational Therapy	0				4.00
5.00	Speech Pathology	0				5.00
6.00	Medical Social Services	0				6.00
7.00	Home Health Aide	0				7.00
8.00	Supplies (see instructions)	0				8.00
9.00	Drugs	0				9.00
10.00	DME	0				10.00
11.00	Home Dialysis Aide Services	0				11.00
12.00	Respiratory Therapy	0				12.00
13.00	Private Duty Nursing	0				13.00
14.00	Clinic	0				14.00
15.00	Health Promotion Activities	0				15.00
16.00	Day Care Program	0				16.00
17.00	Home Delivered Meals Program	0				17.00
18.00	Homemaker Service	0				18.00
19.00	All Others (specify)	0				19.00
20.00	Total (sum of lines 1-19)	0				20.00
21.00	Total cost to be allocated	0				21.00
22.00	Unit cost multiplier	0.000000				22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150037
HHA CCN: 157092

Period: From 01/01/2012 To 12/31/2012

Worksheet H-3 Part I
Date/Time Prepared: 5/24/2013 6:25 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1,194,726		1,194,726	5,568	214.57	1.00
2.00	Physical Therapy	3.00	977,762	0	977,762	3,659	267.22	2.00
3.00	Occupational Therapy	4.00	411,613	0	411,613	1,871	220.00	3.00
4.00	Speech Pathology	5.00	17,210	0	17,210	100	172.10	4.00
5.00	Medical Social Services	6.00	81,051		81,051	72	1,125.71	5.00
6.00	Home Health Aide	7.00	544,433		544,433	12,497	43.57	6.00
7.00	Total (sum of lines 1-6)		3,226,795	0	3,226,795	23,767		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	380	506			8.00
8.01	Skilled Nursing Care		26900	534	1,255			8.01
8.02	Skilled Nursing Care		11300	9	3			8.02
9.00	Physical Therapy		99915	301	336			9.00
9.01	Physical Therapy		26900	752	1,077			9.01
9.02	Physical Therapy		11300	17	23			9.02
10.00	Occupational Therapy		99915	177	130			10.00
10.01	Occupational Therapy		26900	471	606			10.01
10.02	Occupational Therapy		11300	5	10			10.02
11.00	Speech Pathology		99915	24	3			11.00
11.01	Speech Pathology		26900	23	8			11.01
11.02	Speech Pathology		11300	0	0			11.02
12.00	Medical Social Services		99915	1	8			12.00
12.01	Medical Social Services		26900	25	37			12.01
12.02	Medical Social Services		11300	0	0			12.02
13.00	Home Health Aide		99915	66	614			13.00
13.01	Home Health Aide		26900	55	1,194			13.01
13.02	Home Health Aide		11300	1	0			13.02
14.00	Total (sum of lines 8-13)			2,841	5,810			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	923	1,764		198,048	378,501		1.00
2.00	Physical Therapy	1,070	1,436		285,925	383,728		2.00
3.00	Occupational Therapy	653	746		143,660	164,120		3.00
4.00	Speech Pathology	47	11		8,089	1,893		4.00
5.00	Medical Social Services	26	45		29,268	50,657		5.00
6.00	Home Health Aide	122	1,808		5,316	78,775		6.00
7.00	Total (sum of lines 1-6)	2,841	5,810		670,306	1,057,674		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150037
HHA CCN: 157092

Period: From 01/01/2012 To 12/31/2012

Worksheet H-3 Part I
Date/Time Prepared: 5/24/2013 6:25 pm

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	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges			Cost of Services			
		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies							15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	576,549	1.00
2.00	Physical Therapy	669,653	2.00
3.00	Occupational Therapy	307,780	3.00
4.00	Speech Pathology	9,982	4.00
5.00	Medical Social Services	79,925	5.00
6.00	Home Health Aide	84,091	6.00
7.00	Total (sum of lines 1-6)	1,727,980	7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
8.01	Skilled Nursing Care		8.01
8.02	Skilled Nursing Care		8.02
9.00	Physical Therapy		9.00
9.01	Physical Therapy		9.01
9.02	Physical Therapy		9.02
10.00	Occupational Therapy		10.00
10.01	Occupational Therapy		10.01
10.02	Occupational Therapy		10.02
11.00	Speech Pathology		11.00
11.01	Speech Pathology		11.01
11.02	Speech Pathology		11.02
12.00	Medical Social Services		12.00
12.01	Medical Social Services		12.01
12.02	Medical Social Services		12.02
13.00	Home Health Aide		13.00
13.01	Home Health Aide		13.01
13.02	Home Health Aide		13.02
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS	Provider CCN: 150037 HHA CCN: 157092	Period: From 01/01/2012 To 12/31/2012	Worksheet H-3 Part II Date/Time Prepared: 5/24/2013 6:25 pm
		Home Health Agency I	PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.506298	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.332958	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.503997	0	0	col. 2, line 4.00		3.00
3.01	Speech Pathology 1	68.01	0.000000	0	0	col. 2, line 4.01		3.01
4.00	Cost of Medical Supplies	71.00	0.833461	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.244825	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 150037
HHA CCN: 157092

Period: From 01/01/2012 To 12/31/2012

Worksheet H-4 Part I-II
Date/Time Prepared: 5/24/2013 6:25 pm

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount 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(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	584,222	890,940	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	8,060	15,867	13.00
14.00	Total PPS Reimbursement - PEP Episodes	667	4,472	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	592,949	911,279	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	592,949	911,279	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	592,949	911,279	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CCN: 150037 HHA CCN: 157092	Period: From 01/01/2012 To 12/31/2012	Worksheet H-4 Part I-II Date/Time Prepared: 5/24/2013 6:25 pm
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		Part A Services	Part B Services	
		1.00	2.00	
29.00	Total costs - current cost reporting period (line 26 plus line 27)	592,949	911,279	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	592,949	911,279	31.00
32.00	Interim payments (see instructions)	592,949	911,279	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 32 and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 150037
HHA CCN: 157092

Period: From 01/01/2012 To 12/31/2012

Worksheet H-5
Date/Time Prepared: 5/24/2013 6:25 pm

Home Health Agency I

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		592,949		911,279	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			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			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. H-4, Part II, column as appropriate, line 32)		592,949		911,279	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			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		0	6.02
7.00	Total Medicare program liability (see instructions)		592,949		911,279	7.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 150037 HHA CCN: 157092	Period: From 01/01/2012 To 12/31/2012	Worksheet H-5 Date/Time Prepared: 5/24/2013 6:25 pm
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				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150037
Hospice CCN: 151547

Period: From 01/01/2012 To 12/31/2012

Worksheet K
Date/Time Prepared: 5/24/2013 6:25 pm

Hospice I

		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	5,040	0	0	0	775,110	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	633,397	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	90,666	0	0	0	0	15.00
16.00	Spiritual Counseling	496	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	62,508	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	792,107	0	0	0	775,110	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150037
Hospice CCN: 151547

Period: From 01/01/2012 To 12/31/2012

Worksheet K
Date/Time Prepared: 5/24/2013 6:25 pm

Hospice I

		Total (cols. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	780,150	0	780,150	-3,887	776,263	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	633,397	0	633,397	0	633,397	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	90,666	0	90,666	0	90,666	15.00
16.00	Spiritual Counseling	496	0	496	0	496	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	62,508	0	62,508	0	62,508	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	1,567,217	0	1,567,217	-3,887	1,563,330	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150037
Hospice CCN: 151547

Period: From 01/01/2012 To 12/31/2012

Worksheet K-1

Date/Time Prepared: 5/24/2013 6:25 pm

Hospice I

		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	5,040	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	633,397	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	90,666	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	5,040	0	90,666	0	633,397	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150037
Hospice CCN: 151547

Period: From 01/01/2012 To 12/31/2012

Worksheet K-1

Date/Time Prepared: 5/24/2013 6:25 pm

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	0	5,040		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	0		9.00
10.00	Nursing Care		0	0	633,397		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	90,666		15.00
16.00	Spiritual Counseling		0	496	496		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		62,508	0	62,508		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	62,508	496	792,107		39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 150037
Hospice CCN: 151547

Period: From 01/01/2012 To 12/31/2012

Worksheet K-4 Part I
Date/Time Prepared: 5/24/2013 6:25 pm

Hospice I

		NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COST		PLANT OPERATION & MAINT.	TRANSPORTATION	
			BUILDINGS & FIXTURES	MOVABLE EQUIPMENT			
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	776,263	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	633,397	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	90,666	0	0	0	0	15.00
16.00	Spiritual Counseling	496	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	62,508	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	1,563,330	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 150037
Hospice CCN: 151547

Period: From 01/01/2012 To 12/31/2012

Worksheet K-4 Part I
Date/Time Prepared: 5/24/2013 6:25 pm

Hospice I

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (cols. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A ± col. 6)		
		5.00	5A	6.00	7.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance						3.00
4.00	Transportation - Staff						4.00
5.00	Volunteer Service Coordination	0					5.00
6.00	Administrative and General	0	776,263	776,263			6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0		7.00
8.00	Inpatient - Respite Care	0	0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0		9.00
10.00	Nursing Care	0	633,397	624,703	1,258,100		10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services	0	90,666	89,421	180,087		15.00
16.00	Spiritual Counseling	0	496	489	985		16.00
17.00	Dietary Counseling	0	0	0	0		17.00
18.00	Counseling - Other	0	0	0	0		18.00
19.00	Home Health Aide and Homemaker	0	62,508	61,650	124,158		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		20.00
21.00	Other	0	0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0		22.00
23.00	Analgesics	0	0	0	0		23.00
24.00	Sedatives / Hypnotics	0	0	0	0		24.00
25.00	Other - Specify	0	0	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0		26.00
27.00	Patient Transportation	0	0	0	0		27.00
28.00	Imaging Services	0	0	0	0		28.00
29.00	Labs and Diagnostics	0	0	0	0		29.00
30.00	Medical Supplies	0	0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0		31.00
32.00	Radiation Therapy	0	0	0	0		32.00
33.00	Chemotherapy	0	0	0	0		33.00
34.00	Other	0	0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0		35.00
36.00	Volunteer Program Costs	0	0	0	0		36.00
37.00	Fundraising	0	0	0	0		37.00
38.00	Other Program Costs	0	0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	1,563,330		1,563,330		39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150037
Hospice CCN: 151547

Period: From 01/01/2012 To 12/31/2012

Worksheet K-4 Part II
Date/Time Prepared: 5/24/2013 6:25 pm

Hospice I

		CAPITAL RELATED COST					
		BUILDINGS & FIXTURES (SQ. FT.)	MOVABLE EQUIPMENT ($ VALUE)	PLANT OPERATION & MAINT. (SQ. FT.)	TRANSPORTATIO N (MILEAGE)	VOLUNTEER SERVICES COORDINATOR (HOURS)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Movable Equip.	0	0				2.00
3.00	Plant Operation and Maintenance	0	0	0			3.00
4.00	Transportation - Staff	0	0	0	0		4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)	0	0	0	0	0	39.00
40.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	40.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150037
Hospice CCN: 151547

Period:
From 01/01/2012
To 12/31/2012

Worksheet K-4
Part II
Date/Time Prepared:
5/24/2013 6:25 pm

Hospice I

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)		
		6A	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0			1.00
2.00	Capital Related Costs-Movable Equip.	0			2.00
3.00	Plant Operation and Maintenance	0			3.00
4.00	Transportation - Staff	0			4.00
5.00	Volunteer Service Coordination				5.00
6.00	Administrative and General	-776,263	787,067		6.00
	INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	0		7.00
8.00	Inpatient - Respite Care	0	0		8.00
	VISITING SERVICES				
9.00	Physician Services	0	0		9.00
10.00	Nursing Care	0	633,397		10.00
11.00	Nursing Care-Continuous Home Care	0	0		11.00
12.00	Physical Therapy	0	0		12.00
13.00	Occupational Therapy	0	0		13.00
14.00	Speech/ Language Pathology	0	0		14.00
15.00	Medical Social Services	0	90,666		15.00
16.00	Spiritual Counseling	0	496		16.00
17.00	Dietary Counseling	0	0		17.00
18.00	Counseling - Other	0	0		18.00
19.00	Home Health Aide and Homemaker	0	62,508		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		20.00
21.00	Other	0	0		21.00
	OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	0		22.00
23.00	Analgesics	0	0		23.00
24.00	Sedatives / Hypnotics	0	0		24.00
25.00	Other - Specify	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0		26.00
27.00	Patient Transportation	0	0		27.00
28.00	Imaging Services	0	0		28.00
29.00	Labs and Diagnostics	0	0		29.00
30.00	Medical Supplies	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		31.00
32.00	Radiation Therapy	0	0		32.00
33.00	Chemotherapy	0	0		33.00
34.00	Other	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0		35.00
36.00	Volunteer Program Costs	0	0		36.00
37.00	Fundraising	0	0		37.00
38.00	Other Program Costs	0	0		38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		776,263		39.00
40.00	Unit Cost Multiplier		0.986273		40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150037
Hospice CCN: 151547

Period:
From 01/01/2012
To 12/31/2012

Worksheet K-5
Part I
Date/Time Prepared:
5/24/2013 6:25 pm

Hospice I

	Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	4.00	4A	5.00	
1.00	Administrative and General		100,371	154,482	254,853	58,257	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	1,258,100	0	0	1,258,100	287,588	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	180,087	0	0	180,087	41,166	10.00
11.00	Spiritual Counseling	985	0	0	985	225	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	124,158	0	0	124,158	28,381	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	1,563,330	100,371	154,482	1,818,183	415,617	34.00
35.00	Unit Cost Multiplier (see instructions)				0.000000		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150037
Hospice CCN: 151547

Period:
From 01/01/2012
To 12/31/2012

Worksheet K-5
Part I
Date/Time Prepared:
5/24/2013 6:25 pm

Hospice I

	Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	241,764	0	69,384	67,355	52,301	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	241,764	0	69,384	67,355	52,301	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150037
Hospice CCN: 151547

Period:
From 01/01/2012
To 12/31/2012

Worksheet K-5
Part I
Date/Time Prepared:
5/24/2013 6:25 pm

Hospice I

	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal (cols. 4A-23)	
		14.00	15.00	16.00	23.00	24.00	
1.00	Administrative and General	2,296	0	0	0	746,210	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	1,545,688	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	221,253	10.00
11.00	Spiritual Counseling	0	0	0	0	1,210	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	152,539	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	2,296	0	0	0	2,666,900	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150037
Hospice CCN: 151547

Period:
From 01/01/2012
To 12/31/2012

Worksheet K-5
Part I
Date/Time Prepared:
5/24/2013 6:25 pm

Hospice I

	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (cols. 26 ± 27)		
		25.00	26.00	27.00	28.00		
1.00	Administrative and General						1.00
2.00	Inpatient - General Care	0	0	0	0		2.00
3.00	Inpatient - Respite Care	0	0	0	0		3.00
4.00	Physician Services	0	0	0	0		4.00
5.00	Nursing Care	0	1,545,688	600,518	2,146,206		5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0		6.00
7.00	Physical Therapy	0	0	0	0		7.00
8.00	Occupational Therapy	0	0	0	0		8.00
9.00	Speech/ Language Pathology	0	0	0	0		9.00
10.00	Medical Social Services	0	221,253	85,959	307,212		10.00
11.00	Spiritual Counseling	0	1,210	470	1,680		11.00
12.00	Dietary Counseling	0	0	0	0		12.00
13.00	Counseling - Other	0	0	0	0		13.00
14.00	Home Health Aide and Homemaker	0	152,539	59,263	211,802		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		15.00
16.00	Other	0	0	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0		17.00
18.00	Analgesics	0	0	0	0		18.00
19.00	Sedatives / Hypnotics	0	0	0	0		19.00
20.00	Other - Specify	0	0	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0		21.00
22.00	Patient Transportation	0	0	0	0		22.00
23.00	Imaging Services	0	0	0	0		23.00
24.00	Labs and Diagnostics	0	0	0	0		24.00
25.00	Medical Supplies	0	0	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0		26.00
27.00	Radiation Therapy	0	0	0	0		27.00
28.00	Chemotherapy	0	0	0	0		28.00
29.00	Other	0	0	0	0		29.00
30.00	Bereavement Program Costs	0	0	0	0		30.00
31.00	Volunteer Program Costs	0	0	0	0		31.00
32.00	Fundraising	0	0	0	0		32.00
33.00	Other Program Costs	0	0	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	2,666,900		2,666,900		34.00
35.00	Unit Cost Multiplier (see instructions)			0.388511			35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150037
Hospice CCN: 151547

Period:
From 01/01/2012
To 12/31/2012

Worksheet K-5
Part II
Date/Time Prepared:
5/24/2013 6:25 pm

Hospice I

	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	9,240	792,107	0	254,853	9,240	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	1,258,100	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	180,087	0	10.00
11.00	Spiritual Counseling	0	0	0	985	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	124,158	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	9,240	792,107		1,818,183	9,240	34.00
35.00	Total cost to be allocated	100,371	154,482		415,617	241,764	35.00
36.00	Unit Cost Multiplier (see instructions)	10.862662	0.195027		0.228589	26.164935	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150037
Hospice CCN: 151547

Period:
From 01/01/2012
To 12/31/2012

Worksheet K-5
Part II
Date/Time Prepared:
5/24/2013 6:25 pm

Hospice I

	Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	1,304	26,860	26,860	64,980	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	1,304	26,860	26,860	64,980	34.00
35.00	Total cost to be allocated	0	69,384	67,355	52,301	2,296	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	53.208589	2.507632	1.947171	0.035334	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150037
Hospice CCN: 151547

Period:
From 01/01/2012
To 12/31/2012

Worksheet K-5
Part II
Date/Time Prepared:
5/24/2013 6:25 pm

Hospice I

	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	PARAMED ED PRGM (ASSIGNED TIME)		
		15.00	16.00	23.00		
1.00	Administrative and General	0	0	0		1.00
2.00	Inpatient - General Care	0	0	0		2.00
3.00	Inpatient - Respite Care	0	0	0		3.00
4.00	Physician Services	0	0	0		4.00
5.00	Nursing Care	0	0	0		5.00
6.00	Nursing Care-Continuous Home Care	0	0	0		6.00
7.00	Physical Therapy	0	0	0		7.00
8.00	Occupational Therapy	0	0	0		8.00
9.00	Speech/ Language Pathology	0	0	0		9.00
10.00	Medical Social Services	0	0	0		10.00
11.00	Spiritual Counseling	0	0	0		11.00
12.00	Dietary Counseling	0	0	0		12.00
13.00	Counseling - Other	0	0	0		13.00
14.00	Home Health Aide and Homemaker	0	0	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0		15.00
16.00	Other	0	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0		17.00
18.00	Analgesics	0	0	0		18.00
19.00	Sedatives / Hypnotics	0	0	0		19.00
20.00	Other - Specify	0	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0		21.00
22.00	Patient Transportation	0	0	0		22.00
23.00	Imaging Services	0	0	0		23.00
24.00	Labs and Diagnostics	0	0	0		24.00
25.00	Medical Supplies	0	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0		26.00
27.00	Radiation Therapy	0	0	0		27.00
28.00	Chemotherapy	0	0	0		28.00
29.00	Other	0	0	0		29.00
30.00	Bereavement Program Costs	0	0	0		30.00
31.00	Volunteer Program Costs	0	0	0		31.00
32.00	Fundraising	0	0	0		32.00
33.00	Other Program Costs	0	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0		34.00
35.00	Total cost to be allocated	0	0	0		35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 150037
Hospice CCN: 151547

Period:
From 01/01/2012
To 12/31/2012

Worksheet K-5
Part III
Date/Time Prepared:
5/24/2013 6:25 pm

Hospice I

	Cost Center Description	Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1.00	2.00	3.00	
	ANCILLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.506298	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.332958	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.503997	0	0	3.00
3.01	OCCUPATIONAL HEALTH	68.01	0.000000	0	0	3.01
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.244825	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00
6.00	LABORATORY	60.00	0.185586	0	0	6.00
6.01	BLOOD LABORATORY	60.01				6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.833461	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00				8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00				9.00
10.00	CARDIAC	76.00	0.000000	0	0	10.00
10.01	CARDIAC REHABILITATION	76.01	0.527426	0	0	10.01
10.97	CARDIAC REHABILITATION	76.97				10.97
11.00	Totals (sum of lines 1-10)				0	11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 150037
Hospice CCN: 151547

Period:
From 01/01/2012
To 12/31/2012

Worksheet K-6
Date/Time Prepared:
5/24/2013 6:25 pm

Hospice I

		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				2,666,900	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				7,369	2.00
3.00	Average cost per diem (line 1 divided by line 2)				361.91	3.00
4.00	Upduplicated Medicare Days (Worksheet S-9, column 1, line 5)	6,349				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	2,297,767				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		380			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		137,526			7.00
8.00	Upduplicated SNF Days (Worksheet S-9, column 3, line 5)	2,147				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	777,021				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		10			10.00
11.00	Aggregate NF cost (line 3 times line 10)		3,619			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			640		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			231,622		13.00

CALCULATION OF CAPITAL PAYMENT

Provider CCN: 150037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet L Parts I-III Date/Time Prepared: 5/24/2013 6:25 pm

Title XVIII | Hospital | PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	708,639	1.00
2.00	Capital DRG outlier payments	3,704	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	23.46	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)	0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)	712,343	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Provider CCN: 150037
Component CCN: 153987

Period: From 01/01/2012 To 12/31/2012

Worksheet M-1
Date/Time Prepared: 5/24/2013 6:25 pm

Rural Health Clinic (RHC) I Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	119,468	0	119,468	0	119,468	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	19,799	0	19,799	0	19,799	9.00
10.00	Subtotal (sum of lines 1-9)	139,267	0	139,267	0	139,267	10.00
11.00	Physician Services Under Agreement	0	14,280	14,280	0	14,280	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	14,280	14,280	0	14,280	14.00
15.00	Medical Supplies	0	1,324	1,324	0	1,324	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	1,324	1,324	0	1,324	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	139,267	15,604	154,871	0	154,871	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	9,151	9,151	0	9,151	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	9,151	9,151	0	9,151	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	62,686	62,686	0	62,686	29.00
30.00	Administrative Costs	28,930	0	28,930	0	28,930	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	28,930	62,686	91,616	0	91,616	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	168,197	87,441	255,638	0	255,638	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN:150037 Component CCN:153987	Period: From 01/01/2012 To 12/31/2012	Worksheet M-1 Date/Time Prepared: 5/24/2013 6:25 pm
		Rural Health Clinic (RHC) I	Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	119,468		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	19,799		9.00
10.00	Subtotal (sum of lines 1-9)	0	139,267		10.00
11.00	Physician Services Under Agreement	-14,280	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	-14,280	0		14.00
15.00	Medical Supplies	0	1,324		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	1,324		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-14,280	140,591		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	9,151		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	9,151		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	62,686		29.00
30.00	Administrative Costs	0	28,930		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	91,616		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-14,280	241,358		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 150037
Component CCN: 153987

Period: From 01/01/2012 To 12/31/2012

Worksheet M-2
Date/Time Prepared: 5/24/2013 6:25 pm

Rural Health Clinic (RHC) I — Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	0	0		1.00
2.00	Physician Assistant	0.00	0	0	0		2.00
3.00	Nurse Practitioner	0.00	1,594	2,100	0		3.00
4.00	Subtotal (sum of lines 1-3)	0.00	1,594		0	1,594	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	0.00	1,594			1,594	8.00
9.00	Physician Services Under Agreements		24			24	9.00
						1.00	

	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)	140,591	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)	9,151	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	149,742	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)	0.938888	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)	91,616	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	95,520	15.00
16.00	Total overhead (sum of lines 14 and 15)	187,136	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Subtract line 17 from line 16	187,136	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)	175,700	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)	316,291	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN:150037 Component CCN:153987	Period: From 01/01/2012 To 12/31/2012	Worksheet M-3 Date/Time Prepared: 5/24/2013 6:25 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		316,291	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		10,839	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		305,452	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		1,594	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		24	5.00
6.00	Total adjusted visits (line 4 plus line 5)		1,618	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		188.78	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27,Sec. 505 or your contractor)	78.54	78.54	8.00
9.00	Rate for Program covered visits (see instructions)	78.54	78.54	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	336	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	26,389	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		26,389	16.00
16.01	Total program charges (see instructions)(from contractor's records)		63,573	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		16,192	16.04
16.05	Total program cost (see instructions)		16,192	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		6,149	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		16,192	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		2,179	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		18,371	22.00
23.00	Reimbursable bad debts (see instructions)		0	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		18,371	26.00
27.00	Interim payments		16,524	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 27 and 28)		1,847	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN:150037 Component CCN:153987	Period: From 01/01/2012 To 12/31/2012	Worksheet M-4 Date/Time Prepared: 5/24/2013 6:25 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	139,267	139,267	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.002233	0.011376	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	311	1,584	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,793	962	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	2,104	2,546	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	140,591	140,591	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	187,136	187,136	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.014965	0.018109	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	2,800	3,389	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	4,904	5,935	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	32	163	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	153.25	36.41	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	4	43	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	613	1,566	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		10,839	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		2,179	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN:150037 Component CCN:153987	Period: From 01/01/2012 To 12/31/2012	Worksheet M-5 Date/Time Prepared: 5/24/2013 6:25 pm
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		16,524	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	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			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		16,524	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			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		1,847	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		18,371	7.00

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