

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet 5 Parts I-III Date/Time Prepared: 5/30/2014 10:01 am
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**PART I - COST REPORT STATUS**

Provider use only

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

Contractor use only

5.  Cost Report Status  
 (1) As Submitted  
 (2) Settled without Audit  
 (3) Settled with Audit  
 (4) Reopened  
 (5) Amended

6. Date Received:  
 7. Contractor No.  
 8.  Initial Report for this Provider CCN  
 9.  Final Report for this Provider CCN

10. NPR Date:  
 11. Contractor's Vendor Code: 4  
 12.  If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 5/30/2014 Time: 10:01 am

**PART II - CERTIFICATION**

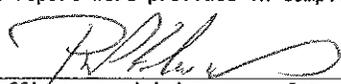
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR 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 01/01/2013 and ending 12/31/2013 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.

**Encryption Information**

ECR: Date: 5/30/2014 Time: 10:01 am  
 pSL7G3Mke07n:Bt.qdXAa.xhpkn3.0  
 XYqvD0cwr.7XM6losX.Ucid9eTF8v1  
 jbvblWGSUT0x6f5L  
 PI: Date: 5/30/2014 Time: 10:01 am  
 vvB0k:53vI5M0Ev6:6iwj11loVPWU0  
 7Tfkr0z0K8J1BUK8QJ6egmepRcnzHD  
 ZZ8w0brsmq06HU9h

(Signed)   
 Officer or Administrator of Provider(s)  
 Title CEO  
 Date 6/2/14

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	-37,651	54,817	-18,966	-75,091	1.00
2.00 Subprovider - IPF	0	528	0	0	0	2.00
3.00 Subprovider - IRF	0	-8,396	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
9.00 HOME HEALTH AGENCY I	0	1	50	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	1,187	0	0	10.00
200.00 Total	0	-45,518	56,054	-18,966	-75,091	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/30/2014 8:53 am
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1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 Zip Code: 46140-		4.00 County: HANCOCK				1.00
1.00	Street: 10 NORTH STATE STREET	2.00 State: IN		3.00 Zip Code: 46140-		4.00 County: HANCOCK				2.00
2.00	City: GREENFIELD	2.00 State: IN		3.00 Zip Code: 46140-		4.00 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	KNI GHTSTOWN RURAL HEALTH	153987	26900		09/22/1998	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FOHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2013		12/31/2013		20.00
21.00	Type of Control (see instructions)					9				21.00

Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					Y		N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)									22.01
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.	323	317	0	0	572	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	2	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/30/2014 8:53 am		
		Urban/Rural S	Date of Geogr			
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1			26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0			35.00	
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 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 this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	Y		39.00	
		V	XVII	XIX		
		1.00	2.00	3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
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	
<b>Teaching Hospitals</b>						
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	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet S-2  
Part I  
Date/Time Prepared:  
5/30/2014 8:53 am

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>						
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
<u>Teaching Hospitals that Claim Residents in Non-Provider Settings</u>						
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 Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))
				1.00	2.00	3.00
<u>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.</u>						
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
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/30/2014 8:53 am																																																																																																																																																																										
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		1.00	2.00	3.00																																																																																																																																																																										
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<table border="1"> <thead> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> <th>3.00</th> <th colspan="2"></th> </tr> </thead> <tbody> <tr> <td colspan="7">Inpatient Psychiatric Facility PPS</td> </tr> <tr> <td>70.00</td> <td>Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.</td> <td></td> <td></td> <td></td> <td>Y</td> <td>70.00</td> </tr> <tr> <td>71.00</td> <td>If line 70 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 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)</td> <td></td> <td></td> <td></td> <td>N N 0</td> <td>71.00</td> </tr> <tr> <td colspan="7">Inpatient Rehabilitation Facility PPS</td> </tr> <tr> <td>75.00</td> <td>Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.</td> <td></td> <td></td> <td></td> <td>Y</td> <td>75.00</td> </tr> <tr> <td>76.00</td> <td>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 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)</td> <td></td> <td></td> <td></td> <td>N N 0</td> <td>76.00</td> </tr> <tr> <td colspan="7"> <table border="1"> <thead> <tr> <th colspan="2"></th> <th colspan="3">1.00</th> <th colspan="2"></th> </tr> </thead> <tbody> <tr> <td colspan="7">Long Term Care Hospital PPS</td> </tr> <tr> <td>80.00</td> <td>Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.</td> <td></td> <td></td> <td></td> <td>N</td> <td>80.00</td> </tr> <tr> <td colspan="7">TEFRA Providers</td> </tr> <tr> <td>85.00</td> <td>Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.</td> <td></td> <td></td> <td></td> <td>N</td> <td>85.00</td> </tr> <tr> <td>86.00</td> <td>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.</td> <td></td> <td></td> <td></td> <td></td> <td>86.00</td> </tr> <tr> <td colspan="7"> <table border="1"> <thead> <tr> <th colspan="2"></th> <th>V</th> <th colspan="2">XIX</th> <th colspan="2"></th> </tr> <tr> <th colspan="2"></th> <th>1.00</th> <th colspan="2">2.00</th> <th colspan="2"></th> </tr> </thead> <tbody> <tr> <td colspan="7">Title V and XIX Services</td> </tr> <tr> <td>90.00</td> <td>Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td></td> <td>N</td> <td>Y</td> <td>90.00</td> </tr> <tr> <td>91.00</td> <td>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.</td> <td></td> <td></td> <td>N</td> <td>Y</td> <td>91.00</td> </tr> <tr> <td>92.00</td> <td>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.</td> <td></td> <td></td> <td></td> <td>N</td> <td>92.00</td> </tr> <tr> <td>93.00</td> <td>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.</td> <td></td> <td></td> <td>N</td> <td>N</td> <td>93.00</td> </tr> <tr> <td>94.00</td> <td>Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.</td> <td></td> <td></td> <td>N</td> <td>N</td> <td>94.00</td> </tr> <tr> <td>95.00</td> <td>If line 94 is "Y", enter the reduction percentage in the applicable column.</td> <td></td> <td></td> <td>0.00</td> <td>0.00</td> <td>95.00</td> </tr> </tbody> </table> </td> </tr> </tbody> </table> </td></tr></tbody></table>									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 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. 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		V	XIX			
		1.00	2.00			
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	
<b>Rural Providers</b>						
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		
<b>Miscellaneous Cost Reporting Information</b>						
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	
		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	
<b>DO NOT USE THIS LINE</b>						
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00	
<b>Transplant Center Information</b>						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/30/2014 8:53 am		
		1.00	2.00			
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	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		
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	
156.00	Subprovider - IPF	N	N	N	N	
157.00	Subprovider - IRF	N	N	N	N	
158.00	SUBPROVIDER					
159.00	SNF	N	N	N	N	
160.00	HOME HEALTH AGENCY	N	N	N	N	
161.00	CMHC		N	N	N	
				1.00		
Multi campus						
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00
		Name	County	State	Zip Code	CBSA
		0	1.00	2.00	3.00	4.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5					0.00
				1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act						
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			0		168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.75		169.00
				Begining	Ending	
				1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			10/01/2012	09/30/2013	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/30/2014 8:53 am	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	04/22/2014	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
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/08/2014	Y	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 01/01/2013  
To 12/31/2013

Worksheet S-2  
Part II  
Date/Time Prepared:  
5/30/2014 8:53 am

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
1.00					
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				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.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				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				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				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.				35.00
Y/N					Date
1.00					2.00
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?				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.				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.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
1.00					2.00
<b>Cost Report Preparer Contact Information</b>					
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		
<b>PS&amp;R Data</b>				
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)	04/08/2014		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)	04/08/2014		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	
<b>Cost Report Preparer Contact Information</b>				
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 01/01/2013 To 12/31/2013	Worksheet S-2 Part IX Date/Time Prepared: 5/30/2014 8:53 am	
			Title V	Title XIX	
			1.00	2.00	
<b>TITLES V AND/OR XIX FOLLOWING MEDICARE</b>					
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	
<b>CRITICAL ACCESS HOSPITALS</b>					
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	
<b>RCE DISALLOWANCE</b>					
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
<b>PASS THROUGH COST</b>					
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") 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 01/01/2013  
To 12/31/2013

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/30/2014 8:53 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	43	15,695	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		43	15,695	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	24	8,760	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	24,455	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	10	3,650		0	16.00
17.00 SUBPROVIDER - IRF	41.00	5	1,825		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	2,555			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
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)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/30/2014 8:53 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,486	323	3,570			1.00
2.00 HMO and other (see instructions)	591	871				2.00
3.00 HMO IPF Subprovider	65	0				3.00
4.00 HMO IRF Subprovider	34	2				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)	1,486	323	3,570			7.00
8.00 INTENSIVE CARE UNIT	2,546	0	4,983			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)	4,032	323	8,553	0.00	545.54	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	2,395	0	2,538	0.00	19.14	16.00
17.00 SUBPROVIDER - IRF	712	0	1,022	0.00	9.98	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	9,392	0	16,457	0.00	27.50	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	768	0.00	18.22	24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	251	0	1,700	0.00	2.78	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	623.16	27.00
28.00 Observation Bed Days		0	2,290			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			82			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	18	46			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/30/2014 8:53 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,240	99	2,559	1.00
2.00 HMO and other (see instructions)			168			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	1,240	99	2,559	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	222	0	240	16.00
17.00 SUBPROVIDER - IRF	0.00	0	68	0	99	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
24.10 HOSPICE (non-distinct part)						24.10
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
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/30/2014 8:53 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	37,901,819	0	37,901,819	1,208,984.00	31.35
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B		165,839	0	165,839	5,423.00	30.58
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		6,988,644	92,473	7,081,117	223,627.00	31.66
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract labor (see instructions)		283,759	0	283,759	4,147.00	68.43
12.00	Contract management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		238,103	0	238,103	1,885.00	126.31
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		9,227,528	0	9,227,528		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		2,326,162	0	2,326,162		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FOHC)		51,291	0	51,291		
25.00	Interns & residents (in an approved program)		0	0	0		
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits Department	4.00	282,764	0	282,764	8,894.00	31.79
27.00	Administrative & General	5.00	6,249,789	-92,473	6,157,316	187,964.00	32.76
28.00	Administrative & General under contract (see inst.)		1,220,546	0	1,220,546	7,616.00	160.26
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	828,110	0	828,110	29,520.00	28.05
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00
32.00	Housekeeping	9.00	826,510	0	826,510	58,810.00	14.05
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	1,070,059	-692,799	377,260	22,765.00	16.57
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	692,799	692,799	42,091.00	16.46
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	883,631	0	883,631	20,346.00	43.43
39.00	Central Services and Supply	14.00	53,302	0	53,302	3,379.00	15.77
40.00	Pharmacy	15.00	1,181,371	-49,695	1,131,676	27,756.00	40.77
41.00	Medical Records & Medical Records Library	16.00	589,994	0	589,994	25,726.00	22.93

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/30/2014 8:53 am

		Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjus ted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
42.00	Soci al Servi ce	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Servi ce	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/30/2014 8:53 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	38,956,526	0	38,956,526	1,211,177.00	32.16	1.00
2.00	Excluded area salaries (see instructions)	6,988,644	92,473	7,081,117	223,627.00	31.66	2.00
3.00	Subtotal salaries (line 1 minus line 2)	31,967,882	-92,473	31,875,409	987,550.00	32.28	3.00
4.00	Subtotal other wages & related costs (see inst.)	521,862	0	521,862	6,032.00	86.52	4.00
5.00	Subtotal wage-related costs (see inst.)	9,227,528	0	9,227,528	0.00	28.95	5.00
6.00	Total (sum of lines 3 thru 5)	41,717,272	-92,473	41,624,799	993,582.00	41.89	6.00
7.00	Total overhead cost (see instructions)	13,186,076	-142,168	13,043,908	434,867.00	30.00	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet S-3 Part IV Date/Time Prepared: 5/30/2014 8:53 am
			Amount Reported	
			1.00	
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
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)		1,114,602	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration Fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		5,382	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)		6,990,611	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		254,165	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		288,637	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)		72,872	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		126,448	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
<b>TAXES</b>				
17.00	FICA-Employers Portion Only		2,661,021	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		2,693	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
<b>OTHER</b>				
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		11,353	22.00
23.00	Tuition Reimbursement		64,987	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		11,592,771	24.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet S-3  
Part V  
Date/Time Prepared:  
5/30/2014 8:53 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
<b>PART V - Contract Labor and Benefit Cost</b>				
<b>Hospital and Hospital-Based Component Identification:</b>				
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	Period: From 01/01/2013 To 12/31/2013	Worksheet S-4
		Component CCN: 157092		Date/Time Prepared: 5/30/2014 8:53 am
			Home Health Agency I	PPS

					1.00	
0.00	County	HANCOCK				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	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	464.00	0.00	0.00	2.00

		Number of Employees (Full Time Equivalent)			
		Staff	Contract	Total	
Enter the number of hours in your normal work week					
		0	1.00	2.00	3.00

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)	0.00			0.00	3.00
4.00	Director(s) and Assistant Director(s)	0.00			0.00	4.00
5.00	Other Administrative Personnel	0.00			0.00	5.00
6.00	Direct Nursing Service	0.00			0.00	6.00
7.00	Nursing Supervisor	0.00			0.00	7.00
8.00	Physical Therapy Service	0.00			0.00	8.00
9.00	Physical Therapy Supervisor	0.00			0.00	9.00
10.00	Occupational Therapy Service	0.00			0.00	10.00
11.00	Occupational Therapy Supervisor	0.00			0.00	11.00
12.00	Speech Pathology Service	0.00			0.00	12.00
13.00	Speech Pathology Supervisor	0.00			0.00	13.00
14.00	Medical Social Service	0.00			0.00	14.00
15.00	Medical Social Service Supervisor	0.00			0.00	15.00
16.00	Home Health Aide	0.00			0.00	16.00
17.00	Home Health Aide Supervisor	0.00			0.00	17.00
18.00	Other (specify)	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.				5	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
20.03		34620				20.03
20.04		29020				20.04

		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)
		Without Outliers	With Outliers			
		1.00	2.00	3.00	4.00	5.00

PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	2,890	145	120	97	3,252
22.00	Skilled Nursing Visit Charges	497,194	25,738	19,394	15,950	558,276
23.00	Physical Therapy Visits	2,726	20	55	138	2,939
24.00	Physical Therapy Visit Charges	512,996	3,865	9,083	25,123	551,067
25.00	Occupational Therapy Visits	1,376	23	7	67	1,473
26.00	Occupational Therapy Visit Charges	264,012	4,445	1,353	12,368	282,178
27.00	Speech Pathology Visits	51	0	2	4	57
28.00	Speech Pathology Visit Charges	9,856	0	387	773	11,016
29.00	Medical Social Service Visits	36	2	0	3	41
30.00	Medical Social Service Visit Charges	7,866	437	0	656	8,959
31.00	Home Health Aide Visits	1,468	128	9	25	1,630
32.00	Home Health Aide Visit Charges	115,576	10,176	477	1,820	128,049
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	8,547	318	193	334	9,392
34.00	Other Charges	0	0	0	0	0
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,407,500	44,661	30,694	56,690	1,539,545
36.00	Total Number of Episodes (standard/non outlier)	466		64	18	548
37.00	Total Number of Outlier Episodes		5		3	8
38.00	Total Non-Routine Medical Supply Charges	37,891	3,657	517	2,032	44,097

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 150037 Component CCN: 153987	Period: From 01/01/2013 To 12/31/2013	Worksheet S-8 Date/Time Prepared: 5/30/2014 8:53 am
			Rural Health Clinic (RHC) I	Cost

					1.00			
1.00	Clinic Address and Identification			437 N. MCCULUM		1.00		
			City	State	Zip Code			
			1.00	2.00	3.00			
2.00	City, State, Zip Code, County		KI NGHTSTOWN	IN		2.00		
					1.00			
3.00	FOHCs 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	12/31/2013	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 FOHC? 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	
11.00	Facility hours of operations (1)			08:00	16:00	08:00	11.00	
			Clinic					
					1.00	2.00		
12.00	Have you received an approval for an exception to the productivity standard?			N		0 12.00		
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, 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.					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	
11.00	Facility hours of operations (1)			16:00	08:00	16:00	08:00	16:00
			Clinic					

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 150037 Component CCN: 153987	Period: From 01/01/2013 To 12/31/2013	Worksheet S-8 Date/Time Prepared: 5/30/2014 8:53 am	
			Rural Health Clinic (RHC) I	Cost	
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
11.00	Facility hours of operations (1) Clinic	08:00	14:00		11.00

HOSPITAL IDENTIFICATION DATA

Provider CCN: 150037  
Component CCN: 151547

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet S-9  
Parts I & II  
Date/Time Prepared:  
5/30/2014 8:53 am

		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	
<b>PART I - ENROLLMENT DAYS</b>								
1.00	Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Routine Home Care	6,156	0	0	0	0	6,156	2.00
3.00	Inpatient Respite Care	203	0	0	0	0	203	3.00
4.00	General Inpatient Care	395	0	0	0	0	395	4.00
5.00	Total Hospice Days	6,754	0	0	0	0	6,754	5.00
<b>Part II - CENSUS DATA</b>								
6.00	Number of Patients Receiving Hospice Care	0	0	0	0	0	0	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)	0.00	0.00	0.00	0.00	0.00	0.00	8.00
9.00	Unduplicated Census Count	202	0	0	0	0	202	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet S-10 Date/Time Prepared: 5/30/2014 8:53 am
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				1.00	
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.352015		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		4,022,904		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		16,253,752		6.00
7.00	Medicaid cost (line 1 times line 6)		5,721,565		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)		1,698,661		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)		1,698,661		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	4,727,063	0	4,727,063	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,663,997	0	1,663,997	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)	1,663,997	0	1,663,997	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)			9,683,993	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			134,918	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			9,549,075	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			3,361,418	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			5,025,415	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			6,724,076	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet A  
Date/Time Prepared:  
5/30/2014 8:53 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		5,755,798		5,755,798	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	282,764	8,383,525		8,666,289	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,249,789	13,592,576	-566,957	19,275,408	5.00
7.00	00700	OPERATION OF PLANT	828,110	3,893,637	3,522	4,725,269	7.00
9.00	00900	HOUSEKEEPING	826,510	631,277		1,457,787	9.00
10.00	01000	DIETARY	1,070,059	921,835	-1,289,697	702,197	10.00
11.00	01100	CAFETERIA	0	0	1,289,697	1,289,697	11.00
13.00	01300	NURSING ADMINISTRATION	883,631	92,160		975,791	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	53,302	40,803		94,105	14.00
15.00	01500	PHARMACY	1,181,371	3,417,934	-58,186	4,541,119	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	589,994	267,314		868,755	16.00
23.00	02300	PARAMED PRGM	66,504	12,571		79,075	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	2,719,757	621,061		3,340,818	30.00
31.00	03100	INTENSIVE CARE UNIT	3,164,259	729,746		3,894,005	31.00
40.00	04000	SUBPROVIDER - IPF	1,141,214	265,567		1,406,781	40.00
41.00	04100	SUBPROVIDER - IRF	522,695	132,265		654,960	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	2,355,100	2,155,663		4,510,763	50.00
51.00	05100	RECOVERY ROOM	252,933	54,539		307,472	51.00
53.00	05300	ANESTHESIOLOGY	0	130,825		130,825	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,348,417	1,690,646		4,039,063	54.00
60.00	06000	LABORATORY	1,585,373	2,375,771	42,228	4,003,372	60.00
65.00	06500	RESPIRATORY THERAPY	1,105,093	297,328	7,480	1,409,901	65.00
66.00	06600	PHYSICAL THERAPY	955,251	229,868		1,185,119	66.00
67.00	06700	OCCUPATIONAL THERAPY	279,632	27,758		307,390	67.00
68.00	06800	SPEECH PATHOLOGY	149,789	32,960		182,749	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0		0	68.01
69.00	06900	ELECTROCARDIOLOGY	443,340	399,911	27,217	870,468	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,454,495		3,454,495	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,679,481		1,679,481	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		0	73.00
76.00	03020	CARDIAC	0	0		0	76.00
76.01	03022	CARDIAC REHABILITATION	48,426	35,647		84,073	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	165,839	82,745		248,584	88.00
90.00	09000	CLINIC	0	0		0	90.00
90.01	09001	WOUND CLINIC	470,219	378,059		848,278	90.01
90.02	09002	DIABETES CLINIC	27,221	4,637		31,858	90.02
90.03	09003	ASTHMA CLINIC	0	0		0	90.03
90.04	09004	ANDIS CLINIC	45,089	71,981		117,070	90.04
90.05	09005	PRIME TIME	0	116,154		116,154	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	105,863	53,848		159,711	90.06
90.07	04951	ONCOLOGY	140,809	156,228		297,037	90.07
90.08	04950	ANDERSON WOMENS CENTER	208,544	67,770		276,314	90.08
91.00	09100	EMERGENCY	2,376,691	546,616		2,923,307	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	HOME HEALTH AGENCY	1,734,706	495,241		2,229,947	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600	HOSPICE	1,238,107	1,293,837		2,531,944	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	35,616,401	54,590,077	-533,249	89,673,229	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	565,768		565,768	190.01
190.02	19002	PHYSICIAN BUILDING	0	80,252		80,252	190.02
190.03	19003	PRIVATE DUTY	151,024	223,871		374,895	190.03
190.04	19004	MARKETING	0	0	566,957	566,957	190.04
190.05	19005	WATER LAB	0	0		0	190.05
190.06	19006	FOUNDATION	95,961	8,309		104,270	190.06
190.07	19007	ASC	0	1,410		1,410	190.07
190.09	19009	HANCOCK OB	1,060,168	1,825,100		2,885,268	190.09
190.10	19010	HANCOCK WELLNESS	897,907	862,806		1,760,713	190.10
190.11	19011	MORRISTOWN CLINIC	0	-241		-241	190.11
190.12	19012	O3PUREMED	80,358	-96,010		-15,652	190.12
200.00		TOTAL (SUM OF LINES 118-199)	37,901,819	58,061,342		95,963,161	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet A  
Date/Time Prepared:  
5/30/2014 8:53 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-867,230	4,888,568	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-2,171,120	6,495,169	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-6,110,152	13,165,256	5.00
7.00	00700 OPERATION OF PLANT	-72,055	4,653,214	7.00
9.00	00900 HOUSEKEEPING	0	1,457,787	9.00
10.00	01000 DIETARY	-373,323	328,874	10.00
11.00	01100 CAFETERIA	-47,658	1,242,039	11.00
13.00	01300 NURSING ADMINISTRATION	-15,964	959,827	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-34,649	59,456	14.00
15.00	01500 PHARMACY	-610,679	3,930,440	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-76,516	792,239	16.00
23.00	02300 PARAMED PRGM	-64,750	14,325	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS	-1,554	3,339,264	30.00
31.00	03100 INTENSIVE CARE UNIT	0	3,894,005	31.00
40.00	04000 SUBPROVIDER - IPF	-93,667	1,313,114	40.00
41.00	04100 SUBPROVIDER - IRF	-72,017	582,943	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	-1,377,748	3,133,015	50.00
51.00	05100 RECOVERY ROOM	0	307,472	51.00
53.00	05300 ANESTHESIOLOGY	-120,547	10,278	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	-470,459	3,568,604	54.00
60.00	06000 LABORATORY	-396,545	3,606,827	60.00
65.00	06500 RESPIRATORY THERAPY	-148,749	1,261,152	65.00
66.00	06600 PHYSICAL THERAPY	-5,515	1,179,604	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	307,390	67.00
68.00	06800 SPEECH PATHOLOGY	-7,125	175,624	68.00
68.01	06801 OCCUPATIONAL HEALTH	0	0	68.01
69.00	06900 ELECTROCARDIOLOGY	-380	870,088	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,454,495	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	1,679,481	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	84,073	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	-14,280	234,304	88.00
90.00	09000 CLINIC	0	0	90.00
90.01	09001 WOUND CLINIC	-197,985	650,293	90.01
90.02	09002 DIABETES CLINIC	0	31,858	90.02
90.03	09003 ASTHMA CLINIC	0	0	90.03
90.04	09004 ANDIS CLINIC	-3,750	113,320	90.04
90.05	09005 PRIME TIME	-50	116,104	90.05
90.06	09006 SHELBYVILLE WOUND CLINIC	-5,150	154,561	90.06
90.07	04951 ONCOLOGY	-58,846	238,191	90.07
90.08	04950 ANDERSON WOMENS CENTER	-1,020	275,294	90.08
91.00	09100 EMERGENCY	-60,833	2,862,474	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
101.00	10100 HOME HEALTH AGENCY	0	2,229,947	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
116.00	11600 HOSPICE	-8,030	2,523,914	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-13,488,346	76,184,883	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001 PROFESSIONAL BUILDING	0	532,060	190.01
190.02	19002 PHYSICIAN BUILDING	0	80,252	190.02
190.03	19003 PRIVATE DUTY	0	374,895	190.03
190.04	19004 MARKETING	0	566,957	190.04
190.05	19005 WATER LAB	0	0	190.05
190.06	19006 FOUNDATION	0	104,270	190.06
190.07	19007 ASC	0	1,410	190.07
190.09	19009 HANCOCK OB	0	2,885,268	190.09
190.10	19010 HANCOCK WELLNESS	0	1,760,713	190.10
190.11	19011 MORRISTOWN CLINIC	0	-241	190.11
190.12	19012 O3PUREMED	0	-15,652	190.12
200.00	TOTAL (SUM OF LINES 118-199)	-13,488,346	82,474,815	200.00

COST CENTERS USED IN COST REPORT		Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet Non-CMS W Date/Time Prepared: 5/30/2014 8:53 am
Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	NEW CAP REL COSTS-BLDG & FIXT	00100		1.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
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
<b>ANCILLARY SERVICE COST CENTERS</b>				
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
<b>OUTPATIENT SERVICE COST CENTERS</b>				
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	ANDI'S CLINIC	09004		90.04
90.05	PRIME TIME	09005		90.05
90.06	SHELBYVILLE WOUND CLINIC	09006		90.06
90.07	ONCOLOGY	04951		90.07
90.08	ANDERSON WOMENS CENTER	04950		90.08
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
101.00	HOME HEALTH AGENCY	10100		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
116.00	HOSPICE	11600		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
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
190.09	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

		Increases			
Cost Center		Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	692,799	596,898	1.00
	TOTALS		692,799	596,898	
B - PLANT					
1.00	OPERATION OF PLANT	7.00	0	3,522	1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	11,447	2.00
3.00	ELECTROCARDIOLOGY	69.00	0	11,259	3.00
4.00	RESPIRATORY THERAPY	65.00	0	7,480	4.00
	TOTALS		0	33,708	
C - MARKETING					
1.00	MARKETING	190.04	92,473	474,484	1.00
	TOTALS		92,473	474,484	
D - OUTPATIENT PROCEDURE					
1.00	LABORATORY	60.00	36,066	6,162	1.00
2.00	ELECTROCARDIOLOGY	69.00	13,629	2,329	2.00
	TOTALS		49,695	8,491	
500.00	Grand Total: Increases		834,967	1,113,581	500.00

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet A-6  
Date/Time Prepared:  
5/30/2014 8:53 am

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA						
1.00	DIETARY	10.00	692,799	596,898	0	1.00
	TOTALS		692,799	596,898		
B - PLANT						
1.00	PROFESSIONAL BUILDING	190.01	0	33,708	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	33,708		
C - MARKETING						
1.00	ADMINISTRATIVE & GENERAL	5.00	92,473	474,484	0	1.00
	TOTALS		92,473	474,484		
D - OUTPATIENT PROCEDURE						
1.00	PHARMACY	15.00	49,695	8,491	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		49,695	8,491		
500.00	Grand Total: Decreases		834,967	1,113,581		500.00

RECLASSIFICATIONS

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet A-6  
Non-CMS Worksheet  
Date/Time Prepared:  
5/30/2014 8:53 am

Increases			Decreases			
Cost Center	Line #	Salary	Cost Center	Line #	Salary	
2.00	3.00	4.00	6.00	7.00	8.00	
<b>A - CAFETERIA</b>						
1.00	CAFETERIA	11.00	692,799	DIETARY	10.00	692,799
	TOTALS		692,799	TOTALS		692,799
<b>B - PLANT</b>						
1.00	OPERATION OF PLANT	7.00	0	PROFESSIONAL BUILDING	190.01	0
2.00	MEDICAL RECORDS & LIBRARY	16.00	0		0.00	0
3.00	ELECTROCARDIOLOGY	69.00	0		0.00	0
4.00	RESPIRATORY THERAPY	65.00	0		0.00	0
	TOTALS		0	TOTALS		0
<b>C - MARKETING</b>						
1.00	MARKETING	190.04	92,473	ADMINISTRATIVE & GENERAL	5.00	92,473
	TOTALS		92,473	TOTALS		92,473
<b>D - OUTPATIENT PROCEDURE</b>						
1.00	LABORATORY	60.00	36,066	PHARMACY	15.00	49,695
2.00	ELECTROCARDIOLOGY	69.00	13,629		0.00	0
	TOTALS		49,695	TOTALS		49,695
500.00	Grand Total: Increases		834,967	Grand Total: Decreases		834,967

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/30/2014 8:53 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	270,285	0	0	0	1.00
2.00	Land Improvements	5,489,851	16,100	0	16,100	2.00
3.00	Buildings and Fixtures	95,462,206	1,280,225	0	1,280,225	3.00
4.00	Building Improvements	235,570	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	55,726,362	2,340,158	0	2,340,158	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	157,184,274	3,636,483	0	3,636,483	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	157,184,274	3,636,483	0	3,636,483	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	270,285	0			1.00
2.00	Land Improvements	5,505,951	0			2.00
3.00	Buildings and Fixtures	96,659,181	0			3.00
4.00	Building Improvements	235,570	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	58,065,804	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	160,736,791	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	160,736,791	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/30/2014 8:53 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	5,755,798	0	0	0	0	1.00
3.00	Total (sum of lines 1-2)	5,755,798	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	5,755,798				
3.00	Total (sum of lines 1-2)	0	5,755,798				

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/30/2014 8:53 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	96,659,181	0	96,659,181	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	96,659,181	0	96,659,181	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	5,553,035	-662,170	1.00
3.00	Total (sum of lines 1-2)	0	0	0	5,553,035	-662,170	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	-2,297	0	0	0	4,888,568	1.00
3.00	Total (sum of lines 1-2)	-2,297	0	0	0	4,888,568	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet A-8

Date/Time Prepared:  
5/30/2014 8:53 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted					
			Cost Center	Line #	Wkst. A-7	Ref.		
			1.00	2.00	3.00	4.00	5.00	
1.00 Investment income - 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	-1,077,659	0				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
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00		0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet A-8

Date/Time Prepared:  
5/30/2014 8:53 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
33.00 HRH MMO RENTAL INCOME	B	-655,101	NEW CAP REL COSTS-BLDG & FIXT	1.00	10 33.00
33.01 HRH OTHER REVENUE SALES TAX	B	41,792	ADMINISTRATIVE & GENERAL	5.00	0 33.01
33.02 HRH OTHER REVENUE MISC REVENUE	B	-1,278	ADMINISTRATIVE & GENERAL	5.00	0 33.02
33.03 HRH GREENFIELD PAR EDUCATION SVC REV	B	-875	ADMINISTRATIVE & GENERAL	5.00	0 33.03
33.04 HRH MED STAFF SVC QA APPLICATION FEE	B	-10,100	ADMINISTRATIVE & GENERAL	5.00	0 33.04
33.05 HRH MEDICAL STAFF DUES	B	-19,850	ADMINISTRATIVE & GENERAL	5.00	0 33.05
33.06 HRH PAT FIN SVC BUS SERV-COPY FEES	B	-2,017	ADMINISTRATIVE & GENERAL	5.00	0 33.06
33.07 HRH PAT FIN SVC EXPENSE REIMBURSE	B	-47,339	ADMINISTRATIVE & GENERAL	5.00	0 33.07
33.08 HRH INFO SERVICES MISC REVENUE	B	-76,019	ADMINISTRATIVE & GENERAL	5.00	0 33.08
33.09 HRH ACCOUNTING MISC REVENUE	B	-8,926	ADMINISTRATIVE & GENERAL	5.00	0 33.09
33.10 HRH ACCOUNTING MANAGEMENT FEES	B	-235	ADMINISTRATIVE & GENERAL	5.00	0 33.10
33.11 HRH COMMUNICATIONS MISC REVENUE	B	-13,388	ADMINISTRATIVE & GENERAL	5.00	0 33.11
33.12 HRH COMMUNICATIONS PHONE LEASE REV	B	-184,349	ADMINISTRATIVE & GENERAL	5.00	0 33.12
33.13 HRH COMM EDUCATION EDUCATION SVC REV	B	-12,081	ADMINISTRATIVE & GENERAL	5.00	0 33.13
33.14 HRH TOBACCO AWARENESS ED SVC REV	B	-75	ADMINISTRATIVE & GENERAL	5.00	0 33.14
33.15 HRH GAIN/LOSS INVENTORY	B	-146,559	ADMINISTRATIVE & GENERAL	5.00	0 33.15
33.16 HRH GAIN/LOSS GROSS VARIANCE INVENT	B	23,559	ADMINISTRATIVE & GENERAL	5.00	0 33.16
33.17 HRH PLANT OFFSITE SERVICES	B	-61,828	OPERATION OF PLANT	7.00	0 33.17
33.18 HRH PLANT REBATES/REFUNDS	B	-31	OPERATION OF PLANT	7.00	0 33.18
33.19 HRH NUTRITIONAL SVC REBATES/REFUNDS	B	-1,516	DIETARY	10.00	0 33.19
33.20 HRH OTHER REVENUE REBATES/REFUNDS	B	-20,890	CENTRAL SERVICES & SUPPLY	14.00	0 33.20
33.21 HRH OTHER REVENUE DIS. EARNED ON INV	B	-13,759	CENTRAL SERVICES & SUPPLY	14.00	0 33.21
33.22 HRH PHARMACY MISC REV	B	-543	PHARMACY	15.00	0 33.22
33.23 HRH PHARMACY REBATES/REFUNDS	B	-1,543	PHARMACY	15.00	0 33.23
33.24 HRH ASSOCIATE PHARM RETAIL PHARM REV	B	-549,540	PHARMACY	15.00	0 33.24
33.25 HRH ASSOCIATE PHARM HOSPICE PHARM RE	B	-59,053	PHARMACY	15.00	0 33.25
33.26 HRH HEALTH INFO SVC MED REC COPY FEE	B	-4,126	MEDICAL RECORDS & LIBRARY	16.00	0 33.26
33.27 HRH HEALTH INFO SVC MISC REVENUE	B	-72,390	MEDICAL RECORDS & LIBRARY	16.00	0 33.27
33.28 HRH JOINT & SPINE REBATES/REFUNDS	B	-1,554	ADULTS & PEDIATRICS	30.00	0 33.28
33.29 HRH HAN GEN SURG PHYS OTHER REVENUE	B	-2,657,330	OPERATING ROOM	50.00	0 33.29
33.30 HRH HAN GEN SUR CONTRACT PHYS OTH RE	B	1,535,091	OPERATING ROOM	50.00	0 33.30
33.31 HRH DIAG IMAGING REBATES/REFUNDS	B	-4,855	RADIOLOGY-DIAGNOSTIC	54.00	0 33.31
33.32 HRH CT SCAN HEARTBEATS REVENUE	B	-434,730	RADIOLOGY-DIAGNOSTIC	54.00	0 33.32
33.33 HRH MMO RADIOLOGY HEARTBEATS REV	B	-2,042	RADIOLOGY-DIAGNOSTIC	54.00	0 33.33
33.34 HRH MMO EXPENSE REIMBURSEMENT	B	-176,483	LABORATORY	60.00	0 33.34
33.35 HRH LAB WATER TESTING	B	-52,555	LABORATORY	60.00	0 33.35
33.36 HRH LAB MISC REVENUE	B	-42,507	LABORATORY	60.00	0 33.36
33.37 HRH LAB HEARTBEATS REVENUE	B	-78,400	RESPIRATORY THERAPY	65.00	0 33.37
33.38 HRH SLEEP STUDY CLINIC MANAGEMENT	B	-52,849	RESPIRATORY THERAPY	65.00	0 33.38
33.39 HRH CARDIO SERV HEARTBEAT REVENUE	B	-380	ELECTROCARDIOLOGY	69.00	0 33.39
33.40 HRH WOUND/SKIN CLIN LEASED EMPL FEE	B	-12,065	WOUND CLINIC	90.01	0 33.40
33.41 HRH WOUND/SKIN CLIN OTHER REVENUE	B	-446,781	WOUND CLINIC	90.01	0 33.41
33.42 HRH WOUND/SKIN CLIN CONTR PHY OTH RE	B	264,763	WOUND CLINIC	90.01	0 33.42
33.43 HRH ER REBATES/REFUNDS	B	-833	EMERGENCY	91.00	0 33.43

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00		3.00	4.00
33.44	HRH HOSPICE CHARITABLE TRUST	B	-4,654	HOSPICE	116.00	0	33.44
33.45	HRH HOSPICE MISC REVENUE	B	-3,376	HOSPICE	116.00	0	33.45
33.46	MOW	A	-371,807	DIETARY	10.00	0	33.46
33.47	CAFETERIA GUEST MEALS	A	-47,658	CAFETERIA	11.00	0	33.47
33.48	PHYSICIAN RECRUITMENT FEES	A	-17,075	ADMINISTRATIVE & GENERAL	5.00	0	33.48
33.49	DONATIONS & SPONSORSHIPS	A	-5,977	ADMINISTRATIVE & GENERAL	5.00	0	33.49
33.50	ADVERTISING FEE	A	-259,391	ADMINISTRATIVE & GENERAL	5.00	0	33.50
33.51	ADVERTISING FEE	A	-17	SUBPROVIDER - IRF	41.00	0	33.51
33.52	ADVERTISING FEE	A	-480	PHYSICAL THERAPY	66.00	0	33.52
33.53	ADVERTISING FEE	A	-60	WOUND CLINIC	90.01	0	33.53
33.54	IHA LOBBYING EXPENSE	A	-1,643	ADMINISTRATIVE & GENERAL	5.00	0	33.54
33.55	AHA LOBBYING EXPENSE	A	-5,354	ADMINISTRATIVE & GENERAL	5.00	0	33.55
33.56	PHY OFFICE BLDG	A	-202,763	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.56
33.57	PHY OFFICE BLDG	A	-1,660	ADMINISTRATIVE & GENERAL	5.00	0	33.57
33.58	PHY OFFICE BLDG	A	-17,132	RADIOLOGY-DIAGNOSTIC	54.00	0	33.58
33.59	INTEREST REVENUE	B	-2,297	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.59
33.60	RENTAL PROPERTIES EXPENSE	A	-181,666	ADMINISTRATIVE & GENERAL	5.00	0	33.60
33.61	RENTAL PROPERTIES EXPENSE	A	-7,069	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.61
33.62	RENTAL PROPERTIES EXPENSE	A	-10,196	OPERATION OF PLANT	7.00	0	33.62
33.63	TELEPHONE SERVICES	A	-33,926	ADMINISTRATIVE & GENERAL	5.00	0	33.63
33.64	XRAY SCHOOL TUITION REVENUE	B	-64,750	PARAMED ED PRGM	23.00	0	33.64
33.65	HRH CLINICAL ED AHA COURSE REV	B	-14,454	NURSING ADMINISTRATION	13.00	0	33.65
33.66	HRH CLINICAL ED EDUC SVC REV	B	-1,510	NURSING ADMINISTRATION	13.00	0	33.66
33.67	HRH NEW PAL PT MISC REV	B	-3,045	PHYSICAL THERAPY	66.00	0	33.67
33.68	HRH COMM ED MISC REV	B	-60	ADMINISTRATIVE & GENERAL	5.00	0	33.68
33.69	HAF EXPENSE	A	-4,906,537	ADMINISTRATIVE & GENERAL	5.00	0	33.69
33.70	HRH AWC GENERAL BOUTIQUE SERVICES	B	-1,020	ANDERSON WOMENS CENTER	90.08	0	33.70
33.71	HRH OTHER REVENUE HEARTBEATS REVENUE	B	-720	ADMINISTRATIVE & GENERAL	5.00	0	33.71
33.72	HRH NUCLEAR MED PET SCAN	B	-11,700	RADIOLOGY-DIAGNOSTIC	54.00	0	33.72
33.73	SELF INSURANCE CLAIM EXPENSE	A	-2,171,120	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.73
33.74			0		0.00	0	33.74
33.75			0		0.00	0	33.75
33.76			0		0.00	0	33.76
33.77			0		0.00	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
33.81			0		0.00	0	33.81
33.82			0		0.00	0	33.82
33.83			0		0.00	0	33.83
33.84			0		0.00	0	33.84
33.85			0		0.00	0	33.85
33.86			0		0.00	0	33.86
33.87			0		0.00	0	33.87
33.88			0		0.00	0	33.88
33.89			0		0.00	0	33.89
33.90			0		0.00	0	33.90
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,488,346				50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet A-8-2

Date/Time Prepared:  
5/30/2014 8:53 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	238,403	238,403	0	0	0	1.00
2.00	40.00	SUBPROVIDER - IPF	93,667	93,667	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	255,509	255,509	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	120,547	120,547	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	17,500	17,500	0	0	0	7.00
8.00	66.00	PHYSICAL THERAPY	1,990	1,990	0	0	0	8.00
9.00	68.00	SPEECH PATHOLOGY	7,125	7,125	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	3,842	3,842	0	0	0	11.00
12.00	90.04	ANDIS CLINIC	3,750	3,750	0	0	0	12.00
13.00	90.05	PRIME TIME	50	50	0	0	0	13.00
14.00	90.06	SHELBYVILLE WOUND CLINIC	5,150	5,150	0	0	0	14.00
15.00	90.07	ONCOLOGY	58,846	58,846	0	0	0	15.00
16.00	91.00	EMERGENCY	60,000	60,000	0	0	0	16.00
200.00			1,077,659	1,077,659	0	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	90.04	ANDIS CLINIC	0	0	0	0	0	12.00
13.00	90.05	PRIME TIME	0	0	0	0	0	13.00
14.00	90.06	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	14.00
15.00	90.07	ONCOLOGY	0	0	0	0	0	15.00
16.00	91.00	EMERGENCY	0	0	0	0	0	16.00
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	238,403	1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	93,667	2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	72,000	3.00
4.00	50.00	OPERATING ROOM	0	0	0	255,509	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	120,547	5.00
6.00	60.00	LABORATORY	0	0	0	125,000	6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	17,500	7.00
8.00	66.00	PHYSICAL THERAPY	0	0	0	1,990	8.00
9.00	68.00	SPEECH PATHOLOGY	0	0	0	7,125	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	3,842	11.00
12.00	90.04	ANDIS CLINIC	0	0	0	3,750	12.00
13.00	90.05	PRIME TIME	0	0	0	50	13.00
14.00	90.06	SHELBYVILLE WOUND CLINIC	0	0	0	5,150	14.00
15.00	90.07	ONCOLOGY	0	0	0	58,846	15.00
16.00	91.00	EMERGENCY	0	0	0	60,000	16.00
200.00			0	0	0	1,077,659	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2014 8:53 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT				
	0	1.00	4.00	4A	5.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	4,888,568	4,888,568			1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	6,495,169	15,869	6,511,038		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	13,165,256	352,748	1,065,706	14,583,710	5.00
7.00 00700	OPERATION OF PLANT	4,653,214	1,194,748	143,328	5,991,290	7.00
9.00 00900	HOUSEKEEPING	1,457,787	31,229	143,051	1,632,067	9.00
10.00 01000	DIETARY	328,874	50,323	65,295	444,492	10.00
11.00 01100	CAFETERIA	1,242,039	92,391	119,908	1,454,338	11.00
13.00 01300	NURSING ADMINISTRATION	959,827	13,287	152,937	1,126,051	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	59,456	0	9,225	68,681	14.00
15.00 01500	PHARMACY	3,930,440	71,624	195,868	4,197,932	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	792,239	42,661	102,115	937,015	16.00
23.00 02300	PARAMED PRGM	14,325	16,294	11,510	42,129	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	3,339,264	372,727	470,730	4,182,721	30.00
31.00 03100	INTENSIVE CARE UNIT	3,894,005	289,137	547,664	4,730,806	31.00
40.00 04000	SUBPROVIDER - I/PF	1,313,114	77,297	197,519	1,587,930	40.00
41.00 04100	SUBPROVIDER - I/RF	582,943	53,221	90,467	726,631	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	3,133,015	285,791	407,616	3,826,422	50.00
51.00 05100	RECOVERY ROOM	307,472	25,701	43,777	376,950	51.00
53.00 05300	ANESTHESIOLOGY	10,278	0	0	10,278	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,568,604	179,059	406,459	4,154,122	54.00
60.00 06000	LABORATORY	3,606,827	77,031	280,635	3,964,493	60.00
65.00 06500	RESPIRATORY THERAPY	1,261,152	28,029	191,267	1,480,448	65.00
66.00 06600	PHYSICAL THERAPY	1,179,604	52,699	165,333	1,397,636	66.00
67.00 06700	OCCUPATIONAL THERAPY	307,390	0	48,398	355,788	67.00
68.00 06800	SPEECH PATHOLOGY	175,624	6,086	25,925	207,635	68.00
68.01 06801	OCCUPATIONAL HEALTH	0	0	0	0	68.01
69.00 06900	ELECTROCARDIOLOGY	870,088	84,280	79,091	1,033,459	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,454,495	0	0	3,454,495	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	1,679,481	0	0	1,679,481	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03020	CARDIAC	0	0	0	0	76.00
76.01 03022	CARDIAC REHABILITATION	84,073	0	8,381	92,454	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	234,304	0	28,703	263,007	88.00
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 09001	WOUND CLINIC	650,293	35,097	81,385	766,775	90.01
90.02 09002	DIABETES CLINIC	31,858	2,340	4,711	38,909	90.02
90.03 09003	ASTHMA CLINIC	0	0	0	0	90.03
90.04 09004	ANDIS CLINIC	113,320	3,989	7,804	125,113	90.04
90.05 09005	PRIME TIME	116,104	0	0	116,104	90.05
90.06 09006	SHELBYVILLE WOUND CLINIC	154,561	0	18,323	172,884	90.06
90.07 04951	ONCOLOGY	238,191	0	24,371	262,562	90.07
90.08 04950	ANDERSON WOMENS CENTER	275,294	20,731	36,094	332,119	90.08
91.00 09100	EMERGENCY	2,862,474	328,259	411,353	3,602,086	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00 10100	HOME HEALTH AGENCY	2,229,947	0	300,239	2,530,186	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
116.00 11600	HOSPICE	2,523,914	112,018	214,289	2,850,221	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	76,184,883	3,914,666	6,099,477	74,799,420	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.01 19001	PROFESSIONAL BUILDING	532,060	686,850	0	1,218,910	190.01
190.02 19002	PHYSICIAN BUILDING	80,252	0	0	80,252	190.02
190.03 19003	PRIVATE DUTY	374,895	0	26,139	401,034	190.03
190.04 19004	MARKETING	566,957	5,346	16,005	588,308	190.04
190.05 19005	WATER LAB	0	0	0	0	190.05
190.06 19006	FOUNDATION	104,270	0	16,609	120,879	190.06
190.07 19007	ASC	1,410	281,706	0	283,116	190.07
190.09 19009	HANCOCK OB	2,885,268	0	183,492	3,068,760	190.09
190.10 19010	HANCOCK WELLNESS	1,760,713	0	155,408	1,916,121	190.10
190.11 19011	MORRISTOWN CLINIC	-241	0	0	-241	190.11
190.12 19012	O3PUREMED	-15,652	0	13,908	-1,744	190.12
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	82,474,815	4,888,568	6,511,038	82,474,815	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2014 8:53 am

Cost Center Description		OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION		
		7.00	9.00	10.00	11.00	13.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT	7,278,247				7.00	
9.00	00900	HOUSEKEEPING	68,403	2,051,045			9.00	
10.00	01000	DIETARY	110,226	32,546	682,743		10.00	
11.00	01100	CAFETERIA	202,368	53,632	0	2,022,736	11.00	
13.00	01300	NURSING ADMINISTRATION	29,103	0	0	48,357	1,445,391	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	81,354	0	8,013	7,117	14.00
15.00	01500	PHARMACY	156,881	59,343	0	65,998	58,617	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	93,444	71,380	0	61,189	0	16.00
23.00	02300	PARAMED PRGM	35,689	82,224	0	4,440	3,943	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	816,404	545,525	205,308	182,814	162,367	30.00
31.00	03100	INTENSIVE CARE UNIT	633,314	112,467	278,876	238,120	211,486	31.00
40.00	04000	SUBPROVIDER - I/PF	169,308	90,009	141,557	88,373	78,488	40.00
41.00	04100	SUBPROVIDER - I/RF	116,572	31,159	57,002	46,077	40,924	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	625,985	218,369	0	35,765	31,765	50.00
51.00	05100	RECOVERY ROOM	56,295	80,408	0	13,999	12,433	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	392,203	79,936	0	177,643	157,774	54.00
60.00	06000	LABORATORY	168,724	76,280	0	156,909	139,359	60.00
65.00	06500	RESPIRATORY THERAPY	61,393	58,422	0	153,710	136,518	65.00
66.00	06600	PHYSICAL THERAPY	115,430	67,898	0	63,950	56,797	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	21,325	0	67.00
68.00	06800	SPEECH PATHOLOGY	13,330	0	0	8,929	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	184,604	132,389	0	33,572	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	5,868	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
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	76,874	0	0	26,293	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	2,517	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	8,736	0	0	3,914	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
90.07	04951	ONCOLOGY	0	0	0	6,950	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	45,407	0	0	17,132	0	90.08
91.00	09100	EMERGENCY	719,003	116,969	0	156,755	139,223	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	0	60,735	0	126,969	112,768	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
116.00	11600	HOSPICE	245,359	0	0	91,344	81,128	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,145,055	2,051,045	682,743	1,846,925	1,430,707	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	1,504,446	0	0	0	0	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	0	16,533	14,684	190.03
190.04	19004	MARKETING	11,710	0	0	12,775	0	190.04
190.05	19005	WATER LAB	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	0	0	0	6,363	0	190.06
190.07	19007	ASC	617,036	0	0	0	0	190.07
190.09	19009	HANCOCK OB	0	0	0	21,273	0	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	116,771	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	2,096	0	190.12
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	7,278,247	2,051,045	682,743	2,022,736	1,445,391	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2014 8:53 am

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED PRGM	Subtotal		
		14.00	15.00	16.00	23.00	24.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					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	179,918				14.00	
15.00	01500	PHARMACY	1,356	5,441,860			15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,364,303		16.00	
23.00	02300	PARAMED PRGM	0	0	0	177,474	23.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	3,661	0	315,025	0	7,312,290	30.00
31.00	03100	INTENSIVE CARE UNIT	6,706	0	39,335	0	7,267,306	31.00
40.00	04000	SUBPROVIDER - I PF	458	0	32,434	0	2,529,651	40.00
41.00	04100	SUBPROVIDER - I RF	205	0	192,879	0	1,367,532	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	4,973	0	414,053	0	5,979,263	50.00
51.00	05100	RECOVERY ROOM	222	0	0	0	621,277	51.00
53.00	05300	ANESTHESIOLOGY	1	0	0	0	12,487	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,593	0	47,271	177,474	6,080,338	54.00
60.00	06000	LABORATORY	35,584	0	104,893	0	5,497,831	60.00
65.00	06500	RESPIRATORY THERAPY	677	0	0	0	2,209,174	65.00
66.00	06600	PHYSICAL THERAPY	139	0	0	0	2,002,068	66.00
67.00	06700	OCCUPATIONAL THERAPY	20	0	0	0	453,558	67.00
68.00	06800	SPEECH PATHOLOGY	187	0	0	0	274,682	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	948	0	53,827	0	1,660,790	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	113,281	0	0	0	4,309,815	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	2,040,240	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,441,860	2,415	0	5,444,275	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	27	0	0	0	118,208	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	78	0	0	0	319,580	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	676	0	0	0	1,035,324	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	49,784	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDI'S CLINIC	6	0	0	0	164,644	90.04
90.05	09005	PRIME TIME	18	0	0	0	141,062	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	138	0	0	0	210,158	90.06
90.07	04951	ONCOLOGY	163	0	0	0	326,074	90.07
90.08	04950	ANDERSON WOMENS CENTER	64	0	0	0	466,062	90.08
91.00	09100	EMERGENCY	4,813	0	161,826	0	5,674,417	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	490	0	345	0	3,374,987	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
116.00	11600	HOSPICE	3,348	0	0	0	3,883,639	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	179,832	5,441,860	1,364,303	177,474	70,826,516	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0	0	2,985,183	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	97,490	190.02
190.03	19003	PRIVATE DUTY	86	0	0	0	518,481	190.03
190.04	19004	MARKETING	0	0	0	0	739,164	190.04
190.05	19005	WATER LAB	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	0	0	0	0	153,207	190.06
190.07	19007	ASC	0	0	0	0	960,966	190.07
190.09	19009	HANCOCK OB	0	0	0	0	3,749,215	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	0	2,444,482	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	-241	190.11
190.12	19012	O3PUREMED	0	0	0	0	352	190.12
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	179,918	5,441,860	1,364,303	177,474	82,474,815	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2014 8:53 am

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	0	7,312,290
31.00	03100	INTENSIVE CARE UNIT	0	7,267,306
40.00	04000	SUBPROVIDER - I PF	0	2,529,651
41.00	04100	SUBPROVIDER - I RF	0	1,367,532
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	0	5,979,263
51.00	05100	RECOVERY ROOM	0	621,277
53.00	05300	ANESTHESIOLOGY	0	12,487
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,080,338
60.00	06000	LABORATORY	0	5,497,831
65.00	06500	RESPIRATORY THERAPY	0	2,209,174
66.00	06600	PHYSICAL THERAPY	0	2,002,068
67.00	06700	OCCUPATIONAL THERAPY	0	453,558
68.00	06800	SPEECH PATHOLOGY	0	274,682
68.01	06801	OCCUPATIONAL HEALTH	0	0
69.00	06900	ELECTROCARDIOLOGY	0	1,660,790
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,309,815
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,040,240
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,444,275
76.00	03020	CARDIAC	0	0
76.01	03022	CARDIAC REHABILITATION	0	118,208
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800	RURAL HEALTH CLINIC	0	319,580
90.00	09000	CLINIC	0	0
90.01	09001	WOUND CLINIC	0	1,035,324
90.02	09002	DIABETES CLINIC	0	49,784
90.03	09003	ASTHMA CLINIC	0	0
90.04	09004	ANDIS CLINIC	0	164,644
90.05	09005	PRIME TIME	0	141,062
90.06	09006	SHELBYVILLE WOUND CLINIC	0	210,158
90.07	04951	ONCOLOGY	0	326,074
90.08	04950	ANDERSON WOMENS CENTER	0	466,062
91.00	09100	EMERGENCY	0	5,674,417
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>				
101.00	10100	HOME HEALTH AGENCY	0	3,374,987
<b>SPECIAL PURPOSE COST CENTERS</b>				
116.00	11600	HOSPICE	0	3,883,639
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	70,826,516
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0
190.01	19001	PROFESSIONAL BUILDING	0	2,985,183
190.02	19002	PHYSICIAN BUILDING	0	97,490
190.03	19003	PRIVATE DUTY	0	518,481
190.04	19004	MARKETING	0	739,164
190.05	19005	WATER LAB	0	0
190.06	19006	FOUNDATION	0	153,207
190.07	19007	ASC	0	960,966
190.09	19009	HANCOCK OB	0	3,749,215
190.10	19010	HANCOCK WELLNESS	0	2,444,482
190.11	19011	MORRISTOWN CLINIC	0	-241
190.12	19012	O3PUREMED	0	352
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	82,474,815

COST ALLOCATION STATISTICS

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet Non-CMS W

Date/Time Prepared:  
5/30/2014 8:53 am

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 DEPARTMENT	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 01/01/2013  
To 12/31/2013

Worksheet B  
Part II  
Date/Time Prepared:  
5/30/2014 8:53 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	15,869	15,869	15,869		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	352,748	352,748	2,595	355,343	5.00
7.00 00700	OPERATION OF PLANT	0	1,194,748	1,194,748	349	31,350	7.00
9.00 00900	HOUSEKEEPING	0	31,229	31,229	349	8,542	9.00
10.00 01000	DIETARY	0	50,323	50,323	159	2,326	10.00
11.00 01100	CAFETERIA	0	92,391	92,391	292	7,612	11.00
13.00 01300	NURSING ADMINISTRATION	0	13,287	13,287	373	5,894	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	22	359	14.00
15.00 01500	PHARMACY	0	71,624	71,624	478	21,972	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	42,661	42,661	249	4,904	16.00
23.00 02300	PARAMED PRGM	0	16,294	16,294	28	221	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	0	372,727	372,727	1,148	21,892	30.00
31.00 03100	INTENSIVE CARE UNIT	0	289,137	289,137	1,335	24,761	31.00
40.00 04000	SUBPROVIDER - IPF	0	77,297	77,297	482	8,311	40.00
41.00 04100	SUBPROVIDER - IRF	0	53,221	53,221	221	3,803	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	0	285,791	285,791	994	20,027	50.00
51.00 05100	RECOVERY ROOM	0	25,701	25,701	107	1,973	51.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	54	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	179,059	179,059	991	21,743	54.00
60.00 06000	LABORATORY	0	77,031	77,031	684	20,750	60.00
65.00 06500	RESPIRATORY THERAPY	0	28,029	28,029	466	7,749	65.00
66.00 06600	PHYSICAL THERAPY	0	52,699	52,699	403	7,315	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	118	1,862	67.00
68.00 06800	SPEECH PATHOLOGY	0	6,086	6,086	63	1,087	68.00
68.01 06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00 06900	ELECTROCARDIOLOGY	0	84,280	84,280	193	5,409	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	18,081	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	8,790	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	20	484	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	70	1,377	88.00
90.00 09000	CLINIC	0	0	0	0	0	90.00
90.01 09001	WOUND CLINIC	0	35,097	35,097	198	4,013	90.01
90.02 09002	DIABETES CLINIC	0	2,340	2,340	11	204	90.02
90.03 09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04 09004	ANDIS CLINIC	0	3,989	3,989	19	655	90.04
90.05 09005	PRIME TIME	0	0	0	0	608	90.05
90.06 09006	SHELBYVILLE WOUND CLINIC	0	0	0	45	905	90.06
90.07 04951	ONCOLOGY	0	0	0	59	1,374	90.07
90.08 04950	ANDERSON WOMENS CENTER	0	20,731	20,731	88	1,738	90.08
91.00 09100	EMERGENCY	0	328,259	328,259	1,003	18,853	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00 10100	HOME HEALTH AGENCY	0	0	0	732	13,243	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00 11600	HOSPICE	0	112,018	112,018	522	14,918	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	3,914,666	3,914,666	14,866	315,159	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01 19001	PROFESSIONAL BUILDING	0	686,850	686,850	0	6,380	190.01
190.02 19002	PHYSICIAN BUILDING	0	0	0	0	420	190.02
190.03 19003	PRIVATE DUTY	0	0	0	64	2,099	190.03
190.04 19004	MARKETING	0	5,346	5,346	39	3,079	190.04
190.05 19005	WATER LAB	0	0	0	0	0	190.05
190.06 19006	FOUNDATION	0	0	0	40	633	190.06
190.07 19007	ASC	0	281,706	281,706	0	1,482	190.07
190.09 19009	HANCOCK OB	0	0	0	447	16,062	190.09
190.10 19010	HANCOCK WELLNESS	0	0	0	379	10,029	190.10
190.11 19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12 19012	O3PUREMED	0	0	0	34	0	190.12
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	4,888,568	4,888,568	15,869	355,343	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 5/30/2014 8:53 am
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Cost Center Description		OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	9.00	10.00	11.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	1,226,447				7.00
9.00	00900	HOUSEKEEPING	11,527	51,647			9.00
10.00	01000	DIETARY	18,574	820	72,202		10.00
11.00	01100	CAFETERIA	34,101	1,350	0	135,746	11.00
13.00	01300	NURSING ADMINISTRATION	4,904	0	0	3,245	27,703
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,049	0	538	136
15.00	01500	PHARMACY	26,436	1,494	0	4,429	1,123
16.00	01600	MEDICAL RECORDS & LIBRARY	15,746	1,797	0	4,106	0
23.00	02300	PARAMED PRGM	6,014	2,070	0	298	76
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	137,571	13,737	21,712	12,269	3,112
31.00	03100	INTENSIVE CARE UNIT	106,719	2,832	29,492	15,980	4,055
40.00	04000	SUBPROVIDER - I/PF	28,530	2,266	14,970	5,931	1,504
41.00	04100	SUBPROVIDER - I/RF	19,643	785	6,028	3,092	784
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	105,484	5,499	0	2,400	609
51.00	05100	RECOVERY ROOM	9,486	2,025	0	939	238
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	66,090	2,013	0	11,922	3,024
60.00	06000	LABORATORY	28,431	1,921	0	10,530	2,671
65.00	06500	RESPIRATORY THERAPY	10,345	1,471	0	10,315	2,617
66.00	06600	PHYSICAL THERAPY	19,451	1,710	0	4,292	1,089
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,431	0
68.00	06800	SPEECH PATHOLOGY	2,246	0	0	599	0
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	31,107	3,334	0	2,253	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03020	CARDIAC	0	0	0	0	0
76.01	03022	CARDIAC REHABILITATION	0	0	0	394	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
90.00	09000	CLINIC	0	0	0	0	0
90.01	09001	WOUND CLINIC	12,954	0	0	1,765	0
90.02	09002	DIABETES CLINIC	0	0	0	169	0
90.03	09003	ASTHMA CLINIC	0	0	0	0	0
90.04	09004	ANDIS CLINIC	1,472	0	0	263	0
90.05	09005	PRIME TIME	0	0	0	0	0
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0
90.07	04951	ONCOLOGY	0	0	0	466	0
90.08	04950	ANDERSON WOMENS CENTER	7,652	0	0	1,150	0
91.00	09100	EMERGENCY	121,158	2,945	0	10,520	2,668
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	HOME HEALTH AGENCY	0	1,529	0	8,521	2,161
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600	HOSPICE	41,345	0	0	6,130	1,555
118.00		SUBTOTALS (SUM OF LINES 1-117)	866,986	51,647	72,202	123,947	27,422
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
190.01	19001	PROFESSIONAL BUILDING	253,512	0	0	0	0
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	0
190.03	19003	PRIVATE DUTY	0	0	0	1,110	281
190.04	19004	MARKETING	1,973	0	0	857	0
190.05	19005	WATER LAB	0	0	0	0	0
190.06	19006	FOUNDATION	0	0	0	427	0
190.07	19007	ASC	103,976	0	0	0	0
190.09	19009	HANCOCK OB	0	0	0	1,428	0
190.10	19010	HANCOCK WELLNESS	0	0	0	7,836	0
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0
190.12	19012	O3PUREMED	0	0	0	141	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,226,447	51,647	72,202	135,746	27,703

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 5/30/2014 8:53 am	
Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED PRGM	Subtotal
	14.00	15.00	16.00	23.00	24.00
<b>GENERAL SERVICE COST CENTERS</b>					
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT				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	3,104			14.00
15.00 01500	PHARMACY	23	127,579		15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	69,463	16.00
23.00 02300	PARAMED PRGM	0	0	0	23.00
23.00 02300	PARAMED PRGM	0	0	25,001	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00 03000	ADULTS & PEDIATRICS	63	0	16,039	30.00
31.00 03100	INTENSIVE CARE UNIT	116	0	2,003	31.00
40.00 04000	SUBPROVIDER - I PF	8	0	1,651	40.00
41.00 04100	SUBPROVIDER - I RF	4	0	9,820	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000	OPERATING ROOM	86	0	21,081	50.00
51.00 05100	RECOVERY ROOM	4	0	0	51.00
53.00 05300	ANESTHESIOLOGY	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	27	0	2,407	54.00
60.00 06000	LABORATORY	614	0	5,341	60.00
65.00 06500	RESPIRATORY THERAPY	12	0	0	65.00
66.00 06600	PHYSICAL THERAPY	2	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	3	0	0	68.00
68.01 06801	OCCUPATIONAL HEALTH	0	0	0	68.01
69.00 06900	ELECTROCARDIOLOGY	16	0	2,741	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,957	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	127,579	123	73.00
76.00 03020	CARDIAC	0	0	0	76.00
76.01 03022	CARDIAC REHABILITATION	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 08800	RURAL HEALTH CLINIC	1	0	0	88.00
90.00 09000	CLINIC	0	0	0	90.00
90.01 09001	WOUND CLINIC	12	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	ANDI'S CLINIC	0	0	0	90.04
90.05 09005	PRIME TIME	0	0	0	90.05
90.06 09006	SHELBYVILLE WOUND CLINIC	2	0	0	90.06
90.07 04951	ONCOLOGY	3	0	0	90.07
90.08 04950	ANDERSON WOMENS CENTER	1	0	0	90.08
91.00 09100	EMERGENCY	83	0	8,239	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
101.00 10100	HOME HEALTH AGENCY	8	0	18	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
116.00 11600	HOSPICE	58	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	3,103	127,579	69,463	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
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	1	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
190.09 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			25,001	200.00
201.00	Negative Cost Centers	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	3,104	127,579	69,463	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 5/30/2014 8:53 am
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	0	600,270
31.00	03100	INTENSIVE CARE UNIT	0	476,430
40.00	04000	SUBPROVIDER - I PF	0	140,950
41.00	04100	SUBPROVIDER - IRF	0	97,401
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	0	441,971
51.00	05100	RECOVERY ROOM	0	40,473
53.00	05300	ANESTHESIOLOGY	0	54
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	287,276
60.00	06000	LABORATORY	0	147,973
65.00	06500	RESPIRATORY THERAPY	0	61,004
66.00	06600	PHYSICAL THERAPY	0	86,961
67.00	06700	OCCUPATIONAL THERAPY	0	3,411
68.00	06800	SPEECH PATHOLOGY	0	10,084
68.01	06801	OCCUPATIONAL HEALTH	0	0
69.00	06900	ELECTROCARDIOLOGY	0	129,333
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	20,038
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	8,790
73.00	07300	DRUGS CHARGED TO PATIENTS	0	127,702
76.00	03020	CARDIAC	0	0
76.01	03022	CARDIAC REHABILITATION	0	898
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800	RURAL HEALTH CLINIC	0	1,448
90.00	09000	CLINIC	0	0
90.01	09001	WOUND CLINIC	0	54,039
90.02	09002	DIABETES CLINIC	0	2,724
90.03	09003	ASTHMA CLINIC	0	0
90.04	09004	ANDIS CLINIC	0	6,398
90.05	09005	PRIME TIME	0	608
90.06	09006	SHELBYVILLE WOUND CLINIC	0	952
90.07	04951	ONCOLOGY	0	1,902
90.08	04950	ANDERSON WOMENS CENTER	0	31,360
91.00	09100	EMERGENCY	0	493,728
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	
<b>OTHER REIMBURSABLE COST CENTERS</b>				
101.00	10100	HOME HEALTH AGENCY	0	26,212
<b>SPECIAL PURPOSE COST CENTERS</b>				
116.00	11600	HOSPICE	0	176,546
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,476,936
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0
190.01	19001	PROFESSIONAL BUILDING	0	946,742
190.02	19002	PHYSICIAN BUILDING	0	420
190.03	19003	PRIVATE DUTY	0	3,555
190.04	19004	MARKETING	0	11,294
190.05	19005	WATER LAB	0	0
190.06	19006	FOUNDATION	0	1,100
190.07	19007	ASC	0	387,164
190.09	19009	HANCOCK OB	0	17,937
190.10	19010	HANCOCK WELLNESS	0	18,244
190.11	19011	MORRISTOWN CLINIC	0	0
190.12	19012	O3PUREMED	0	175
200.00		Cross Foot Adjustments	0	25,001
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	4,888,568

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet B-1  
Date/Time Prepared:  
5/30/2014 8:53 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)						
	1.00		4.00	5A	5.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	403,242					1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,309	37,619,055				4.00
5.00 00500	ADMINISTRATIVE & GENERAL	29,097	6,157,316	-14,583,710	67,893,090		5.00
7.00 00700	OPERATION OF PLANT	98,551	828,110	0	5,991,290	274,092	7.00
9.00 00900	HOUSEKEEPING	2,576	826,510	0	1,632,067	2,576	9.00
10.00 01000	DIETARY	4,151	377,260	0	444,492	4,151	10.00
11.00 01100	CAFETERIA	7,621	692,799	0	1,454,338	7,621	11.00
13.00 01300	NURSING ADMINISTRATION	1,096	883,631	0	1,126,051	1,096	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	53,302	0	68,681	0	14.00
15.00 01500	PHARMACY	5,908	1,131,676	0	4,197,932	5,908	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	3,519	589,994	0	937,015	3,519	16.00
23.00 02300	PARAMED ED PRGM	1,344	66,504	0	42,129	1,344	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	30,745	2,719,757	0	4,182,721	30,745	30.00
31.00 03100	INTENSIVE CARE UNIT	23,850	3,164,259	0	4,730,806	23,850	31.00
40.00 04000	SUBPROVIDER - I PF	6,376	1,141,214	0	1,587,930	6,376	40.00
41.00 04100	SUBPROVIDER - I RF	4,390	522,695	0	726,631	4,390	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	23,574	2,355,100	0	3,826,422	23,574	50.00
51.00 05100	RECOVERY ROOM	2,120	252,933	0	376,950	2,120	51.00
53.00 05300	ANESTHESIOLOGY	0	0	0	10,278	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	14,770	2,348,417	0	4,154,122	14,770	54.00
60.00 06000	LABORATORY	6,354	1,621,439	0	3,964,493	6,354	60.00
65.00 06500	RESPIRATORY THERAPY	2,312	1,105,093	0	1,480,448	2,312	65.00
66.00 06600	PHYSICAL THERAPY	4,347	955,251	0	1,397,636	4,347	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	279,632	0	355,788	0	67.00
68.00 06800	SPEECH PATHOLOGY	502	149,789	0	207,635	502	68.00
68.01 06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00 06900	ELECTROCARDIOLOGY	6,952	456,969	0	1,033,459	6,952	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,454,495	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,679,481	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	48,426	0	92,454	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800	RURAL HEALTH CLINIC	0	165,839	0	263,007	0	88.00
90.00 09000	CLINIC	0	0	0	0	0	90.00
90.01 09001	WOUND CLINIC	2,895	470,219	0	766,775	2,895	90.01
90.02 09002	DIABETES CLINIC	193	27,221	0	38,909	0	90.02
90.03 09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04 09004	ANDI S CLINIC	329	45,089	0	125,113	329	90.04
90.05 09005	PRIME TIME	0	0	0	116,104	0	90.05
90.06 09006	SHELBYVILLE WOUND CLINIC	0	105,863	0	172,884	0	90.06
90.07 04951	ONCOLOGY	0	140,809	0	262,562	0	90.07
90.08 04950	ANDERSON WOMENS CENTER	1,710	208,544	0	332,119	1,710	90.08
91.00 09100	EMERGENCY	27,077	2,376,691	0	3,602,086	27,077	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00 10100	HOME HEALTH AGENCY	0	1,734,706	0	2,530,186	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00 11600	HOSPICE	9,240	1,238,107	0	2,850,221	9,240	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	322,908	35,241,164	-14,583,710	60,215,710	193,758	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01 19001	PROFESSIONAL BUILDING	56,656	0	0	1,218,910	56,656	190.01
190.02 19002	PHYSICIAN BUILDING	0	0	0	80,252	0	190.02
190.03 19003	PRIVATE DUTY	0	151,024	0	401,034	0	190.03
190.04 19004	MARKETING	441	92,473	0	588,308	441	190.04
190.05 19005	WATER LAB	0	0	0	0	0	190.05
190.06 19006	FOUNDATION	0	95,961	0	120,879	0	190.06
190.07 19007	ASC	23,237	0	0	283,116	23,237	190.07
190.09 19009	HANCOCK OB	0	1,060,168	0	3,068,760	0	190.09
190.10 19010	HANCOCK WELLNESS	0	897,907	0	1,916,121	0	190.10
190.11 19011	MORRISTOWN CLINIC	0	0	241	0	0	190.11
190.12 19012	O3PUREMED	0	80,358	1,744	0	0	190.12
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet B-1

Date/Time Prepared:  
5/30/2014 8:53 am

Cost Center Description	1.00	4.00	5A	5.00	7.00	
	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
202.00 Cost to be allocated (per Wkst. B, Part I)	4,888,568	6,511,038		14,583,710	7,278,247	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	12.123162	0.173078		0.214804	26.554029	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)		15,869		355,343	1,226,447	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)		0.000422		0.005234	4.474582	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet B-1

Date/Time Prepared:  
5/30/2014 8:53 am

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	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
9.00	00900	412,334					9.00
10.00	01000	6,543	12,241				10.00
11.00	01100	10,782	0	854,230			11.00
13.00	01300	0	0	20,422	687,279		13.00
14.00	01400	16,355	0	3,384	3,384	5,486,265	14.00
15.00	01500	11,930	0	27,872	27,872	41,349	15.00
16.00	01600	14,350	0	25,841	0	0	16.00
23.00	02300	16,530	0	1,875	1,875	6	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	109,670	3,681	77,205	77,205	111,651	30.00
31.00	03100	22,610	5,000	100,561	100,561	204,490	31.00
40.00	04000	18,095	2,538	37,321	37,321	13,963	40.00
41.00	04100	6,264	1,022	19,459	19,459	6,251	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	43,900	0	15,104	15,104	151,633	50.00
51.00	05100	16,165	0	5,912	5,912	6,755	51.00
53.00	05300	0	0	0	0	22	53.00
54.00	05400	16,070	0	75,021	75,021	48,572	54.00
60.00	06000	15,335	0	66,265	66,265	1,085,090	60.00
65.00	06500	11,745	0	64,914	64,914	20,653	65.00
66.00	06600	13,650	0	27,007	27,007	4,242	66.00
67.00	06700	0	0	9,006	0	610	67.00
68.00	06800	0	0	3,771	0	5,700	68.00
68.01	06801	0	0	0	0	0	68.01
69.00	06900	26,615	0	14,178	0	28,917	69.00
71.00	07100	0	0	0	0	3,454,266	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03020	0	0	0	0	0	76.00
76.01	03022	0	0	2,478	0	811	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	2,367	88.00
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	11,104	0	20,616	90.01
90.02	09002	0	0	1,063	0	0	90.02
90.03	09003	0	0	0	0	0	90.03
90.04	09004	0	0	1,653	0	185	90.04
90.05	09005	0	0	0	0	540	90.05
90.06	09006	0	0	0	0	4,198	90.06
90.07	04951	0	0	2,935	0	4,981	90.07
90.08	04950	0	0	7,235	0	1,939	90.08
91.00	09100	23,515	0	66,200	66,200	146,775	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	12,210	0	53,621	53,621	14,953	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600	0	0	38,576	38,576	102,100	116.00
118.00		412,334	12,241	779,983	680,297	5,483,635	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	0	0	0	0	0	190.01
190.02	19002	0	0	0	0	0	190.02
190.03	19003	0	0	6,982	6,982	2,630	190.03
190.04	19004	0	0	5,395	0	0	190.04
190.05	19005	0	0	0	0	0	190.05
190.06	19006	0	0	2,687	0	0	190.06
190.07	19007	0	0	0	0	0	190.07
190.09	19009	0	0	8,984	0	0	190.09
190.10	19010	0	0	49,314	0	0	190.10
190.11	19011	0	0	0	0	0	190.11
190.12	19012	0	0	885	0	0	190.12
200.00							200.00
201.00							201.00
202.00		2,051,045	682,743	2,022,736	1,445,391	179,918	202.00
203.00		4.974232	55.775100	2.367906	2.103063	0.032794	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet B-1

Date/Time Prepared:  
5/30/2014 8:53 am

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)	51,647	72,202	135,746	27,703	3,104	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.125255	5.898374	0.158910	0.040308	0.000566	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet B-1  
Date/Time Prepared:  
5/30/2014 8:53 am

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				1.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500	100			15.00
16.00	01600	0	3,954		16.00
23.00	02300	0	0	100	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	0	913	0	30.00
31.00	03100	0	114	0	31.00
40.00	04000	0	94	0	40.00
41.00	04100	0	559	0	41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	0	1,200	0	50.00
51.00	05100	0	0	0	51.00
53.00	05300	0	0	0	53.00
54.00	05400	0	137	100	54.00
60.00	06000	0	304	0	60.00
65.00	06500	0	0	0	65.00
66.00	06600	0	0	0	66.00
67.00	06700	0	0	0	67.00
68.00	06800	0	0	0	68.00
68.01	06801	0	0	0	68.01
69.00	06900	0	156	0	69.00
71.00	07100	0	0	0	71.00
72.00	07200	0	0	0	72.00
73.00	07300	100	7	0	73.00
76.00	03020	0	0	0	76.00
76.01	03022	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	0	0	0	88.00
90.00	09000	0	0	0	90.00
90.01	09001	0	0	0	90.01
90.02	09002	0	0	0	90.02
90.03	09003	0	0	0	90.03
90.04	09004	0	0	0	90.04
90.05	09005	0	0	0	90.05
90.06	09006	0	0	0	90.06
90.07	04951	0	0	0	90.07
90.08	04950	0	0	0	90.08
91.00	09100	0	469	0	91.00
92.00	09200	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	0	1	0	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	0	0	0	116.00
118.00		100	3,954	100	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	0	0	0	190.00
190.01	19001	0	0	0	190.01
190.02	19002	0	0	0	190.02
190.03	19003	0	0	0	190.03
190.04	19004	0	0	0	190.04
190.05	19005	0	0	0	190.05
190.06	19006	0	0	0	190.06
190.07	19007	0	0	0	190.07
190.09	19009	0	0	0	190.09
190.10	19010	0	0	0	190.10
190.11	19011	0	0	0	190.11
190.12	19012	0	0	0	190.12
200.00					200.00
201.00					201.00
202.00		5,441,860	1,364,303	177,474	202.00
203.00		54,418.600000	345.043753	1,774.740000	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet B-1

Date/Time Prepared:  
5/30/2014 8:53 am

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)	127,579	69,463	25,001	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1,275.790000	17.567779	250.010000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet C  
Part I  
Date/Time Prepared:  
5/30/2014 8:53 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	Hospital			
					RCE Disallowance	Total Costs		PPS
		1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	7,312,290		7,312,290	0	7,312,290	30.00
31.00	03100	INTENSIVE CARE UNIT	7,267,306		7,267,306	0	7,267,306	31.00
40.00	04000	SUBPROVIDER - I/PF	2,529,651		2,529,651	0	2,529,651	40.00
41.00	04100	SUBPROVIDER - I/RF	1,367,532		1,367,532	0	1,367,532	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	5,979,263		5,979,263	0	5,979,263	50.00
51.00	05100	RECOVERY ROOM	621,277		621,277	0	621,277	51.00
53.00	05300	ANESTHESIOLOGY	12,487		12,487	0	12,487	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,080,338		6,080,338	0	6,080,338	54.00
60.00	06000	LABORATORY	5,497,831		5,497,831	0	5,497,831	60.00
65.00	06500	RESPIRATORY THERAPY	2,209,174	0	2,209,174	0	2,209,174	65.00
66.00	06600	PHYSICAL THERAPY	2,002,068	0	2,002,068	0	2,002,068	66.00
67.00	06700	OCCUPATIONAL THERAPY	453,558	0	453,558	0	453,558	67.00
68.00	06800	SPEECH PATHOLOGY	274,682	0	274,682	0	274,682	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	1,660,790		1,660,790	0	1,660,790	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,309,815		4,309,815	0	4,309,815	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,040,240		2,040,240	0	2,040,240	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,444,275		5,444,275	0	5,444,275	73.00
76.00	03020	CARDIAC	0		0	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	118,208		118,208	0	118,208	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	319,580		319,580	0	319,580	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CLINIC	1,035,324		1,035,324	0	1,035,324	90.01
90.02	09002	DIABETES CLINIC	49,784		49,784	0	49,784	90.02
90.03	09003	ASTHMA CLINIC	0		0	0	0	90.03
90.04	09004	ANDIS CLINIC	164,644		164,644	0	164,644	90.04
90.05	09005	PRIME TIME	141,062		141,062	0	141,062	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	210,158		210,158	0	210,158	90.06
90.07	04951	ONCOLOGY	326,074		326,074	0	326,074	90.07
90.08	04950	ANDERSON WOMENS CENTER	466,062		466,062	0	466,062	90.08
91.00	09100	EMERGENCY	5,674,417		5,674,417	0	5,674,417	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,857,531		2,857,531	0	2,857,531	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	3,374,987		3,374,987		3,374,987	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
116.00	11600	HOSPICE	3,883,639		3,883,639		3,883,639	116.00
200.00		Subtotal (see instructions)	73,684,047	0	73,684,047	0	73,684,047	200.00
201.00		Less Observation Beds	2,857,531		2,857,531		2,857,531	201.00
202.00		Total (see instructions)	70,826,516	0	70,826,516	0	70,826,516	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet C  
Part I  
Date/Time Prepared:  
5/30/2014 8:53 am

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
		9.00			10.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	5,304,740		5,304,740		30.00
31.00	03100	INTENSIVE CARE UNIT	6,938,898		6,938,898		31.00
40.00	04000	SUBPROVIDER - I/PF	2,959,066		2,959,066		40.00
41.00	04100	SUBPROVIDER - I/RF	1,184,861		1,184,861		41.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	6,036,098	10,023,051	16,059,149	0.372328	50.00
51.00	05100	RECOVERY ROOM	926,419	1,054,231	1,980,650	0.313673	51.00
53.00	05300	ANESTHESIOLOGY	12,495	1,544	14,039	0.889451	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,582,682	37,704,574	42,287,256	0.143787	54.00
60.00	06000	LABORATORY	6,222,511	27,336,381	33,558,892	0.163826	60.00
65.00	06500	RESPIRATORY THERAPY	2,672,293	3,993,480	6,665,773	0.331421	65.00
66.00	06600	PHYSICAL THERAPY	1,217,938	2,813,505	4,031,443	0.496613	66.00
67.00	06700	OCCUPATIONAL THERAPY	861,193	446,292	1,307,485	0.346893	67.00
68.00	06800	SPEECH PATHOLOGY	177,143	406,612	583,755	0.470543	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	3,584,814	7,688,006	11,272,820	0.147327	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,570,114	3,128,358	5,698,472	0.756311	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,058,870	991,505	6,050,375	0.337209	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,226,133	11,515,582	20,741,715	0.262480	73.00
76.00	03020	CARDIAC	0	0	0	0.000000	76.00
76.01	03022	CARDIAC REHABILITATION	0	222,640	222,640	0.530938	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	372,147	372,147		88.00
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.01	09001	WOUND CLINIC	11,566	4,640,352	4,651,918	0.222559	90.01
90.02	09002	DIABETES CLINIC	0	8,067	8,067	6.171315	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0.000000	90.03
90.04	09004	ANDIS CLINIC	0	54,642	54,642	3.013140	90.04
90.05	09005	PRIME TIME	100	241,084	241,184	0.584873	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	418,284	418,284	0.502429	90.06
90.07	04951	ONCOLOGY	0	249,037	249,037	1.309340	90.07
90.08	04950	ANDERSON WOMENS CENTER	10,000	2,588,385	2,598,385	0.179366	90.08
91.00	09100	EMERGENCY	2,358,966	16,386,559	18,745,525	0.302708	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,000	2,253,655	2,255,655	1.266830	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	HOME HEALTH AGENCY	0	2,665,090	2,665,090		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600	HOSPICE	656,403	1,424,578	2,080,981		116.00
200.00		Subtotal (see instructions)	62,575,303	138,627,641	201,202,944		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	62,575,303	138,627,641	201,202,944		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/30/2014 8:53 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.372328		50.00
51.00	05100 RECOVERY ROOM	0.313673		51.00
53.00	05300 ANESTHESIOLOGY	0.889451		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.143787		54.00
60.00	06000 LABORATORY	0.163826		60.00
65.00	06500 RESPIRATORY THERAPY	0.331421		65.00
66.00	06600 PHYSICAL THERAPY	0.496613		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.346893		67.00
68.00	06800 SPEECH PATHOLOGY	0.470543		68.00
68.01	06801 OCCUPATIONAL HEALTH	0.000000		68.01
69.00	06900 ELECTROCARDIOLOGY	0.147327		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.756311		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.337209		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.262480		73.00
76.00	03020 CARDIAC	0.000000		76.00
76.01	03022 CARDIAC REHABILITATION	0.530938		76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC			88.00
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 WOUND CLINIC	0.222559		90.01
90.02	09002 DIABETES CLINIC	6.171315		90.02
90.03	09003 ASTHMA CLINIC	0.000000		90.03
90.04	09004 ANDIS CLINIC	3.013140		90.04
90.05	09005 PRIME TIME	0.584873		90.05
90.06	09006 SHELBYVILLE WOUND CLINIC	0.502429		90.06
90.07	04951 ONCOLOGY	1.309340		90.07
90.08	04950 ANDERSON WOMENS CENTER	0.179366		90.08
91.00	09100 EMERGENCY	0.302708		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.266830		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
101.00	10100 HOME HEALTH AGENCY			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet C  
Part I  
Date/Time Prepared:  
5/30/2014 8:53 am

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS		7,312,290	0	7,312,290	30.00	
31.00	03100 INTENSIVE CARE UNIT		7,267,306	0	7,267,306	31.00	
40.00	04000 SUBPROVIDER - I/PF		2,529,651	0	2,529,651	40.00	
41.00	04100 SUBPROVIDER - I/RF		1,367,532	0	1,367,532	41.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM		5,979,263	0	5,979,263	50.00	
51.00	05100 RECOVERY ROOM		621,277	0	621,277	51.00	
53.00	05300 ANESTHESIOLOGY		12,487	0	12,487	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		6,080,338	0	6,080,338	54.00	
60.00	06000 LABORATORY		5,497,831	0	5,497,831	60.00	
65.00	06500 RESPIRATORY THERAPY	0	2,209,174	0	2,209,174	65.00	
66.00	06600 PHYSICAL THERAPY	0	2,002,068	0	2,002,068	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	453,558	0	453,558	67.00	
68.00	06800 SPEECH PATHOLOGY	0	274,682	0	274,682	68.00	
68.01	06801 OCCUPATIONAL HEALTH	0	0	0	0	68.01	
69.00	06900 ELECTROCARDIOLOGY		1,660,790	0	1,660,790	69.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		4,309,815	0	4,309,815	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		2,040,240	0	2,040,240	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		5,444,275	0	5,444,275	73.00	
76.00	03020 CARDIAC		0	0	0	76.00	
76.01	03022 CARDIAC REHABILITATION		118,208	0	118,208	76.01	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC		319,580	0	319,580	88.00	
90.00	09000 CLINIC		0	0	0	90.00	
90.01	09001 WOUND CLINIC		1,035,324	0	1,035,324	90.01	
90.02	09002 DIABETES CLINIC		49,784	0	49,784	90.02	
90.03	09003 ASTHMA CLINIC		0	0	0	90.03	
90.04	09004 ANDIS CLINIC		164,644	0	164,644	90.04	
90.05	09005 PRIME TIME		141,062	0	141,062	90.05	
90.06	09006 SHELBYVILLE WOUND CLINIC		210,158	0	210,158	90.06	
90.07	04951 ONCOLOGY		326,074	0	326,074	90.07	
90.08	04950 ANDERSON WOMENS CENTER		466,062	0	466,062	90.08	
91.00	09100 EMERGENCY		5,674,417	0	5,674,417	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		2,857,531	0	2,857,531	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100 HOME HEALTH AGENCY		3,374,987		3,374,987	101.00	
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600 HOSPICE		3,883,639		3,883,639	116.00	
200.00	Subtotal (see instructions)		73,684,047	0	73,684,047	200.00	
201.00	Less Observation Beds		2,857,531		2,857,531	201.00	
202.00	Total (see instructions)		70,826,516	0	70,826,516	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet C  
Part I  
Date/Time Prepared:  
5/30/2014 8:53 am

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
		Hospital			Cost		
		9.00	10.00				
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	5,304,740		5,304,740		30.00
31.00	03100	INTENSIVE CARE UNIT	6,938,898		6,938,898		31.00
40.00	04000	SUBPROVIDER - I/PF	2,959,066		2,959,066		40.00
41.00	04100	SUBPROVIDER - I/RF	1,184,861		1,184,861		41.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	6,036,098	10,023,051	16,059,149	0.372328	50.00
51.00	05100	RECOVERY ROOM	926,419	1,054,231	1,980,650	0.313673	51.00
53.00	05300	ANESTHESIOLOGY	12,495	1,544	14,039	0.889451	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,582,682	37,704,574	42,287,256	0.143787	54.00
60.00	06000	LABORATORY	6,222,511	27,336,381	33,558,892	0.163826	60.00
65.00	06500	RESPIRATORY THERAPY	2,672,293	3,993,480	6,665,773	0.331421	65.00
66.00	06600	PHYSICAL THERAPY	1,217,938	2,813,505	4,031,443	0.496613	66.00
67.00	06700	OCCUPATIONAL THERAPY	861,193	446,292	1,307,485	0.346893	67.00
68.00	06800	SPEECH PATHOLOGY	177,143	406,612	583,755	0.470543	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	3,584,814	7,688,006	11,272,820	0.147327	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,570,114	3,128,358	5,698,472	0.756311	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,058,870	991,505	6,050,375	0.337209	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,226,133	11,515,582	20,741,715	0.262480	73.00
76.00	03020	CARDIAC	0	0	0	0.000000	76.00
76.01	03022	CARDIAC REHABILITATION	0	222,640	222,640	0.530938	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	372,147	372,147	0.858747	88.00
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.01	09001	WOUND CLINIC	11,566	4,640,352	4,651,918	0.222559	90.01
90.02	09002	DIABETES CLINIC	0	8,067	8,067	6.171315	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0.000000	90.03
90.04	09004	ANDIS CLINIC	0	54,642	54,642	3.013140	90.04
90.05	09005	PRIME TIME	100	241,084	241,184	0.584873	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	418,284	418,284	0.502429	90.06
90.07	04951	ONCOLOGY	0	249,037	249,037	1.309340	90.07
90.08	04950	ANDERSON WOMENS CENTER	10,000	2,588,385	2,598,385	0.179366	90.08
91.00	09100	EMERGENCY	2,358,966	16,386,559	18,745,525	0.302708	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,000	2,253,655	2,255,655	1.266830	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	HOME HEALTH AGENCY	0	2,665,090	2,665,090		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600	HOSPICE	656,403	1,424,578	2,080,981		116.00
200.00		Subtotal (see instructions)	62,575,303	138,627,641	201,202,944		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	62,575,303	138,627,641	201,202,944		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet C  
Part I  
Date/Time Prepared:  
5/30/2014 8:53 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVIDER - IPF				40.00
41.00	04100 SUBPROVIDER - IRF				41.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
68.01	06801 OCCUPATIONAL HEALTH	0.000000			68.01
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03020 CARDIAC	0.000000			76.00
76.01	03022 CARDIAC REHABILITATION	0.000000			76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0.000000			88.00
90.00	09000 CLINIC	0.000000			90.00
90.01	09001 WOUND CLINIC	0.000000			90.01
90.02	09002 DIABETES CLINIC	0.000000			90.02
90.03	09003 ASTHMA CLINIC	0.000000			90.03
90.04	09004 ANDIS CLINIC	0.000000			90.04
90.05	09005 PRIME TIME	0.000000			90.05
90.06	09006 SHELBYVILLE WOUND CLINIC	0.000000			90.06
90.07	04951 ONCOLOGY	0.000000			90.07
90.08	04950 ANDERSON WOMENS CENTER	0.000000			90.08
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
101.00	10100 HOME HEALTH AGENCY				101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
116.00	11600 HOSPICE				116.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150037		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part I Date/Time Prepared: 5/30/2014 8:53 am		
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	600,270	0	600,270	5,860	102.44	30.00	
31.00	INTENSIVE CARE UNIT	476,430	0	476,430	4,983	95.61	31.00	
40.00	SUBPROVIDER - IPF	140,950	0	140,950	2,538	55.54	40.00	
41.00	SUBPROVIDER - IRF	97,401	0	97,401	1,022	95.30	41.00	
200.00	Total (lines 30-199)	1,315,051		1,315,051	14,403		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	1,486	152,226					30.00
31.00	INTENSIVE CARE UNIT	2,546	243,423					31.00
40.00	SUBPROVIDER - IPF	2,395	133,018					40.00
41.00	SUBPROVIDER - IRF	712	67,854					41.00
200.00	Total (lines 30-199)	7,139	596,521					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/30/2014 8:53 am
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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	441,971	16,059,149	0.027521	2,593,627	71,379	50.00
51.00	05100 RECOVERY ROOM	40,473	1,980,650	0.020434	367,124	7,502	51.00
53.00	05300 ANESTHESIOLOGY	54	14,039	0.003846	1,696	7	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	287,276	42,287,256	0.006793	2,630,538	17,869	54.00
60.00	06000 LABORATORY	147,973	33,558,892	0.004409	3,396,977	14,977	60.00
65.00	06500 RESPIRATORY THERAPY	61,004	6,665,773	0.009152	1,516,965	13,883	65.00
66.00	06600 PHYSICAL THERAPY	86,961	4,031,443	0.021571	432,596	9,332	66.00
67.00	06700 OCCUPATIONAL THERAPY	3,411	1,307,485	0.002609	227,623	594	67.00
68.00	06800 SPEECH PATHOLOGY	10,084	583,755	0.017274	92,131	1,591	68.00
68.01	06801 OCCUPATIONAL HEALTH	0	0	0.000000	0	0	68.01
69.00	06900 ELECTROCARDIOLOGY	129,333	11,272,820	0.011473	1,608,783	18,458	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	20,038	5,698,472	0.003516	1,100,127	3,868	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	8,790	6,050,375	0.001453	2,287,562	3,324	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	127,702	20,741,715	0.006157	4,692,019	28,889	73.00
76.00	03020 CARDIAC	0	0	0.000000	0	0	76.00
76.01	03022 CARDIAC REHABILITATION	898	222,640	0.004033	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	1,448	372,147	0.003891	0	0	88.00
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
90.01	09001 WOUND CLINIC	54,039	4,651,918	0.011616	4,683	54	90.01
90.02	09002 DIABETES CLINIC	2,724	8,067	0.337672	0	0	90.02
90.03	09003 ASTHMA CLINIC	0	0	0.000000	0	0	90.03
90.04	09004 ANDIS CLINIC	6,398	54,642	0.117089	0	0	90.04
90.05	09005 PRIME TIME	608	241,184	0.002521	46	0	90.05
90.06	09006 SHELBYVILLE WOUND CLINIC	952	418,284	0.002276	0	0	90.06
90.07	04951 ONCOLOGY	1,902	249,037	0.007637	0	0	90.07
90.08	04950 ANDERSON WOMENS CENTER	31,360	2,598,385	0.012069	7,876	95	90.08
91.00	09100 EMERGENCY	493,728	18,745,525	0.026338	1,524,165	40,143	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	234,578	2,255,655	0.103996	1,479	154	92.00
200.00	Total (lines 50-199)	2,193,705	180,069,308		22,486,017	232,119	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part III Date/Time Prepared: 5/30/2014 8:53 am
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Cost Center Description			Title XVIII			Hospital		PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	41.00
200.00		Total (lines 30-199)	0	0	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	5,860	0.00	1,486	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,983	0.00	2,546	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	2,538	0.00	2,395	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	1,022	0.00	712	0	0	0	41.00
200.00		Total (lines 30-199)	14,403		7,139	0	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 01/01/2013  
To 12/31/2013

Worksheet D  
Part IV  
Date/Time Prepared:  
5/30/2014 8:53 am

Cost Center Description		Title XVIII				Hospital	PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	177,474	0	177,474 54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	0	0	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	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	90.06
90.07	04951	ONCOLOGY	0	0	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	0	90.08
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	177,474	0	177,474 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet D  
Part IV  
Date/Time Prepared:  
5/30/2014 8:53 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Title XVIII		Hospital		Inpatient Program Charges	
			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)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	16,059,149	0.000000	0.000000	2,593,627	50.00
51.00	05100	RECOVERY ROOM	0	1,980,650	0.000000	0.000000	367,124	51.00
53.00	05300	ANESTHESIOLOGY	0	14,039	0.000000	0.000000	1,696	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	177,474	42,287,256	0.004197	0.004197	2,630,538	54.00
60.00	06000	LABORATORY	0	33,558,892	0.000000	0.000000	3,396,977	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,665,773	0.000000	0.000000	1,516,965	65.00
66.00	06600	PHYSICAL THERAPY	0	4,031,443	0.000000	0.000000	432,596	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,307,485	0.000000	0.000000	227,623	67.00
68.00	06800	SPEECH PATHOLOGY	0	583,755	0.000000	0.000000	92,131	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0.000000	0.000000	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	11,272,820	0.000000	0.000000	1,608,783	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,698,472	0.000000	0.000000	1,100,127	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	6,050,375	0.000000	0.000000	2,287,562	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,741,715	0.000000	0.000000	4,692,019	73.00
76.00	03020	CARDIAC	0	0	0.000000	0.000000	0	76.00
76.01	03022	CARDIAC REHABILITATION	0	222,640	0.000000	0.000000	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	372,147	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	4,651,918	0.000000	0.000000	4,683	90.01
90.02	09002	DIABETES CLINIC	0	8,067	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	54,642	0.000000	0.000000	0	90.04
90.05	09005	PRIME TIME	0	241,184	0.000000	0.000000	46	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	418,284	0.000000	0.000000	0	90.06
90.07	04951	ONCOLOGY	0	249,037	0.000000	0.000000	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	2,598,385	0.000000	0.000000	7,876	90.08
91.00	09100	EMERGENCY	0	18,745,525	0.000000	0.000000	1,524,165	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,255,655	0.000000	0.000000	1,479	92.00
200.00		Total (lines 50-199)	177,474	180,069,308			22,486,017	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet D  
Part IV  
Date/Time Prepared:  
5/30/2014 8:53 am

Cost Center Description		Title XVIII			Hospital	PPS		
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	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	2,346,730	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	273,881	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	884	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,040	10,562,637	44,331	0	0	54.00
60.00	06000	LABORATORY	0	828,689	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,289,739	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	6,498	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,941	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	50,873	0	0	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	3,291,828	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	970,965	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	411,119	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,853,342	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	0	108,020	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	2,143,337	0	0	0	90.01
90.02	09002	DIABETES CLINIC	0	115	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	2,203	0	0	0	90.04
90.05	09005	PRIME TIME	0	16,869	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	226,708	0	0	0	90.06
90.07	04951	ONCOLOGY	0	80,592	0	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	476	0	0	0	90.08
91.00	09100	EMERGENCY	0	3,460,614	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	960,343	0	0	0	92.00
200.00		Total (lines 50-199)	11,040	30,890,403	44,331	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/30/2014 8:53 am
Title XVIII		Hospital	PPS

Cost Center Description		PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	
		23.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
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
<b>OUTPATIENT SERVICE COST CENTERS</b>				
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 ANDI'S CLINIC	0	0	90.04
90.05	09005 PRIME TIME	0	0	90.05
90.06	09006 SHELBYVILLE WOUND CLINIC	0	0	90.06
90.07	04951 ONCOLOGY	0	0	90.07
90.08	04950 ANDERSON WOMENS CENTER	0	0	90.08
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 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/30/2014 8:53 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.372328	2,346,730	0	0	873,753	50.00
51.00	05100	RECOVERY ROOM	0.313673	273,881	0	0	85,909	51.00
53.00	05300	ANESTHESIOLOGY	0.889451	884	0	0	786	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.143787	10,562,637	0	0	1,518,770	54.00
60.00	06000	LABORATORY	0.163826	828,689	7,493	0	135,761	60.00
65.00	06500	RESPIRATORY THERAPY	0.331421	1,289,739	0	0	427,447	65.00
66.00	06600	PHYSICAL THERAPY	0.496613	6,498	0	0	3,227	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.346893	3,941	0	0	1,367	67.00
68.00	06800	SPEECH PATHOLOGY	0.470543	50,873	0	0	23,938	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.147327	3,291,828	0	0	484,975	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.756311	970,965	0	0	734,352	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.337209	411,119	0	0	138,633	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.262480	3,853,342	0	23,277	1,011,425	73.00
76.00	03020	CARDIAC	0.000000	0	0	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	0.530938	108,020	0	0	57,352	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.222559	2,143,337	0	0	477,019	90.01
90.02	09002	DIABETES CLINIC	6.171315	115	0	0	710	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ANDI'S CLINIC	3.013140	2,203	0	0	6,638	90.04
90.05	09005	PRIME TIME	0.584873	16,869	0	0	9,866	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.502429	226,708	0	0	113,905	90.06
90.07	04951	ONCOLOGY	1.309340	80,592	0	0	105,522	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.179366	476	0	0	85	90.08
91.00	09100	EMERGENCY	0.302708	3,460,614	0	0	1,047,556	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.266830	960,343	0	0	1,216,591	92.00
200.00		Subtotal (see instructions)		30,890,403	7,493	23,277	8,475,587	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		30,890,403	7,493	23,277	8,475,587	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/30/2014 8:53 am
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
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	1,228	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	6,110		73.00
76.00 03020 CARDIAC	0	0		76.00
76.01 03022 CARDIAC REHABILITATION	0	0		76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
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 ANDI'S CLINIC	0	0		90.04
90.05 09005 PRIME TIME	0	0		90.05
90.06 09006 SHELBYVILLE WOUND CLINIC	0	0		90.06
90.07 04951 ONCOLOGY	0	0		90.07
90.08 04950 ANDERSON WOMENS CENTER	0	0		90.08
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)	1,228	6,110		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (Line 200 +/- Line 201)	1,228	6,110		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150037 Component CCN: 15S037		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part II Date/Time Prepared: 5/30/2014 8:53 am		
		Title XVIII		Subprovider - IPF		PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	441,971	16,059,149	0.027521	18,899	520	50.00
51.00	05100	RECOVERY ROOM	40,473	1,980,650	0.020434	1,788	37	51.00
53.00	05300	ANESTHESIOLOGY	54	14,039	0.003846	29	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	287,276	42,287,256	0.006793	109,149	741	54.00
60.00	06000	LABORATORY	147,973	33,558,892	0.004409	389,533	1,717	60.00
65.00	06500	RESPIRATORY THERAPY	61,004	6,665,773	0.009152	90,519	828	65.00
66.00	06600	PHYSICAL THERAPY	86,961	4,031,443	0.021571	96,032	2,072	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,411	1,307,485	0.002609	81,272	212	67.00
68.00	06800	SPEECH PATHOLOGY	10,084	583,755	0.017274	6,010	104	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	129,333	11,272,820	0.011473	9,735	112	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,038	5,698,472	0.003516	122,205	430	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,790	6,050,375	0.001453	417	1	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	127,702	20,741,715	0.006157	348,267	2,144	73.00
76.00	03020	CARDIAC	0	0	0.000000	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	898	222,640	0.004033	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	1,448	372,147	0.003891	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	54,039	4,651,918	0.011616	766	9	90.01
90.02	09002	DIABETES CLINIC	2,724	8,067	0.337672	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	6,398	54,642	0.117089	0	0	90.04
90.05	09005	PRIME TIME	608	241,184	0.002521	5	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	952	418,284	0.002276	0	0	90.06
90.07	04951	ONCOLOGY	1,902	249,037	0.007637	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	31,360	2,598,385	0.012069	1,421	17	90.08
91.00	09100	EMERGENCY	493,728	18,745,525	0.026338	42,351	1,115	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,255,655	0.000000	0	0	92.00
200.00		Total (lines 50-199)	1,959,127	180,069,308		1,318,398	10,059	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150037 Component CCN: 15S037	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/30/2014 8:53 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
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	177,474	0	177,474	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
<b>OUTPATIENT SERVICE COST CENTERS</b>							
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
90.07	04951 ONCOLOGY	0	0	0	0	0	90.07
90.08	04950 ANDERSON WOMENS CENTER	0	0	0	0	0	90.08
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	177,474	0	177,474	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150037 Component CCN: 15S037	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/30/2014 8:53 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description			Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	16,059,149	0.000000	0.000000	18,899	50.00
51.00	05100	RECOVERY ROOM	0	1,980,650	0.000000	0.000000	1,788	51.00
53.00	05300	ANESTHESIOLOGY	0	14,039	0.000000	0.000000	29	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	177,474	42,287,256	0.004197	0.004197	109,149	54.00
60.00	06000	LABORATORY	0	33,558,892	0.000000	0.000000	389,533	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,665,773	0.000000	0.000000	90,519	65.00
66.00	06600	PHYSICAL THERAPY	0	4,031,443	0.000000	0.000000	96,032	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,307,485	0.000000	0.000000	81,272	67.00
68.00	06800	SPEECH PATHOLOGY	0	583,755	0.000000	0.000000	6,010	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0.000000	0.000000	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	11,272,820	0.000000	0.000000	9,735	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,698,472	0.000000	0.000000	122,205	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	6,050,375	0.000000	0.000000	417	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,741,715	0.000000	0.000000	348,267	73.00
76.00	03020	CARDIAC	0	0	0.000000	0.000000	0	76.00
76.01	03022	CARDIAC REHABILITATION	0	222,640	0.000000	0.000000	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	372,147	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	4,651,918	0.000000	0.000000	766	90.01
90.02	09002	DIABETES CLINIC	0	8,067	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	54,642	0.000000	0.000000	0	90.04
90.05	09005	PRIME TIME	0	241,184	0.000000	0.000000	5	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	418,284	0.000000	0.000000	0	90.06
90.07	04951	ONCOLOGY	0	249,037	0.000000	0.000000	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	2,598,385	0.000000	0.000000	1,421	90.08
91.00	09100	EMERGENCY	0	18,745,525	0.000000	0.000000	42,351	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,255,655	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	177,474	180,069,308			1,318,398	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150037 Component CCN: 15S037	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/30/2014 8:53 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	458	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	CARDIAC	0	0	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	0	0	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	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	90.06
90.07	04951	ONCOLOGY	0	0	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	0	90.08
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	458	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150037 Component CCN: 15S037	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/30/2014 8:53 am
	Title XVII I	Subprovider - IPF	PPS

Cost Center Description		PSA Adj . Allied Health	PSA Adj . AI I Other Medical Education Cost	
		23.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
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
<b>OUTPATIENT SERVICE COST CENTERS</b>				
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
90.07	04951 ONCOLOGY	0	0	90.07
90.08	04950 ANDERSON WOMENS CENTER	0	0	90.08
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 01/01/2013 To 12/31/2013		Worksheet D Part II Date/Time Prepared: 5/30/2014 8:53 am		
		Title XVIII		Subprovider - IRF		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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	441,971	16,059,149	0.027521	9,284	256	50.00
51.00	05100	RECOVERY ROOM	40,473	1,980,650	0.020434	1,739	36	51.00
53.00	05300	ANESTHESIOLOGY	54	14,039	0.003846	13	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	287,276	42,287,256	0.006793	57,324	389	54.00
60.00	06000	LABORATORY	147,973	33,558,892	0.004409	108,229	477	60.00
65.00	06500	RESPIRATORY THERAPY	61,004	6,665,773	0.009152	59,108	541	65.00
66.00	06600	PHYSICAL THERAPY	86,961	4,031,443	0.021571	300,560	6,483	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,411	1,307,485	0.002609	310,511	810	67.00
68.00	06800	SPEECH PATHOLOGY	10,084	583,755	0.017274	58,003	1,002	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	129,333	11,272,820	0.011473	10,038	115	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,038	5,698,472	0.003516	31,057	109	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,790	6,050,375	0.001453	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	127,702	20,741,715	0.006157	154,578	952	73.00
76.00	03020	CARDIAC	0	0	0.000000	0	0	76.00
76.01	03022	CARDIAC REHABILITATION	898	222,640	0.004033	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	1,448	372,147	0.003891	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	54,039	4,651,918	0.011616	200	2	90.01
90.02	09002	DIABETES CLINIC	2,724	8,067	0.337672	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	6,398	54,642	0.117089	0	0	90.04
90.05	09005	PRIME TIME	608	241,184	0.002521	2	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	952	418,284	0.002276	0	0	90.06
90.07	04951	ONCOLOGY	1,902	249,037	0.007637	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	31,360	2,598,385	0.012069	368	4	90.08
91.00	09100	EMERGENCY	493,728	18,745,525	0.026338	9,733	256	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,255,655	0.000000	0	0	92.00
200.00		Total (lines 50-199)	1,959,127	180,069,308		1,110,747	11,432	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150037 Component CCN: 15T037	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/30/2014 8:53 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
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	177,474	0	177,474	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
<b>OUTPATIENT SERVICE COST CENTERS</b>							
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
90.07	04951 ONCOLOGY	0	0	0	0	0	90.07
90.08	04950 ANDERSON WOMENS CENTER	0	0	0	0	0	90.08
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	177,474	0	177,474	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150037 Component CCN: 15T037	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/30/2014 8:53 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description			Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	16,059,149	0.000000	0.000000	9,284	50.00
51.00	05100	RECOVERY ROOM	0	1,980,650	0.000000	0.000000	1,739	51.00
53.00	05300	ANESTHESIOLOGY	0	14,039	0.000000	0.000000	13	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	177,474	42,287,256	0.004197	0.004197	57,324	54.00
60.00	06000	LABORATORY	0	33,558,892	0.000000	0.000000	108,229	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,665,773	0.000000	0.000000	59,108	65.00
66.00	06600	PHYSICAL THERAPY	0	4,031,443	0.000000	0.000000	300,560	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,307,485	0.000000	0.000000	310,511	67.00
68.00	06800	SPEECH PATHOLOGY	0	583,755	0.000000	0.000000	58,003	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0.000000	0.000000	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	11,272,820	0.000000	0.000000	10,038	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,698,472	0.000000	0.000000	31,057	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	6,050,375	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,741,715	0.000000	0.000000	154,578	73.00
76.00	03020	CARDIAC	0	0	0.000000	0.000000	0	76.00
76.01	03022	CARDIAC REHABILITATION	0	222,640	0.000000	0.000000	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	372,147	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	4,651,918	0.000000	0.000000	200	90.01
90.02	09002	DIABETES CLINIC	0	8,067	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	54,642	0.000000	0.000000	0	90.04
90.05	09005	PRIME TIME	0	241,184	0.000000	0.000000	2	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	418,284	0.000000	0.000000	0	90.06
90.07	04951	ONCOLOGY	0	249,037	0.000000	0.000000	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	2,598,385	0.000000	0.000000	368	90.08
91.00	09100	EMERGENCY	0	18,745,525	0.000000	0.000000	9,733	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,255,655	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	177,474	180,069,308			1,110,747	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150037 Component CCN: 15T037	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/30/2014 8:53 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description			Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
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	241	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
<b>OUTPATIENT SERVICE COST CENTERS</b>								
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
90.07	04951	ONCOLOGY	0	0	0	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	0	0	90.08
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)	241	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150037 Component CCN: 15T037	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/30/2014 8:53 am
Title XVII		Subprovider - IRF	PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
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
<b>OUTPATIENT SERVICE COST CENTERS</b>				
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
90.07	04951 ONCOLOGY	0	0	90.07
90.08	04950 ANDERSON WOMENS CENTER	0	0	90.08
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 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/30/2014 8:53 am
Cost Center Description		PPS		
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,860	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,860	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)		3,570	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)		1,486	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
<b>SWING BED ADJUSTMENT</b>				
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)		7,312,290	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)		7,312,290	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		7,312,290	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,247.83	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,854,275	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)		1,854,275	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150037		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 5/30/2014 8:53 am	
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	7,267,306	4,983	1,458.42	2,546	3,713,137		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)					6,394,731	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					11,962,143	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)					395,649	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					243,159	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					638,808	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					11,323,335	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)					2,290	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,247.83	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,857,531	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150037		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/30/2014 8:53 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	600,270	7,312,290	0.082091	2,857,531	234,578	90.00
91.00	Nursing School cost	0	7,312,290	0.000000	2,857,531	0	91.00
92.00	Allied health cost	0	7,312,290	0.000000	2,857,531	0	92.00
93.00	All other Medical Education	0	7,312,290	0.000000	2,857,531	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Component CCN: 15S037		Date/Time Prepared: 5/30/2014 8:53 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,538	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,538	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)		2,538	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)		2,395	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
<b>SWING BED ADJUSTMENT</b>				
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)		2,529,651	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)		2,529,651	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,529,651	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		996.71	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,387,120	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)		2,387,120	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150037		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
		Component CCN: 15S037				Date/Time Prepared: 5/30/2014 8:53 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	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)					394,507	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,781,627	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)					133,018	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					10,517	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					143,535	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,638,092	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 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/30/2014 8:53 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	140,950	2,529,651	0.055719	0	0	90.00
91.00	Nursing School cost	0	2,529,651	0.000000	0	0	91.00
92.00	Allied health cost	0	2,529,651	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,529,651	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Component CCN: 15T037		Date/Time Prepared: 5/30/2014 8:53 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,022	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,022	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)		1,022	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)		712	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
<b>SWING BED ADJUSTMENT</b>				
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)		1,367,532	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)		1,367,532	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,367,532	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,338.09	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		952,720	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)		952,720	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150037		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
		Component CCN: 15T037				Date/Time Prepared: 5/30/2014 8:53 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	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)					402,446	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,355,166	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)					67,854	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					11,673	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					79,527	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,275,639	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 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/30/2014 8:53 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	97,401	1,367,532	0.071224	0	0	90.00
91.00	Nursing School cost	0	1,367,532	0.000000	0	0	91.00
92.00	Allied health cost	0	1,367,532	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,367,532	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XIX		Hospital
				Date/Time Prepared: 5/30/2014 8:53 am
Cost Center Description			Cost	
			1.00	
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,860	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,860	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)		3,570	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)		323	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
<b>SWING BED ADJUSTMENT</b>				
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)		7,312,290	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)		7,312,290	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		7,312,290	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,247.83	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		403,049	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)		403,049	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150037		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
Date/Time Prepared: 5/30/2014 8:53 am		Title XIX		Hospital		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)							42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	7,267,306	4,983	1,458.42	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)					423,332		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					826,381		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)						2,290	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,247.83	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						2,857,531	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet D-1  
Date/Time Prepared:  
5/30/2014 8:53 am

Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Hospital		Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
				Total Observation Bed Cost (from line 89)	Cost		
	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	0	90.00
91.00 Nursing School cost	0	0	0.000000	0	0	0	91.00
92.00 Allied health cost	0	0	0.000000	0	0	0	92.00
93.00 All other Medical Education	0	0	0.000000	0	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/30/2014 8:53 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		1,036,561	30.00
31.00	03100	INTENSIVE CARE UNIT		3,846,264	31.00
40.00	04000	SUBPROVIDER - IPF		20,420	40.00
41.00	04100	SUBPROVIDER - IRF		5,546	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.372328	2,593,627	50.00
51.00	05100	RECOVERY ROOM	0.313673	367,124	51.00
53.00	05300	ANESTHESIOLOGY	0.889451	1,696	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.143787	2,630,538	54.00
60.00	06000	LABORATORY	0.163826	3,396,977	60.00
65.00	06500	RESPIRATORY THERAPY	0.331421	1,516,965	65.00
66.00	06600	PHYSICAL THERAPY	0.496613	432,596	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.346893	227,623	67.00
68.00	06800	SPEECH PATHOLOGY	0.470543	92,131	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.147327	1,608,783	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.756311	1,100,127	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.337209	2,287,562	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.262480	4,692,019	73.00
76.00	03020	CARDIAC	0.000000	0	76.00
76.01	03022	CARDIAC REHABILITATION	0.530938	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
90.00	09000	CLINIC	0.000000	0	90.00
90.01	09001	WOUND CLINIC	0.222559	4,683	90.01
90.02	09002	DIABETES CLINIC	6.171315	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	90.03
90.04	09004	ANDI'S CLINIC	3.013140	0	90.04
90.05	09005	PRIME TIME	0.584873	46	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.502429	0	90.06
90.07	04951	ONCOLOGY	1.309340	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.179366	7,876	90.08
91.00	09100	EMERGENCY	0.302708	1,524,165	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.266830	1,479	92.00
200.00		Total (sum of lines 50-94 and 96-98)		22,486,017	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)		22,486,017	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3	
		Component CCN: 15S037		Date/Time Prepared: 5/30/2014 8:53 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		2,807,181		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.372328	18,899	7,037	50.00
51.00	05100 RECOVERY ROOM	0.313673	1,788	561	51.00
53.00	05300 ANESTHESIOLOGY	0.889451	29	26	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.143787	109,149	15,694	54.00
60.00	06000 LABORATORY	0.163826	389,533	63,816	60.00
65.00	06500 RESPIRATORY THERAPY	0.331421	90,519	30,000	65.00
66.00	06600 PHYSICAL THERAPY	0.496613	96,032	47,691	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.346893	81,272	28,193	67.00
68.00	06800 SPEECH PATHOLOGY	0.470543	6,010	2,828	68.00
68.01	06801 OCCUPATIONAL HEALTH	0.000000	0	0	68.01
69.00	06900 ELECTROCARDIOLOGY	0.147327	9,735	1,434	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.756311	122,205	92,425	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.337209	417	141	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.262480	348,267	91,413	73.00
76.00	03020 CARDIAC	0.000000	0	0	76.00
76.01	03022 CARDIAC REHABILITATION	0.530938	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
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	0.222559	766	170	90.01
90.02	09002 DIABETES CLINIC	6.171315	0	0	90.02
90.03	09003 ASTHMA CLINIC	0.000000	0	0	90.03
90.04	09004 ANDIS CLINIC	3.013140	0	0	90.04
90.05	09005 PRIME TIME	0.584873	5	3	90.05
90.06	09006 SHELBYVILLE WOUND CLINIC	0.502429	0	0	90.06
90.07	04951 ONCOLOGY	1.309340	0	0	90.07
90.08	04950 ANDERSON WOMENS CENTER	0.179366	1,421	255	90.08
91.00	09100 EMERGENCY	0.302708	42,351	12,820	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.266830	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,318,398	394,507	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)		1,318,398		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150037 Component CCN: 15T037	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/30/2014 8:53 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
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		840,415	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.372328	9,284	3,457 50.00
51.00	05100 RECOVERY ROOM	0.313673	1,739	545 51.00
53.00	05300 ANESTHESIOLOGY	0.889451	13	12 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.143787	57,324	8,242 54.00
60.00	06000 LABORATORY	0.163826	108,229	17,731 60.00
65.00	06500 RESPIRATORY THERAPY	0.331421	59,108	19,590 65.00
66.00	06600 PHYSICAL THERAPY	0.496613	300,560	149,262 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.346893	310,511	107,714 67.00
68.00	06800 SPEECH PATHOLOGY	0.470543	58,003	27,293 68.00
68.01	06801 OCCUPATIONAL HEALTH	0.000000	0	0 68.01
69.00	06900 ELECTROCARDIOLOGY	0.147327	10,038	1,479 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.756311	31,057	23,489 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.337209	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.262480	154,578	40,574 73.00
76.00	03020 CARDIAC	0.000000	0	0 76.00
76.01	03022 CARDIAC REHABILITATION	0.530938	0	0 76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
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	0.222559	200	45 90.01
90.02	09002 DIABETES CLINIC	6.171315	0	0 90.02
90.03	09003 ASTHMA CLINIC	0.000000	0	0 90.03
90.04	09004 ANDIS CLINIC	3.013140	0	0 90.04
90.05	09005 PRIME TIME	0.584873	2	1 90.05
90.06	09006 SHELBYVILLE WOUND CLINIC	0.502429	0	0 90.06
90.07	04951 ONCOLOGY	1.309340	0	0 90.07
90.08	04950 ANDERSON WOMENS CENTER	0.179366	368	66 90.08
91.00	09100 EMERGENCY	0.302708	9,733	2,946 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.266830	0	0 92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,110,747	402,446 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net Charges (line 200 minus line 201)		1,110,747	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/30/2014 8:53 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		597,768	30.00
31.00	03100	INTENSIVE CARE UNIT		159,279	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.372328	257,618	50.00
51.00	05100	RECOVERY ROOM	0.313673	30,984	51.00
53.00	05300	ANESTHESIOLOGY	0.889451	1,276	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.143787	109,607	54.00
60.00	06000	LABORATORY	0.163826	217,673	60.00
65.00	06500	RESPIRATORY THERAPY	0.331421	63,990	65.00
66.00	06600	PHYSICAL THERAPY	0.496613	8,367	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.346893	4,720	67.00
68.00	06800	SPEECH PATHOLOGY	0.470543	731	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.147327	110,874	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.756311	119,228	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.337209	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.262480	429,831	73.00
76.00	03020	CARDIAC	0.000000	0	76.00
76.01	03022	CARDIAC REHABILITATION	0.530938	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.858747	0	88.00
90.00	09000	CLINIC	0.000000	0	90.00
90.01	09001	WOUND CLINIC	0.222559	1,395	90.01
90.02	09002	DIABETES CLINIC	6.171315	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	90.03
90.04	09004	ANDI'S CLINIC	3.013140	0	90.04
90.05	09005	PRIME TIME	0.584873	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.502429	0	90.06
90.07	04951	ONCOLOGY	1.309340	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.179366	0	90.08
91.00	09100	EMERGENCY	0.302708	59,978	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.266830	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,416,272	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)		1,416,272	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/30/2014 8:53 am
		Title XVII	Hospital	PPS
		0	1.00	2.00
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER PPS</b>				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013 (see instructions)		6,862,357	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		1,999,871	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI (see instructions)		0	1.03
2.00	Outlier payments for discharges. (see instructions)		103,063	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		60.73	4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
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 factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
29.00	Total IME payment ( sum of lines 22 and 28)		0	29.00
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.56	30.00
31.00	Percentage of Medicaid patient days (see instructions)		13.96	31.00
32.00	Sum of lines 30 and 31		16.52	32.00
33.00	Allowable disproportionate share percentage (see instructions)		3.49	33.00
34.00	Disproportionate share adjustment (see instructions)		256,945	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/30/2014 8:53 am	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1	On/After October 1	
			1.00	2.00	
<b>Uncompensated Care Adjustment</b>					
35.00	Total uncompensated care amount (see instructions)			9,046,380,143	35.00
35.01	Factor 3 (see instructions)			0.000046089	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)			416,936	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			105,091	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		105,091		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)			0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)			0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)			0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41)			0	46.00
47.00	Subtotal (see instructions)		9,327,327		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)		9,327,327		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		708,307		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)			0	55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)			0	56.00
57.00	Routine service other pass through costs (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)		11,040		58.00
59.00	Total (sum of amounts on lines 49 through 58)		10,046,674		59.00
60.00	Primary payer payments		6,189		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		10,040,485		61.00
62.00	Deductibles billed to program beneficiaries		1,079,528		62.00
63.00	Coinurance billed to program beneficiaries		11,248		63.00
64.00	Allowable bad debts (see instructions)		68,707		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		44,660		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		68,707		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		8,994,369		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			-899	70.00
70.92	Bundled Model 1 discount amount			0	70.92
70.93	HVBP incentive payment (see instructions)			-11,267	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 adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2012	103,384		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2013	63,286		70.97
70.98	Low Volume Payment-3			0	70.98

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/30/2014 8:53 am	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	On/After October 1 2.00	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		9,148,873		71.00
71.01	Sequestration adjustment (see instructions)		138,148		71.01
72.00	Interim payments		9,048,376		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) line 71 minus lines 71.01, 72 and 73		-37,651		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		90,000		75.00
<b>TO BE COMPLETED BY CONTRACTOR</b>					
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

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 150037		Period: From 01/01/2013 To 12/31/2013		Worksheet DSH	
		Title XVIII		Hospital		Date/Time Prepared: 5/30/2014 8:53 am	
		PPS					
	Original .mcrcx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value		
	1.00	2.00	3.00	4.00	5.00		
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	2.56	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	13.96	0.00			13.96	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	16.52	0.00			13.96	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	Urban				Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	60.73	0.00			60.73	5.00
6.00	Disproportionate Share Payment Percentage (transfer to Worksheet E, Part A, line 33)	3.49	0.00			0.00	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				No	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No				No	9.00
10.00	S-2, Line 45	No				No	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	Yes				Yes	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.56	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	323	0			323	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	317	0			317	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	572	0			572	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	1,212	0			1,212	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	8,553	0			8,553	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	46	0			46	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	82	0			82	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	8,681	0			8,681	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	13.96	0.00			13.96	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 150037		Period: From 01/01/2013 To 12/31/2013		Worksheet DSH Date/Time Prepared: 5/30/2014 8:53 am	
		Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
<b>CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE</b>							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	False	0.00		0.00	False	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	True	3.49		0.00	True	29.00
30.00	Line 28 or 29 as applicable		3.49		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		0.00		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
<b>DETERMINATION OF PROVIDER TYPE</b>							
32.00	Does the hospital qualify under the Pickle amendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet DSH Date/Time Prepared: 5/30/2014 8:53 am
		Title XVIII	Hospital	PPS

		Revised		
		Percentage		
		6.00		
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE				
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	0.00		28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	3.18		29.00
30.00	Line 28 or 29 as applicable	3.18		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	0.00		31.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
5/30/2014 8:53 am

		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	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013	1.01	6,862,357	0	6,862,357	0	6,862,357	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013	1.02	1,999,871	0	0	1,999,871	1,999,871	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI	1.03	0	0	0	0	0	1.03
2.00	Outlier payments for discharges (see instructions)	2.00	103,063	0	69,954	33,109	103,063	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
<b>Indirect Medical Education Adjustment</b>								
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	0	6.00
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>								
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	0	8.00
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
<b>Disproportionate Share Adjustment</b>								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0349	0.0349	0.0349	0.0349		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	256,945	0	239,496	17,449	256,945	11.00
11.01	Uncompensated care payments	36.00	105,091	0	0	105,091	105,091	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	9,327,327	0	7,171,807	2,155,520	9,327,327	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	0	14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	49.00	9,327,327	0	7,171,807	2,155,520	9,327,327	15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50.00	708,307	0	547,430	160,877	708,307	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	7,719,237	2,316,397	10,035,634	19.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
5/30/2014 8:53 am

		Title XVIII		Hospital		PPS		
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	704,804	0	544,951	159,853	704,804	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	3,503	0	2,479	1,024	3,503	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
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	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	0	25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	12.00	708,307	0	547,430	160,877	708,307	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.013393	0.027321		27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.96			103,384		103,384	28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.97				63,286	63,286	29.00
100.00	Transfer low volume adjustments to W/S E Part A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/30/2014 8:53 am
		Title XVII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		7,338	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		8,431,256	2.00
3.00	PPS payments		5,892,803	3.00
4.00	Outlier payment (see instructions)		33,742	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		44,331	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		7,338	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		30,770	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)		30,770	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		30,770	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		23,432	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)		7,338	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)		5,970,876	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
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)		1,422,744	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)		4,555,470	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)		4,555,470	30.00
31.00	Primary payer payments		510	31.00
32.00	Subtotal (line 30 minus line 31)		4,554,960	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		138,859	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		90,258	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		138,859	36.00
37.00	Subtotal (see instructions)		4,645,218	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	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		4,645,213	40.00
40.01	Sequestration adjustment (see instructions)		70,143	40.01
41.00	Interim payments		4,520,253	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		54,817	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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	
<b>WORKSHEET OVERRIDE VALUES</b>				
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 01/01/2013  
To 12/31/2013

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/30/2014 8:53 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		8,926,510		4,434,175	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	12/31/2013	58,580	12/31/2013	86,078	3.01	
3.02		12/31/2013	63,286		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)		121,866		86,078	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)		9,048,376		4,520,253	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		54,817	6.01	
6.02	SETTLEMENT TO PROGRAM		37,651		0	6.02	
7.00	Total Medicare program liability (see instructions)		9,010,725		4,575,070	7.00	
				Contractor Number	NPR 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 01/01/2013  
To 12/31/2013

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/30/2014 8:53 am

Title XVIII

Subprovider -  
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,920,427		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)		1,920,427		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		528		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,920,955		0	7.00
				Contractor Number	NPR 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 01/01/2013  
To 12/31/2013

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/30/2014 8:53 am  
PPS

Title XVIII

Subprovider -  
IRF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider				0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,054,328		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)		1,054,328		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		8,396		0	6.02
7.00	Total Medicare program liability (see instructions)		1,045,932		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet E-1 Part II Date/Time Prepared: 5/30/2014 8:53 am
		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14		2,559	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12		4,032	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2		591	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12		8,553	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200		201,202,944	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20		4,727,063	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)		947,315	8.00
9.00	Sequestration adjustment amount (see instructions)		18,946	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		928,369	10.00
<b>INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)		947,335	30.00
31.00	Other Adjustment (specify)		0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		-18,966	32.00
				<b>Overrides</b>
				1.00
<b>CONTRACTOR OVERRIDES</b>				
108.00	Override of HIT payment			0108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part II Date/Time Prepared: 5/30/2014 8:53 am
		Component CCN: 15S037	Title XVIII	Subprovider - IPF
		PPS		
		1.00		
<b>PART II - MEDICARE PART A SERVICES - IPF PPS</b>				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		2,123,490	1.00
2.00	Net IPF PPS Outlier Payments		4,659	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 excluding FTEs in the new program growth period 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 new program growth period 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)		6.953425	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line } 8/\text{line } 9))) \text{ raised to the power of } .5150 - 1\}$ .		0.000000	10.00
11.00	Teaching 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)		2,128,149	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			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)		2,128,149	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		2,128,149	18.00
19.00	Deductibles		170,412	19.00
20.00	Subtotal (line 18 minus line 19)		1,957,737	20.00
21.00	Coinsurance		7,696	21.00
22.00	Subtotal (line 20 minus line 21)		1,950,041	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)		1,950,041	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)		458	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER		-93	30.00
30.99	Recovery of Accelerated Depreciation		0	30.99
31.00	Total amount payable to the provider (see instructions)		1,950,406	31.00
31.01	Sequestration adjustment (see instructions)		29,451	31.01
32.00	Interim payments		1,920,427	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33		528	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	35.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		4,659	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 01/01/2013 To 12/31/2013	Worksheet E-3 Part III Date/Time Prepared: 5/30/2014 8:53 am
		Title XVIIII	Subprovider - IRF	PPS
		Prior to 10/01	On/After 10/01	
		1.00	1.01	
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)	823,454	207,334	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0056		2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	2,882	498	3.00
4.00	Outlier Payments	59,188		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 excluding FTEs in the new program growth period 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 new program growth period 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)	2.800000		10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	0	12.00
13.00	Total PPS Payment (see instructions)	1,093,356		13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0		14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			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)	1,093,356		17.00
18.00	Primary payer payments	0		18.00
19.00	Subtotal (line 17 less line 18).	1,093,356		19.00
20.00	Deductibles	21,284		20.00
21.00	Subtotal (line 19 minus line 20)	1,072,072		21.00
22.00	Coinurance	9,472		22.00
23.00	Subtotal (line 21 minus line 22)	1,062,600		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)	1,062,600		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)	241		29.00
30.00	Outlier payments reconciliation	0		30.00
31.00	OTHER	-873		31.00
31.99	Recovery of Accelerated Depreciation	0		31.99
32.00	Total amount payable to the provider (see instructions)	1,061,968		32.00
32.01	Sequestration adjustment (see instructions)	16,036		32.01
33.00	Interim payments	1,054,328		33.00
34.00	Tentative settlement (for contractor use only)	0		34.00
35.00	Balance due provider/program line 32 minus lines 32.01, 33 and 34	-8,396		35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0		36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4	59,188		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 01/01/2013 To 12/31/2013	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2014 8:53 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		826,381		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)		826,381	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)		826,381	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		757,047		8.00
9.00	Ancillary service charges		1,416,272	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)		2,173,319	0	12.00
<b>CUSTOMARY CHARGES</b>					
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)		2,173,319	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		1,346,938	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)		826,381	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
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)		826,381	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
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)		826,381	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		826,381	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		826,381	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)		826,381	0	40.00
41.00	Interim payments		901,472	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		-75,091		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		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 01/01/2013  
To 12/31/2013

Worksheet G

Date/Time Prepared:  
5/30/2014 8:53 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	24,295,387	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	8,086,840	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	6,260,857	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	38,643,084	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	5,776,236	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	96,894,751	0	0	0	15.00
16.00	Accumulated depreciation	-105,353,011	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	58,065,804	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)	55,383,780	0	0	0	30.00
<b>OTHER ASSETS</b>						
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	60,669,367	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	60,669,367	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	154,696,231	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	6,410,724	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,550,389	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,040,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,435,825	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	17,436,938	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	27,205,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	27,205,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	44,641,938	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	110,054,293				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)	110,054,293	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	154,696,231	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet G-1

Date/Time Prepared:  
5/30/2014 8:53 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		100,678,921		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		9,375,372			2.00
3.00	Total (sum of line 1 and line 2)		110,054,293		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		110,054,293		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		110,054,293		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 01/01/2013  
To 12/31/2013

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/30/2014 8:53 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	6,456,559		6,456,559	1.00
2.00	SUBPROVIDER - IPF	2,959,066		2,959,066	2.00
3.00	SUBPROVIDER - IRF	1,184,861		1,184,861	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)	10,600,486		10,600,486	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	8,178,594		8,178,594	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)	8,178,594		8,178,594	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	18,779,080		18,779,080	17.00
18.00	Ancillary services	43,684,920	108,982,895	152,667,815	18.00
19.00	Outpatient services	2,393,012	25,229,500	27,622,512	19.00
20.00	RURAL HEALTH CLINIC	0	373,798	373,798	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,665,090	2,665,090	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	660,924	1,432,564	2,093,488	26.00
27.00	A&G, DIETARY, PRIVATE DUTY	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	65,517,936	138,683,847	204,201,783	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		95,963,161		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)		95,963,161		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150037

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet G-3

Date/Time Prepared:  
5/30/2014 8:53 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	204,201,783	1.00
2.00	Less contractual allowances and discounts on patients' accounts	115,278,112	2.00
3.00	Net patient revenues (line 1 minus line 2)	88,923,671	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	95,963,161	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-7,039,490	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPER/NONOPERATING REV	16,291,862	24.00
25.00	Total other income (sum of lines 6-24)	16,291,862	25.00
26.00	Total (line 5 plus line 25)	9,252,372	26.00
27.00	MISC EXPENSE	-123,000	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-123,000	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	9,375,372	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 150037

Period: From 01/01/2013

Worksheet H

HHA CCN: 157092

To 12/31/2013

Date/Time Prepared: 5/30/2014 8:53 am

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00			0		0	0	1.00
2.00			0		0	0	2.00
3.00	0	0	0	0	0	0	3.00
4.00	0	0	0	0	0	0	4.00
5.00	528,921	0	132,215	0	363,026	1,024,162	5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	385,538	0	0	0	0	385,538	6.00
7.00	470,861	0	0	0	0	470,861	7.00
8.00	206,574	0	0	0	0	206,574	8.00
9.00	9,405	0	0	0	0	9,405	9.00
10.00	15,763	0	0	0	0	15,763	10.00
11.00	117,644	0	0	0	0	117,644	11.00
12.00	0	0	0	0	0	0	12.00
13.00	0	0	0	0	0	0	13.00
14.00	0	0	0	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	0	0	0	0	0	0	15.00
16.00	0	0	0	0	0	0	16.00
17.00	0	0	0	0	0	0	17.00
18.00	0	0	0	0	0	0	18.00
19.00	0	0	0	0	0	0	19.00
20.00	0	0	0	0	0	0	20.00
21.00	0	0	0	0	0	0	21.00
22.00	0	0	0	0	0	0	22.00
23.00	0	0	0	0	0	0	23.00
24.00	1,734,706	0	132,215	0	363,026	2,229,947	24.00
	Reclassifi cation	Reclassifi ed Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	0	0	0	0			1.00
2.00	0	0	0	0			2.00
3.00	0	0	0	0			3.00
4.00	0	0	0	0			4.00
5.00	0	1,024,162	0	1,024,162			5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	0	385,538	0	385,538			6.00
7.00	0	470,861	0	470,861			7.00
8.00	0	206,574	0	206,574			8.00
9.00	0	9,405	0	9,405			9.00
10.00	0	15,763	0	15,763			10.00
11.00	0	117,644	0	117,644			11.00
12.00	0	0	0	0			12.00
13.00	0	0	0	0			13.00
14.00	0	0	0	0			14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	0	0	0	0			15.00
16.00	0	0	0	0			16.00
17.00	0	0	0	0			17.00
18.00	0	0	0	0			18.00
19.00	0	0	0	0			19.00
20.00	0	0	0	0			20.00
21.00	0	0	0	0			21.00
22.00	0	0	0	0			22.00
23.00	0	0	0	0			23.00
24.00	0	2,229,947	0	2,229,947			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet H-1 Part I Date/Time Prepared: 5/30/2014 8:53 am
		HHA CCN: 157092	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		Bldgs & Fixtures	Movable Equipment				
		1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>							
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	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	1,024,162	0	0	0	1,024,162	5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	385,538	0	0	0	385,538	6.00
7.00	Physical Therapy	470,861	0	0	0	470,861	7.00
8.00	Occupational Therapy	206,574	0	0	0	206,574	8.00
9.00	Speech Pathology	9,405	0	0	0	9,405	9.00
10.00	Medical Social Services	15,763	0	0	0	15,763	10.00
11.00	Home Health Aide	117,644	0	0	0	117,644	11.00
12.00	Supplies (see instructions)	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	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	2,229,947	0	0	0	2,229,947	24.00
		Administrative & General	Total (cols. 4A + 5)				
		5.00	6.00				
<b>GENERAL SERVICE COST CENTERS</b>							
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	1,024,162					5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	327,466	713,004				6.00
7.00	Physical Therapy	399,936	870,797				7.00
8.00	Occupational Therapy	175,459	382,033				8.00
9.00	Speech Pathology	7,988	17,393				9.00
10.00	Medical Social Services	13,389	29,152				10.00
11.00	Home Health Aide	99,924	217,568				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
<b>HHA NONREIMBURSABLE SERVICES</b>							
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)		2,229,947				24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 150037

Period:

Worksheet H-1

HHA CCN: 157092

From 01/01/2013  
To 12/31/2013

Part II  
Date/Time Prepared:  
5/30/2014 8:53 am

Home Health  
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	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
<b>GENERAL SERVICE COST CENTERS</b>							
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	-1,024,162	1,205,785
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	0	0	0	0	0	385,538
7.00	Physical Therapy	0	0	0	0	0	470,861
8.00	Occupational Therapy	0	0	0	0	0	206,574
9.00	Speech Pathology	0	0	0	0	0	9,405
10.00	Medical Social Services	0	0	0	0	0	15,763
11.00	Home Health Aide	0	0	0	0	0	117,644
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-1,024,162	1,205,785
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		1,024,162
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.849374

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150037

Period: From 01/01/2013

Worksheet H-2

HHA CCN: 157092

To 12/31/2013

Part I  
Date/Time Prepared:  
5/30/2014 8:53 am

Home Health Agency I

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Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		NEW BLDG & FIXT						
	0	1.00		4.00	4A	5.00	7.00	
1.00 Administrative and General	0	0		300,239	300,239	64,493	0	1.00
2.00 Skilled Nursing Care	713,004	0		0	713,004	153,156	0	2.00
3.00 Physical Therapy	870,797	0		0	870,797	187,051	0	3.00
4.00 Occupational Therapy	382,033	0		0	382,033	82,062	0	4.00
5.00 Speech Pathology	17,393	0		0	17,393	3,736	0	5.00
6.00 Medical Social Services	29,152	0		0	29,152	6,262	0	6.00
7.00 Home Health Aide	217,568	0		0	217,568	46,734	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)	2,229,947	0		300,239	2,530,186	543,494	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	60,735	0	126,969	112,768	490	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	60,735	0	126,969	112,768	490	0	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

Period: From 01/01/2013

Worksheet H-2

HHA CCN: 157092

To 12/31/2013

Part I  
Date/Time Prepared: 5/30/2014 8:53 am

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	345	0	666,039	0	666,039		1.00
2.00	Skilled Nursing Care	0	0	866,160	0	866,160	212,959	2.00
3.00	Physical Therapy	0	0	1,057,848	0	1,057,848	260,090	3.00
4.00	Occupational Therapy	0	0	464,095	0	464,095	114,105	4.00
5.00	Speech Pathology	0	0	21,129	0	21,129	5,195	5.00
6.00	Medical Social Services	0	0	35,414	0	35,414	8,707	6.00
7.00	Home Health Aide	0	0	264,302	0	264,302	64,983	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)	345	0	3,374,987	0	3,374,987	666,039	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.						0.245866	21.00
Cost Center Description		Total HHA Costs						
		28.00						
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	1,079,119						2.00
3.00	Physical Therapy	1,317,938						3.00
4.00	Occupational Therapy	578,200						4.00
5.00	Speech Pathology	26,324						5.00
6.00	Medical Social Services	44,121						6.00
7.00	Home Health Aide	329,285						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)	3,374,987						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 01/01/2013 To 12/31/2013

Worksheet H-2 Part II  
Date/Time Prepared: 5/30/2014 8:53 am  
PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	HOUSEKEEPING (HOURS OF SERVICE)	
	NEW BLDG & FIXT (SQUARE FEET)							
	1.00	4.00						
1.00 Administrative and General	0		1,734,706	0	300,239	0	12,210	1.00
2.00 Skilled Nursing Care	0		0	0	713,004	0	0	2.00
3.00 Physical Therapy	0		0	0	870,797	0	0	3.00
4.00 Occupational Therapy	0		0	0	382,033	0	0	4.00
5.00 Speech Pathology	0		0	0	17,393	0	0	5.00
6.00 Medical Social Services	0		0	0	29,152	0	0	6.00
7.00 Home Health Aide	0		0	0	217,568	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		1,734,706		2,530,186	0	12,210	20.00
21.00 Total cost to be allocated	0		300,239		543,494	0	60,735	21.00
22.00 Unit cost multiplier	0.000000		0.173078		0.214804	0.000000	4.974201	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	53,621	53,621	14,953	0	0	1	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	53,621	53,621	14,953	0	0	1	20.00
21.00 Total cost to be allocated	0	126,969	112,768	490	0	0	345	21.00
22.00 Unit cost multiplier	0.000000	2.367897	2.103057	0.032769	0.000000	0.000000	345.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 150037 HHA CCN: 157092	Period: From 01/01/2013 To 12/31/2013	Worksheet H-2 Part II Date/Time Prepared: 5/30/2014 8:53 am PPS
		Home Health Agency I	

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	Period: From 01/01/2013 To 12/31/2013	Worksheet H-3 Part I Date/Time Prepared: 5/30/2014 8:53 am	
				HHA CCN: 157092	Title XVIII	Home Health Agency I PPS	
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 1,079,119		1,079,119	5,784	186.57	1.00
2.00	Physical Therapy	3.00 1,317,938	0	1,317,938	4,724	278.99	2.00
3.00	Occupational Therapy	4.00 578,200	0	578,200	2,290	252.49	3.00
4.00	Speech Pathology	5.00 26,324	0	26,324	99	265.90	4.00
5.00	Medical Social Services	6.00 44,121		44,121	77	573.00	5.00
6.00	Home Health Aide	7.00 329,285		329,285	3,483	94.54	6.00
7.00	Total (sum of lines 1-6)		0	3,374,987	16,457		7.00
Program Visits							
Part B							
Not Subject to Deductibles & Insurance							
Subject to Deductibles							
	0	1.00	2.00	3.00	4.00	5.00	
Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	333	654		8.00
8.01	Skilled Nursing Care		26900	643	1,568		8.01
8.02	Skilled Nursing Care		11300	19	19		8.02
8.03	Skilled Nursing Care		34620	0	0		8.03
8.04	Skilled Nursing Care		29020	0	16		8.04
9.00	Physical Therapy		99915	230	410		9.00
9.01	Physical Therapy		26900	730	1,460		9.01
9.02	Physical Therapy		11300	35	37		9.02
9.03	Physical Therapy		34620	11	0		9.03
9.04	Physical Therapy		29020	0	26		9.04
10.00	Occupational Therapy		99915	98	189		10.00
10.01	Occupational Therapy		26900	417	741		10.01
10.02	Occupational Therapy		11300	9	8		10.02
10.03	Occupational Therapy		34620	5	0		10.03
10.04	Occupational Therapy		29020	0	6		10.04
11.00	Speech Pathology		99915	2	3		11.00
11.01	Speech Pathology		26900	14	25		11.01
11.02	Speech Pathology		11300	13	0		11.02
11.03	Speech Pathology		34620	0	0		11.03
11.04	Speech Pathology		29020	0	0		11.04
12.00	Medical Social Services		99915	1	8		12.00
12.01	Medical Social Services		26900	8	23		12.01
12.02	Medical Social Services		11300	1	0		12.02
12.03	Medical Social Services		34620	0	0		12.03
12.04	Medical Social Services		29020	0	0		12.04
13.00	Home Health Aide		99915	120	522		13.00
13.01	Home Health Aide		26900	131	854		13.01
13.02	Home Health Aide		11300	2	1		13.02
13.03	Home Health Aide		34620	0	0		13.03
13.04	Home Health Aide		29020	0	0		13.04
14.00	Total (sum of lines 8-13)			2,822	6,570		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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150037

Period: From 01/01/2013

Worksheet H-3

HHA CCN: 157092

To 12/31/2013

Part I  
Date/Time Prepared:  
5/30/2014 8:53 am

Title XVII I

Home Health Agency I

PPS

Cost Center Description	Program Visits			Cost of Services				
	Part A	Part B		Part A	Part B			
		Not Subject to Deductibles & Coi nsurance	Subject to Deductibles & Coi nsurance		Not Subject to Deductibles & Coi nsurance			Subject to Deductibles & Coi nsurance
	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	995	2,257		185,637	421,088		1.00
2.00	Physical Therapy	1,006	1,933		280,664	539,288		2.00
3.00	Occupational Therapy	529	944		133,567	238,351		3.00
4.00	Speech Pathology	29	28		7,711	7,445		4.00
5.00	Medical Social Services	10	31		5,730	17,763		5.00
6.00	Home Health Aide	253	1,377		23,919	130,182		6.00
7.00	Total (sum of lines 1-6)	2,822	6,570		637,228	1,354,117		7.00
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
8.03	Skilled Nursing Care							8.03
8.04	Skilled Nursing Care							8.04
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
9.03	Physical Therapy							9.03
9.04	Physical Therapy							9.04
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
10.03	Occupational Therapy							10.03
10.04	Occupational Therapy							10.04
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
11.03	Speech Pathology							11.03
11.04	Speech Pathology							11.04
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
12.03	Medical Social Services							12.03
12.04	Medical Social Services							12.04
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
13.03	Home Health Aide							13.03
13.04	Home Health Aide							13.04
14.00	Total (sum of lines 8-13)							14.00
Program Covered Charges								
Cost Center Description	Program Covered Charges			Cost of Services				
	Part A	Part B		Part A	Part B			
		Not Subject to Deductibles & Coi nsurance	Subject to Deductibles & Coi nsurance		Not Subject to Deductibles & Coi nsurance			Subject to Deductibles & Coi nsurance
	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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150037

Period:

Worksheet H-3

HHA CCN: 157092

From 01/01/2013  
To 12/31/2013

Part I  
Date/Time Prepared:  
5/30/2014 8:53 am

Title XVII I

Home Health  
Agency I

PPS

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	606,725		1.00
2.00	Physical Therapy	819,952		2.00
3.00	Occupational Therapy	371,918		3.00
4.00	Speech Pathology	15,156		4.00
5.00	Medical Social Services	23,493		5.00
6.00	Home Health Aide	154,101		6.00
7.00	Total (sum of lines 1-6)	1,991,345		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
8.03	Skilled Nursing Care			8.03
8.04	Skilled Nursing Care			8.04
9.00	Physical Therapy			9.00
9.01	Physical Therapy			9.01
9.02	Physical Therapy			9.02
9.03	Physical Therapy			9.03
9.04	Physical Therapy			9.04
10.00	Occupational Therapy			10.00
10.01	Occupational Therapy			10.01
10.02	Occupational Therapy			10.02
10.03	Occupational Therapy			10.03
10.04	Occupational Therapy			10.04
11.00	Speech Pathology			11.00
11.01	Speech Pathology			11.01
11.02	Speech Pathology			11.02
11.03	Speech Pathology			11.03
11.04	Speech Pathology			11.04
12.00	Medical Social Services			12.00
12.01	Medical Social Services			12.01
12.02	Medical Social Services			12.02
12.03	Medical Social Services			12.03
12.04	Medical Social Services			12.04
13.00	Home Health Aide			13.00
13.01	Home Health Aide			13.01
13.02	Home Health Aide			13.02
13.03	Home Health Aide			13.03
13.04	Home Health Aide			13.04
14.00	Total (sum of lines 8-13)			14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150037

Period:

Worksheet H-3

HHA CCN: 157092

From 01/01/2013

Part II

To 12/31/2013

Date/Time Prepared:

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		
<b>PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS</b>							
1.00 Physical Therapy	66.00	0.496613	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.346893	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.470543	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	0.756311	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.262480	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 150037 HHA CCN: 157092	Period: From 01/01/2013 To 12/31/2013	Worksheet H-4 Part I-II Date/Time Prepared: 5/30/2014 8:53 am
		Title XVII I	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
<b>PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES</b>				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	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	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	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	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	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	8.00
9.00	Primary payer amounts	0	1	9.00
			Part A Services	Part B Services
			1.00	2.00
<b>PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT</b>				
10.00	Total reasonable cost (see instructions)		0	-1
11.00	Total PPS Reimbursement - Full Episodes without Outliers		507,176	1,005,475
12.00	Total PPS Reimbursement - Full Episodes with Outliers		4,070	14,306
13.00	Total PPS Reimbursement - LUPA Episodes		5,517	16,344
14.00	Total PPS Reimbursement - PEP Episodes		12,911	17,475
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		301	3,314
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	593
17.00	Total Other Payments		0	25
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)			0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		529,975	1,057,531
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		529,975	1,057,531
25.00	Coinsurance billed to program patients (from your records)			0
26.00	Net cost (line 24 minus line 25)		529,975	1,057,531
27.00	Reimbursable bad debts (from your records)			
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			
29.00	Total costs - current cost reporting period (line 26 plus line 27)		529,975	1,057,531
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		529,975	1,057,531
31.01	Sequestration adjustment (see instructions)		7,489	17,685
32.00	Interim payments (see instructions)		522,485	1,039,796
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33		1	50
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	0

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

Provider CCN: 150037

Period: From 01/01/2013

Worksheet H-5

HHA CCN: 157092

To 12/31/2013

Date/Time Prepared: 5/30/2014 8:53 am

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		522,485		1,039,796	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)		522,485		1,039,796	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		1		50	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		522,486		1,039,846	7.00
				Contractor Number	NPR 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

Period: From 01/01/2013

Worksheet K

Hospice CCN: 151547

To 12/31/2013

Date/Time Prepared: 5/30/2014 8:53 am

		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	
<b>GENERAL SERVICE COST CENTERS</b>							
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	5,069	0	0	0	1,293,837	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services	192,634	0	0	0	0	9.00
10.00	Nursing Care	810,034	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	95,110	0	0	0	0	15.00
16.00	Spiritual Counseling	12,557	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	122,703	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
<b>OTHER HOSPICE SERVICE COSTS</b>							
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
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
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)	1,238,107	0	0	0	1,293,837	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150037

Period: From 01/01/2013

Worksheet K

Hospice CCN: 151547

To 12/31/2013

Date/Time Prepared: 5/30/2014 8:53 am

		Hospice I					
		Total (col. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	1,298,906	0	1,298,906	-8,030	1,290,876	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services	192,634	0	192,634	0	192,634	9.00
10.00	Nursing Care	810,034	0	810,034	0	810,034	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	95,110	0	95,110	0	95,110	15.00
16.00	Spiritual Counseling	12,557	0	12,557	0	12,557	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	122,703	0	122,703	0	122,703	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
<b>OTHER HOSPICE SERVICE COSTS</b>							
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
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
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)	2,531,944	0	2,531,944	-8,030	2,523,914	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150037

Period: From 01/01/2013

Worksheet K-1

Hospice CCN: 151547

To 12/31/2013

Date/Time Prepared: 5/30/2014 8:53 am

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	5,069	0	0	0	0	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services	0	0	0	192,634	0	9.00
10.00	Nursing Care	0	0	0	0	810,034	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	95,110	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
<b>OTHER HOSPICE SERVICE COSTS</b>							
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
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
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)	5,069	0	95,110	192,634	810,034	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150037

Period: From 01/01/2013

Worksheet K-1

Hospice CCN: 151547

To 12/31/2013

Date/Time Prepared: 5/30/2014 8:53 am

		Hospice I				
		Total Therapists	Aides	All-Other	Total (1)	
		6.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>						
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	5,069	6.00
<b>INPATIENT CARE SERVICE</b>						
7.00	Inpatient - General Care		0	0	0	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
<b>VISITING SERVICES</b>						
9.00	Physician Services		0	0	192,634	9.00
10.00	Nursing Care		0	0	810,034	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	95,110	15.00
16.00	Spiritual Counseling		0	12,557	12,557	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		122,703	0	122,703	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>						
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
<b>HOSPICE NONREIMBURSABLE SERVICE</b>						
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	122,703	12,557	1,238,107	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 150037

Period: From 01/01/2013

Worksheet K-4

Hospice CCN: 151547

To 12/31/2013

Part I  
Date/Time Prepared:  
5/30/2014 8:53 am

		CAPITAL RELATED COST				Hospice I	
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
			1.00	2.00			
<b>GENERAL SERVICE COST CENTERS</b>							
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	1,290,876	0	0	0	0	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services	192,634	0	0	0	0	9.00
10.00	Nursing Care	810,034	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	95,110	0	0	0	0	15.00
16.00	Spiritual Counseling	12,557	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	122,703	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
<b>OTHER HOSPICE SERVICE COSTS</b>							
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
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
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)	2,523,914	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 150037

Period: From 01/01/2013

Worksheet K-4

Hospice CCN: 151547

To 12/31/2013

Part I  
Date/Time Prepared:  
5/30/2014 8:53 am

		Hospice I			
	VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (col s. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A ± col. 6)	
	5.00	5A	6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
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	1,290,876	1,290,876	6.00
<b>INPATIENT CARE SERVICE</b>					
7.00	Inpatient - General Care	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	8.00
<b>VISITING SERVICES</b>					
9.00	Physician Services	0	192,634	201,670	9.00
10.00	Nursing Care	0	810,034	848,030	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	11.00
12.00	Physical Therapy	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	14.00
15.00	Medical Social Services	0	95,110	99,571	15.00
16.00	Spiritual Counseling	0	12,557	13,146	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	0	122,703	128,459	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	20.00
21.00	Other	0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>					
22.00	Drugs, Biological and Infusion Therapy	0	0	0	22.00
23.00	Analgesics	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	24.00
25.00	Other - Specify	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	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
<b>HOSPICE NONREIMBURSABLE SERVICE</b>					
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	2,523,914	2,523,914	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150037

Period: From 01/01/2013

Worksheet K-4

Hospice CCN: 151547

To 12/31/2013

Part II  
Date/Time Prepared:  
5/30/2014 8:53 am

		CAPITAL RELATED COST		PLANT OPERATION & MAINT. (SQ. FT.)	TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICES COORDINATOR (HOURS)	
		BUILDINGS & FIXTURES (SQ. FT.)	MOVABLE EQUIPMENT (\$ VALUE)				
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
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
<b>OTHER HOSPICE SERVICE COSTS</b>							
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
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
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	Period:	Worksheet K-4
	Hospice CCN: 151547	From 01/01/2013 To 12/31/2013	Part II Date/Time Prepared: 5/30/2014 8:53 am

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	Hospice I
		6A	6.00	
<b>GENERAL SERVICE COST CENTERS</b>				
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	-1,290,876	1,233,038	6.00
<b>INPATIENT CARE SERVICE</b>				
7.00	Inpatient - General Care	0	0	7.00
8.00	Inpatient - Respite Care	0	0	8.00
<b>VISITING SERVICES</b>				
9.00	Physician Services	0	192,634	9.00
10.00	Nursing Care	0	810,034	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	95,110	15.00
16.00	Spiritual Counseling	0	12,557	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	122,703	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	20.00
21.00	Other	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>				
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
<b>HOSPICE NONREIMBURSABLE SERVICE</b>				
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)		1,290,876	39.00
40.00	Unit Cost Multiplier		1.046907	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150037

Period: From 01/01/2013

Worksheet K-5

Hospice CCN: 151547

To 12/31/2013

Part I  
Date/Time Prepared:  
5/30/2014 8:53 am

Cost Center Description		Hospice Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			NEW BLDG & FIXT					
		0	1.00		4.00	4A	5.00	
1.00	Administrative and General		112,018		214,289	326,307	70,092	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	394,304	0		0	394,304	84,698	4.00
5.00	Nursing Care	1,658,064	0		0	1,658,064	356,159	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	194,681	0		0	194,681	41,818	10.00
11.00	Spiritual Counseling	25,703	0		0	25,703	5,521	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	251,162	0		0	251,162	53,951	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)	2,523,914	112,018		214,289	2,850,221	612,239	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

Period:

Worksheet K-5

Hospice CCN: 151547

From 01/01/2013  
To 12/31/2013

Part I  
Date/Time Prepared:  
5/30/2014 8:53 am

Cost Center Description		Hospice I					
		OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	245,359	0	0	91,344	81,128	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)	245,359	0	0	91,344	81,128	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150037

Period: From 01/01/2013

Worksheet K-5

Hospice CCN: 151547

To 12/31/2013

Part I  
Date/Time Prepared:  
5/30/2014 8:53 am

Cost Center Description		Hospice I				Subtotal (col s. 4A-23)	
		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM		
		14.00	15.00	16.00	23.00	24.00	
1.00	Administrative and General	3,348	0	0	0	817,578	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	479,002	4.00
5.00	Nursing Care	0	0	0	0	2,014,223	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	236,499	10.00
11.00	Spiritual Counseling	0	0	0	0	31,224	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	305,113	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)	3,348	0	0	0	3,883,639	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150037

Period: From 01/01/2013

Worksheet K-5

Hospice CCN: 151547

To 12/31/2013

Part I  
Date/Time Prepared:  
5/30/2014 8:53 am

Cost Center Description		Hospice I					
		Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (col.s. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (col.s. 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	479,002	127,728	606,730		4.00
5.00	Nursing Care	0	2,014,223	537,101	2,551,324		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	236,499	63,063	299,562		10.00
11.00	Spiritual Counseling	0	31,224	8,326	39,550		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	305,113	81,360	386,473		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	3,883,639		3,883,639		34.00
35.00	Unit Cost Multiplier (see instructions)			0.266654			35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS  
STATISTICAL BASIS

Provider CCN: 150037

Period:

Worksheet K-5

Hospice CCN: 151547

From 01/01/2013  
To 12/31/2013

Part II  
Date/Time Prepared:  
5/30/2014 8:53 am

Cost Center Description	Hospice I						
	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)	1.00					
1.00 Administrative and General	9,240		1,238,107	0	326,307	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	394,304	0	4.00
5.00 Nursing Care	0		0	0	1,658,064	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	194,681	0	10.00
11.00 Spiritual Counseling	0		0	0	25,703	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	251,162	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		1,238,107		2,850,221	9,240	34.00
35.00 Total cost to be allocated	112,018		214,289		612,239	245,359	35.00
36.00 Unit Cost Multiplier (see instructions)	12.123160		0.173078		0.214804	26.554004	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS  
STATISTICAL BASIS

Provider CCN: 150037

Period:

Worksheet K-5

Hospice CCN: 151547

From 01/01/2013  
To 12/31/2013

Part II  
Date/Time Prepared:  
5/30/2014 8:53 am

Cost Center Description		Hospice I					
		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	0	35,531	35,531	102,100	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	0	35,531	35,531	102,100	34.00
35.00	Total cost to be allocated	0	0	91,344	81,128	3,348	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	2.570825	2.283302	0.032791	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS  
STATISTICAL BASIS

Provider CCN: 150037

Hospice CCN: 151547

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet K-5  
Part II  
Date/Time Prepared:  
5/30/2014 8:53 am

Cost Center Description		Hospice I			
		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

Period: From 01/01/2013

Worksheet K-5

Hospice CCN: 151547

To 12/31/2013

Part III  
Date/Time Prepared:  
5/30/2014 8:53 am

Cost Center Description		Hospice I			
		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
ANCI LLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.496613	0	0 1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.346893	0	0 2.00
3.00	SPEECH PATHOLOGY	68.00	0.470543	0	0 3.00
3.01	OCCUPATIONAL HEALTH	68.01	0.000000	0	0 3.01
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.262480	0	0 4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00			5.00
6.00	LABORATORY	60.00	0.163826	0	0 6.00
6.01	BLOOD LABORATORY	60.01			6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.756311	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	0.530938	0	0 10.01
11.00	Totals (sum of lines 1-10)				0 11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 150037

Period: From 01/01/2013

Worksheet K-6

Hospice CCN: 151547

To 12/31/2013

Date/Time Prepared: 5/30/2014 8:53 am

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				3,883,639	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				6,754	2.00
3.00	Average cost per diem (line 1 divided by line 2)				575.01	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	6,754				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	3,883,618				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		0			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		0			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	0				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11.00	Aggregate NF cost (line 3 times line 10)		0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			0		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			0		13.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet L Parts I-III Date/Time Prepared: 5/30/2014 8:53 am
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		704,804	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		3,503	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		23.66	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 (multiply line 5 by the sum of lines 1 and 1.01)		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 (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 10 times the sum of lines 1 and 1.01)		0	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		708,307	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
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
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
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 01/01/2013  
To 12/31/2013

Worksheet M-1  
Date/Time Prepared:  
5/30/2014 8:53 am

				Rural Health Clinic (RHC) I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	Reclassified	
		1.00	2.00	3.00	4.00	5.00	
					Balance	Balance	
					(col. 3 + col. 4)	(col. 3 + col. 4)	
<b>FACILITY HEALTH CARE STAFF COSTS</b>							
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	112,759	0	112,759	0	112,759	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	21,532	0	21,532	0	21,532	9.00
10.00	Subtotal (sum of lines 1-9)	134,291	0	134,291	0	134,291	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	2,367	2,367	0	2,367	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	2,367	2,367	0	2,367	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	134,291	16,647	150,938	0	150,938	22.00
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>							
23.00	Pharmacy	0	6,363	6,363	0	6,363	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	6,363	6,363	0	6,363	28.00
<b>FACILITY OVERHEAD</b>							
29.00	Facility Costs	0	61,579	61,579	0	61,579	29.00
30.00	Administrative Costs	29,577	127	29,704	0	29,704	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	29,577	61,706	91,283	0	91,283	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	163,868	84,716	248,584	0	248,584	32.00

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

Provider CCN: 150037  
Component CCN: 153987

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet M-1  
Date/Time Prepared:  
5/30/2014 8:53 am  
Rural Health Clinic (RHC) I  
Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
<b>FACILITY HEALTH CARE STAFF COSTS</b>				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	112,759	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	21,532	9.00
10.00	Subtotal (sum of lines 1-9)	0	134,291	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	2,367	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	2,367	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-14,280	136,658	22.00
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>				
23.00	Pharmacy	0	6,363	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	6,363	28.00
<b>FACILITY OVERHEAD</b>				
29.00	Facility Costs	0	61,579	29.00
30.00	Administrative Costs	0	29,704	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	91,283	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-14,280	234,304	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 150037	Period: From 01/01/2013	Worksheet M-2
		Component CCN: 153987	To 12/31/2013	Date/Time Prepared: 5/30/2014 8:53 am
			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	
<b>VISITS AND PRODUCTIVITY</b>						
<b>Positions</b>						
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	1.12	1,678	2,100	2,352	3.00
4.00	Subtotal (sum of lines 1-3)	1.12	1,678		2,352	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)	1.12	1,678		2,352	8.00
9.00	Physician Services Under Agreements		22		22	9.00
					1.00	

<b>DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES</b>					
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)			136,658	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)			6,363	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)			143,021	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)			0.955510	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)			91,283	14.00
15.00	Parent provider overhead allocated to facility (see instructions)			85,276	15.00
16.00	Total overhead (sum of lines 14 and 15)			176,559	16.00
17.00	Allowable GME overhead (see instructions)			0	17.00
18.00	Subtract line 17 from line 16			176,559	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)			168,704	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)			305,362	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 150037	Period: From 01/01/2013 To 12/31/2013	Worksheet M-3
		Component CCN: 153987		Date/Time Prepared: 5/30/2014 8:53 am
		Title XVIII	Rural Health Clinic (RHC) I	Cost
				1.00
<b>DETERMINATION OF RATE FOR RHC/FQHC SERVICES</b>				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		305,362	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		9,592	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		295,770	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		2,352	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		22	5.00
6.00	Total adjusted visits (line 4 plus line 5)		2,374	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		124.59	7.00
		<b>Calculation of Limit (1)</b>		
		<b>Prior to January 1</b>	<b>On or After January 1</b>	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.17	79.17	8.00
9.00	Rate for Program covered visits (see instructions)	79.17	79.17	9.00
<b>CALCULATION OF SETTLEMENT</b>				
10.00	Program covered visits excluding mental health services (from contractor records)	0	251	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	19,872	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) *		19,872	16.00
16.01	Total program charges (see instructions)(from contractor's records)		57,953	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.)		11,923	16.04
16.05	Total program cost (see instructions)		11,923	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		4,968	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		10,597	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		11,923	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		2,034	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		13,957	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable 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 (see instructions)		13,957	26.00
26.01	Sequestration adjustment (see instructions)		211	26.01
27.00	Interim payments		12,559	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program line 26 minus lines 26.01, 27 and 28		1,187	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 01/01/2013 To 12/31/2013	Worksheet M-4 Date/Time Prepared: 5/30/2014 8:53 am
		Title XVIII	Rural Health Clinic (RHC) I	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	134,291	134,291	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001565	0.009178	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	210	1,233	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,323	1,419	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,533	2,652	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	136,658	136,658	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	176,559	176,559	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.011218	0.019406	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,981	3,426	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	3,514	6,078	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	22	129	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	159.73	47.12	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	3	33	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	479	1,555	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)		9,592	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)		2,034	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 01/01/2013 To 12/31/2013	Worksheet M-5 Date/Time Prepared: 5/30/2014 8:53 am
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		12,559	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)		12,559	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		1,187	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		13,746	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00