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 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/27/2015 12:05 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/27/2015 Time: 12:05 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HANCOCK REGIONAL HOSPITAL (150037) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 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: 5/27/2015 Time: 12:05 pm
z2N7aAqTEQdFXse:WiPU09wkAksng0
ejpZ:0W0LhXtIRZpjpHz6Akn8y7Ztz
iyvW1Tq7KA06oPXY
PI: Date: 5/27/2015 Time: 12:05 pm
7XPVeCJ11o7AifqDSI.us831r:yGu0
nNrkH02FVSAe4:wi7SJHfv9kFi9GOX
PhD70j5n6Z0r:khG

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

CFO
Title

5-28-15
Date

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	45,318	37,179	-47,067	-434,873	1.00
2.00	Subprovider - IPF	0	440	0		0	2.00
3.00	Subprovider - IRF	0	35	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		2,635		0	10.00
200.00	Total	0	45,793	39,814	-47,067	-434,873	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. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2015 11:52 am

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

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

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2014	12/31/2014	20.00
21.00	Type of Control (see instructions)	9		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	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 column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	430	453	0	3	484	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2015 11:52 am

		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	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		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
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	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 Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	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 Wkst. D, Parts III & IV and D-2, Pt. 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, § 2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	Y			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2015 11:52 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
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			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

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

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2015 11:52 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, 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 fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y			75.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2015 11:52 am

		1.00	2.00	3.00	
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, 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 fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)	N	N	0	76.00

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. 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	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2015 11:52 am

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

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	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 the costs for inpatient services only? Enter "Y" for yes or "N" for no.	N	145.00

		1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150037	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 11:52 am

							1.00	
	Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
							1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under 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)						0.50	169.00
						Beginning	Ending	
						1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					10/01/2013	09/30/2014	170.00
							1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)						N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/27/2015 11:52 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		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)		Y	03/10/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 5/27/2015 11:52 am

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/27/2015 11:52 am

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	03/10/2015			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I Date/Time Prepared: 5/27/2015 11:52 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	37	13,505	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)		37	13,505	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)		61	22,265	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)		83				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 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/27/2015 11:52 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,269	426	3,598			1.00
2.00	HMO and other (see instructions)	834	918				2.00
3.00	HMO IPF Subprovider	32	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,269	426	3,598			7.00
8.00	INTENSIVE CARE UNIT	2,309	0	5,037			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	3,578	426	8,635	0.00	536.46	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,434	0	2,643	0.00	18.09	16.00
17.00	SUBPROVIDER - IRF	186	0	296	0.00	3.10	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	11,264	0	18,440	0.00	29.27	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	16.79	24.00
24.10	HOSPICE (non-distinct part)	0	0	694			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	269	0	1,569	0.00	2.88	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	606.59	27.00
28.00	Observation Bed Days		0	2,060			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			118			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	26	50			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 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/27/2015 11:52 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,121	96	2,579	1.00
2.00	HMO and other (see instructions)			252	236		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	1,121	96	2,579	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	206	0	218	16.00
17.00	SUBPROVIDER - IRF	0.00	0	17	0	27	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 01/01/2014 To 12/31/2014 | Worksheet S-3 Part II Date/Time Prepared: 5/27/2015 11:52 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	36,574,339	0	36,574,339	1,178,041.91	31.05	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		171,059	0	171,059	5,620.46	30.44	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		5,746,072	91,001	5,837,073	210,128.00	27.78	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		283,759	0	283,759	5,148.00	55.12	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		258,788	0	258,788	2,054.00	125.99	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		8,417,606	0	8,417,606			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,771,883	0	1,771,883			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		48,061	0	48,061			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	236,024	0	236,024	8,771.00	26.91	26.00
27.00	Administrative & General	5.00	6,030,175	-91,001	5,939,174	168,137.00	35.32	27.00
28.00	Administrative & General under contract (see inst.)		1,039,087	0	1,039,087	6,204.00	167.49	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	810,917	0	810,917	27,573.00	29.41	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	818,608	0	818,608	57,506.00	14.24	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,080,269	-708,906	371,363	22,091.00	16.81	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	708,906	708,906	43,017.00	16.48	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,261,447	0	1,261,447	31,461.00	40.10	38.00
39.00	Central Services and Supply	14.00	64,059	0	64,059	3,649.00	17.56	39.00
40.00	Pharmacy	15.00	1,385,223	-16,067	1,369,156	33,340.00	41.07	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part II Date/Time Prepared: 5/27/2015 11:52 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	579,917	0	579,917	24,328.00	23.84	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part III Date/Time Prepared: 5/27/2015 11:52 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		37,442,367	0	37,442,367	1,178,625.45	31.77	1.00
2.00	Excluded area salaries (see instructions)		5,746,072	91,001	5,837,073	210,128.00	27.78	2.00
3.00	Subtotal salaries (line 1 minus line 2)		31,696,295	-91,001	31,605,294	968,497.45	32.63	3.00
4.00	Subtotal other wages & related costs (see inst.)		542,547	0	542,547	7,202.00	75.33	4.00
5.00	Subtotal wage-related costs (see inst.)		8,417,606	0	8,417,606	0.00	26.63	5.00
6.00	Total (sum of lines 3 thru 5)		40,656,448	-91,001	40,565,447	975,699.45	41.58	6.00
7.00	Total overhead cost (see instructions)		13,305,726	-107,068	13,198,658	426,077.00	30.98	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part IV Date/Time Prepared: 5/27/2015 11:52 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1,284,370	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	10,328	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	239,204	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	132,766	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	202,544	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	0	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	20,736	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	8,821	22.00
23.00	Tuition Reimbursement	49,942	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	1,948,711	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part V Date/Time Prepared: 5/27/2015 11:52 am

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

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 150037 | Component CCN: 157092 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-4 | Date/Time Prepared: 5/27/2015 11:52 am

Home Health Agency I | PPS

		1.00	
0.00	County		0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	521.00	0.00	0.00	0.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	0.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		0.00	0.00	0.00	5.00
6.00	Direct Nursing Service		0.00	0.00	0.00	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		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					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	4,003	88	95	119	4,305	21.00
22.00	Skilled Nursing Visit Charges	659,572	15,406	11,419	19,756	706,153	22.00
23.00	Physical Therapy Visits	3,584	4	67	34	3,689	23.00
24.00	Physical Therapy Visit Charges	653,960	773	9,663	5,991	670,387	24.00
25.00	Occupational Therapy Visits	1,653	0	20	25	1,698	25.00
26.00	Occupational Therapy Visit Charges	316,350	0	3,285	4,638	324,273	26.00
27.00	Speech Pathology Visits	150	0	0	0	150	27.00
28.00	Speech Pathology Visit Charges	28,601	0	0	0	28,601	28.00
29.00	Medical Social Service Visits	102	0	0	1	103	29.00
30.00	Medical Social Service Visit Charges	22,069	0	0	219	22,288	30.00
31.00	Home Health Aide Visits	1,234	13	6	66	1,319	31.00
32.00	Home Health Aide Visit Charges	95,639	1,034	318	5,247	102,238	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	10,726	105	188	245	11,264	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,776,191	17,213	24,685	35,851	1,853,940	35.00
36.00	Total Number of Episodes (standard/non outlier)	599		48	13	660	36.00
37.00	Total Number of Outlier Episodes		3		1	4	37.00
38.00	Total Non-Routine Medical Supply Charges	71,719	209	370	7,095	79,393	38.00

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

Provider CCN: 150037 Component CCN: 153987 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-8 Date/Time Prepared: 5/27/2015 11:52 am

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	224 WEST MAIN STREET	1.00

		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	KNIGHTSTOWN	IN		2.00

		1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	148,632	01/01/2014	4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00

		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

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

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 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.	N	0	13.00

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

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

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

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

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 150037 Component CCN: 153987	Period: From 01/01/2014 To 12/31/2014	Worksheet S-8 Date/Time Prepared: 5/27/2015 11:52 am
		Rural Health Clinic (RHC) I	Cost

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

HOSPITAL IDENTIFICATION DATA	Provider CCN: 150037 Component CCN: 151547	Period: From 01/01/2014 To 12/31/2014	Worksheet S-9 Parts I & II Date/Time Prepared: 5/27/2015 11:52 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	
	PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Routine Home Care	3,636	13	0	0	268	3,917	2.00
3.00	Inpatient Respite Care	184	0	0	0	12	196	3.00
4.00	General Inpatient Care	355	18	0	0	9	382	4.00
5.00	Total Hospice Days	4,175	31	0	0	289	4,495	5.00
	Part II - CENSUS DATA							
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	154	0	0	0	0	154	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150037	Period: From 01/01/2014 To 12/31/2014	Worksheet S-10 Date/Time Prepared: 5/27/2015 11:52 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.332391	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	11,194,352	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	16,511,402	6.00
7.00	Medicaid cost (line 1 times line 6)	5,488,241	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)	0	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)	0	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	4,686,211	0	4,686,211	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,557,654	0	1,557,654	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)	1,557,654	0	1,557,654	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)	10,891,326	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	104,852	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	10,786,474	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	3,585,327	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	5,142,981	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,142,981	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/27/2015 11:52 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		6,042,435	6,042,435	0	6,042,435	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	236,024	8,016,567	8,252,591	0	8,252,591	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,030,175	12,346,952	18,377,127	-669,074	17,708,053	5.00
7.00	00700	OPERATION OF PLANT	810,917	4,264,895	5,075,812	3,483	5,079,295	7.00
9.00	00900	HOUSEKEEPING	818,608	662,700	1,481,308	0	1,481,308	9.00
10.00	01000	DIETARY	1,080,269	917,609	1,997,878	-1,311,069	686,809	10.00
11.00	01100	CAFETERIA	0	0	0	1,311,069	1,311,069	11.00
13.00	01300	NURSING ADMINISTRATION	1,261,447	386,438	1,647,885	0	1,647,885	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	64,059	62,249	126,308	0	126,308	14.00
15.00	01500	PHARMACY	1,385,223	6,360,355	7,745,578	-18,611	7,726,967	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	579,917	267,991	847,908	11,318	859,226	16.00
23.00	02300	PARAMED ED PRGM	68,188	12,508	80,696	0	80,696	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,522,427	654,753	3,177,180	0	3,177,180	30.00
31.00	03100	INTENSIVE CARE UNIT	2,960,513	748,832	3,709,345	0	3,709,345	31.00
40.00	04000	SUBPROVIDER - IPF	1,107,800	258,265	1,366,065	0	1,366,065	40.00
41.00	04100	SUBPROVIDER - IRF	156,648	60,790	217,438	0	217,438	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,389,797	2,234,659	4,624,456	0	4,624,456	50.00
51.00	05100	RECOVERY ROOM	198,149	54,419	252,568	0	252,568	51.00
53.00	05300	ANESTHESIOLOGY	0	139,038	139,038	0	139,038	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,280,541	2,014,263	4,294,804	0	4,294,804	54.00
60.00	06000	LABORATORY	1,466,165	2,539,388	4,005,553	7,910	4,013,463	60.00
65.00	06500	RESPIRATORY THERAPY	1,108,772	296,926	1,405,698	7,395	1,413,093	65.00
66.00	06600	PHYSICAL THERAPY	904,370	224,383	1,128,753	0	1,128,753	66.00
67.00	06700	OCCUPATIONAL THERAPY	251,541	25,310	276,851	0	276,851	67.00
68.00	06800	SPEECH PATHOLOGY	173,388	26,555	199,943	0	199,943	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	443,679	507,168	950,847	21,833	972,680	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,189,177	3,189,177	0	3,189,177	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,649,055	1,649,055	0	1,649,055	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	03160	CARDIOPULMONARY	50,114	43,883	93,997	0	93,997	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	171,059	93,356	264,415	0	264,415	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	591,241	273,414	864,655	0	864,655	90.01
90.02	09002	DIABETES CLINIC	33,598	7,751	41,349	0	41,349	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	43,753	61,857	105,610	0	105,610	90.04
90.05	09005	PRIME TIME	0	108,748	108,748	0	108,748	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	127,238	135,538	262,776	0	262,776	90.06
90.07	04951	ONCOLOGY	452,144	1,004,251	1,456,395	0	1,456,395	90.07
90.08	04950	ANDERSON WOMENS CENTER	221,923	67,000	288,923	0	288,923	90.08
91.00	09100	EMERGENCY	2,171,216	536,626	2,707,842	0	2,707,842	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	796,304	-333,869	462,435	0	462,435	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	1,038,801	1,140,921	2,179,722	0	2,179,722	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	33,996,008	57,103,156	91,099,164	-635,746	90,463,418	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	538,872	538,872	-33,328	505,544	190.01
190.02	19002	PHYSICIAN BUILDING	6	103,400	103,406	0	103,406	190.02
190.03	19003	PRIVATE DUTY	406,663	224,655	631,318	0	631,318	190.03
190.04	19004	MARKETING	0	0	0	669,074	669,074	190.04
190.05	19005	WATER LAB	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	121,658	60,256	181,914	0	181,914	190.06
190.07	19007	ASC	0	720	720	0	720	190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	1,067,887	2,486,476	3,554,363	0	3,554,363	190.09
190.10	19010	HANCOCK WELLNESS	841,127	1,140,714	1,981,841	0	1,981,841	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	95,508	-93,808	1,700	0	1,700	190.12
190.13	19013	MCCORD WELLNESS	0	7,736	7,736	0	7,736	190.13
190.14	19014	3 WEST UNIT	45,482	82,564	128,046	0	128,046	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	36,000	36,000	0	36,000	190.15
200.00		TOTAL (SUM OF LINES 118-199)	36,574,339	61,690,741	98,265,080	0	98,265,080	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/27/2015 11:52 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-1,149,700	4,892,735		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,904,301	5,348,290		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-5,172,065	12,535,988		5.00
7.00	00700	OPERATION OF PLANT	-57,080	5,022,215		7.00
9.00	00900	HOUSEKEEPING	-11,700	1,469,608		9.00
10.00	01000	DIETARY	-356,300	330,509		10.00
11.00	01100	CAFETERIA	-47,853	1,263,216		11.00
13.00	01300	NURSING ADMINISTRATION	-22,805	1,625,080		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-37,149	89,159		14.00
15.00	01500	PHARMACY	-680,530	7,046,437		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-66,513	792,713		16.00
23.00	02300	PARAMED ED PRGM	-60,105	20,591		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,747	3,175,433		30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,709,345		31.00
40.00	04000	SUBPROVIDER - IPF	-96,000	1,270,065		40.00
41.00	04100	SUBPROVIDER - IRF	-36,000	181,438		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-388,298	4,236,158		50.00
51.00	05100	RECOVERY ROOM	0	252,568		51.00
53.00	05300	ANESTHESIOLOGY	-130,587	8,451		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-355,446	3,939,358		54.00
60.00	06000	LABORATORY	-213,202	3,800,261		60.00
65.00	06500	RESPIRATORY THERAPY	-130,313	1,282,780		65.00
66.00	06600	PHYSICAL THERAPY	0	1,128,753		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	276,851		67.00
68.00	06800	SPEECH PATHOLOGY	-1,250	198,693		68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	-290	972,390		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,189,177		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,649,055		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	CARDIAC	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	93,997		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-6,670	257,745		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	-7,248	857,407		90.01
90.02	09002	DIABETES CLINIC	-350	40,999		90.02
90.03	09003	ASTHMA CLINIC	0	0		90.03
90.04	09004	ANDIS CLINIC	-4,875	100,735		90.04
90.05	09005	PRIME TIME	0	108,748		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	-324	262,452		90.06
90.07	04951	ONCOLOGY	-520,077	936,318		90.07
90.08	04950	ANDERSON WOMENS CENTER	-3,065	285,858		90.08
91.00	09100	EMERGENCY	-61,104	2,646,738		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	2,821,144	3,283,579		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	-44,840	2,134,882		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-9,746,643	80,716,775		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	505,544		190.01
190.02	19002	PHYSICIAN BUILDING	0	103,406		190.02
190.03	19003	PRIVATE DUTY	0	631,318		190.03
190.04	19004	MARKETING	0	669,074		190.04
190.05	19005	WATER LAB	0	0		190.05
190.06	19006	FOUNDATION	0	181,914		190.06
190.07	19007	ASC	0	720		190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.08
190.09	19009	HANCOCK OB	0	3,554,363		190.09
190.10	19010	HANCOCK WELLNESS	0	1,981,841		190.10
190.11	19011	MORRISTOWN CLINIC	0	0		190.11
190.12	19012	O3PUREMED	0	1,700		190.12
190.13	19013	MCCORD WELLNESS	0	7,736		190.13
190.14	19014	3 WEST UNIT	0	128,046		190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	36,000		190.15
200.00		TOTAL (SUM OF LINES 118-199)	-9,746,643	88,518,437		200.00

RECLASSIFICATIONS | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/27/2015 11:52 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	708,906	602,163		1.00
	TOTALS		708,906	602,163		
	B - PLANT RECLASS					
1.00	OPERATION OF PLANT	7.00	0	3,483		1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	11,318		2.00
3.00	ELECTROCARDIOLOGY	69.00	0	11,132		3.00
4.00	RESPIRATORY THERAPY	65.00	0	7,395		4.00
	TOTALS		0	33,328		
	C - MARKETING RECLASS					
1.00	MARKETING	190.04	91,001	578,073		1.00
	TOTALS		91,001	578,073		
	D - OUTPATIENT PROCEDURE RECLASS					
1.00	LABORATORY	60.00	6,829	1,081		1.00
2.00	ELECTROCARDIOLOGY	69.00	9,238	1,463		2.00
	TOTALS		16,067	2,544		
500.00	Grand Total: Increases		815,974	1,216,108		500.00

RECLASSIFICATIONS | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/27/2015 11:52 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	708,906	602,163	0		1.00
	TOTALS		708,906	602,163			
	B - PLANT RECLASS						
1.00	PROFESSIONAL BUILDING	190.01	0	33,328	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	33,328			
	C - MARKETING RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	91,001	578,073	0		1.00
	TOTALS		91,001	578,073			
	D - OUTPATIENT PROCEDURE RECLASS						
1.00	PHARMACY	15.00	16,067	2,544	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		16,067	2,544			
500.00	Grand Total: Decreases		815,974	1,216,108			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part I | Date/Time Prepared: 5/27/2015 11:52 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	270,285	970,909	0	970,909	0	1.00
2.00	Land Improvements	5,505,951	0	0	0	0	2.00
3.00	Buildings and Fixtures	43,186,865	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	53,707,886	2,798,103	0	2,798,103	228,820	5.00
6.00	Movable Equipment	58,064,889	4,229,131	0	4,229,131	60,610	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	160,735,876	7,998,143	0	7,998,143	289,430	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	160,735,876	7,998,143	0	7,998,143	289,430	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,241,194	0	1.00
2.00	Land Improvements	5,505,951	0	2.00
3.00	Buildings and Fixtures	43,186,865	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	56,277,169	0	5.00
6.00	Movable Equipment	62,233,410	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	168,444,589	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	168,444,589	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part II | Date/Time Prepared: 5/27/2015 11:52 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	6,042,435	0	0	0	0	1.00
3.00	Total (sum of lines 1-2)	6,042,435	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	6,042,435		1.00
3.00	Total (sum of lines 1-2)	0	6,042,435		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part III Date/Time Prepared: 5/27/2015 11:52 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	43,186,865	0	43,186,865	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	43,186,865	0	43,186,865	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	5,555,560	-660,452	1.00
3.00	Total (sum of lines 1-2)	0	0	0	5,555,560	-660,452	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	-2,373	0	0	0	4,892,735	1.00
3.00	Total (sum of lines 1-2)	-2,373	0	0	0	4,892,735	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/27/2015 11:52 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	-1,832,521			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 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/27/2015 11:52 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	HRH MMO RENTAL INCOME	B	-652,294	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.00
33.01	HRH HUMAN RESOURCES MISCELLANEOUS RE	B	-15,604	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	HRH OTHER REVENUE SALES TAX	B	36,618	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	HRH OTHER REVENUE MISCELLANEOUS REVE	B	-578	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	HRH OTHER REVENUE HEARTBEATS REVENUE	B	-435	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	HRH OTHER REVENUE CHARGE CARD-OTHER	B	-90	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	HRH GREENFIELD PAR EDUCATION SERVICE	B	78	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	HRH MED STAFF SERV QA APPLICATION FE	B	-18,000	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	HRH MEDICAL DUES MEDICAL STAFF DUES	B	-21,450	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	HRH PAT FIN. SERV. BUSINESS SERV-COP	B	-2,012	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	HRH PAT FIN. SERV. EXPENSE REIMBURSE	B	-49,398	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	HRH INFO SERVICES MISCELLANEOUS REVE	B	-91,716	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	HRH ACCOUNTING MISCELLANEOUS REVENUE	B	-9,045	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	HRH ACCOUNTING MANAGEMENT FEES	B	-16,575	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	HRH EXEC ADMIN MISCELLANEOUS REVENUE	B	-74,500	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	HRH PURCHASING REBATES/REFUNDS	B	-225	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	HRH COMMUNICATIONS MISCELLANEOUS REV	B	-8,181	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	HRH COMMUNICATIONS PHONE LEASE REVEN	B	-184,349	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	HRH COMM EDUCATION MISCELLANEOUS REV	B	-100	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	HRH COMM EDUCATION EDUCATION SERVICE	B	-9,176	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	HRH TOBACCO AWARENE MISCELLANEOUS RE	B	-200	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.22	HRH GAIN/LOSS INVENTORY	B	-107,171	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23	HRH GAIN/LOSS GROSS VARIANCE INVENTO	B	31,088	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24	HRH SECURITY MISCELLANEOUS REVENUE	B	-100	ADMINISTRATIVE & GENERAL	5.00	0	33.24
33.25	HRH PLANT OFFSITE SERVICES	B	-55,284	OPERATION OF PLANT	7.00	0	33.25
33.28	HRH HOUSEKEEPING ENVIRONMENTAL SERVI	B	-11,700	HOUSEKEEPING	9.00	0	33.28
33.29	HRH NUTRITIONAL SER REBATES/REFUNDS	B	-2,066	DIETARY	10.00	0	33.29
33.30	HRH NUTRITIONAL SER LTACH REVENUE	B	-16,462	DIETARY	10.00	0	33.30
33.31	HRH NUTRITIONAL SER MISCELLANEOUS RE	B	-528	DIETARY	10.00	0	33.31
33.32	HRH CLINICAL EDUCAT AHA COURSE REVEN	B	-14,781	NURSING ADMINISTRATION	13.00	0	33.32
33.33	HRH CLINICAL EDUCAT EDUCATION SERVIC	B	-195	NURSING ADMINISTRATION	13.00	0	33.33
33.34	HRH OTHER REVENUE REBATES/REFUNDS	B	-22,340	CENTRAL SERVICES & SUPPLY	14.00	0	33.34
33.35	HRH OTHER REVENUE DISCOUNTS EARNED O	B	-14,809	CENTRAL SERVICES & SUPPLY	14.00	0	33.35
33.36	HRH PHARMACY MISCELLANEOUS REVENUE	B	-3,739	PHARMACY	15.00	0	33.36
33.37	HRH PHARMACY REBATES/REFUNDS	B	-12,225	PHARMACY	15.00	0	33.37
33.38	HRH ASSOCIATE PHARM RETAIL PHARMACY-	B	-587,000	PHARMACY	15.00	0	33.38
33.39	HRH ASSOCIATE PHARM HOSPICE PHARMACY	B	-72,107	PHARMACY	15.00	0	33.39
33.40	HRH ASSOCIATE PHARM MISCELLANEOUS RE	B	-5,459	PHARMACY	15.00	0	33.40

ADJUSTMENTS TO EXPENSES | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/27/2015 11:52 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.41	HRH HEALTH INFO SER MEDICAL RECORDS-	B	-1,089	MEDICAL RECORDS & LIBRARY	16.00	0	33.41
33.42	HRH HEALTH INFO SER MISCELLANEOUS RE	B	-65,424	MEDICAL RECORDS & LIBRARY	16.00	0	33.42
33.43	HRH ANDIS UNIT REBATES/REFUNDS	B	-1,747	ADULTS & PEDIATRICS	30.00	0	33.43
33.44			0		0.00	0	33.44
33.45			0		0.00	0	33.45
33.46	HRH DIAG IMAGING MISCELLANEOUS REVEN	B	-175	RADIOLOGY-DIAGNOSTIC	54.00	0	33.46
33.47	HRH DIAG IMAGING HEARTBEATS REVENUE	B	-6,039	RADIOLOGY-DIAGNOSTIC	54.00	0	33.47
33.48	HRH PIC - AHN EXPENSE REIMBURSEMENT	B	-65,946	RADIOLOGY-DIAGNOSTIC	54.00	0	33.48
33.50	HRH MMO-RAD HEARTBEATS REVENUE	B	-1,359	RADIOLOGY-DIAGNOSTIC	54.00	0	33.50
33.51	HRH MMO EXPENSE REIMBURSEMENT	B	-176,483	RADIOLOGY-DIAGNOSTIC	54.00	0	33.51
33.52	HRH LAB WATER TESTING	B	-57,980	LABORATORY	60.00	0	33.52
33.53	HRH LAB HEARTBEATS REVENUE	B	-39,093	LABORATORY	60.00	0	33.53
33.54	HRH LAB MISCELLANEOUS REVENUE	B	-1,546	LABORATORY	60.00	0	33.54
33.55	HRH SLEEP STUDY CLINIC MANAGMENT	B	-51,642	RESPIRATORY THERAPY	65.00	0	33.55
33.56	HRH SLEEP STUDY SLEEP STUDY FEES	B	-60,171	RESPIRATORY THERAPY	65.00	0	33.56
33.58	HRH CARDIO SERV HEARTBEATS REVENUE	B	-290	ELECTROCARDIOLOGY	69.00	0	33.58
33.59			0		0.00	0	33.59
33.60			0		0.00	0	33.60
33.62			0		0.00	0	33.62
33.63			0		0.00	0	33.63
33.64	HRH AWC GENERAL BOUTIQUE SERVICES	B	-3,065	ANDERSON WOMENS CENTER	90.08	0	33.64
33.65	HRH E R REBATES/REFUNDS	B	-1,104	EMERGENCY	91.00	0	33.65
33.66	HRH HOME HEALTH MISCELLANEOUS REVENU	B	98,345	HOME HEALTH AGENCY	101.00	0	33.66
33.67			0		0.00	0	33.67
33.68			0		0.00	0	33.68
33.69	HRH HOSPICE MISCELLANEOUS REVENUE	B	-44,840	HOSPICE	116.00	0	33.69
33.70	MOW	A	-337,244	DIETARY	10.00	0	33.70
33.71	CAFETERIA GUEST MEALS	A	-47,853	CAFETERIA	11.00	0	33.71
33.72	PHYSICIAN RECRUITMENT FEES	A	-58,968	ADMINISTRATIVE & GENERAL	5.00	0	33.72
33.73	DONATIONS & SPONSORSHIPS	A	-5,690	ADMINISTRATIVE & GENERAL	5.00	0	33.73
33.74	ADVERTISING FEE	A	-352,033	ADMINISTRATIVE & GENERAL	5.00	0	33.74
33.77	ADVERTISING FEE	A	-2,903	WOUND CLINIC	90.01	0	33.77
33.78	ADVERTISING FEE	A	-324	SHELBYVILLE WOUND CLINIC	90.06	0	33.78
33.79	IHA LOBBYING EXPENSE	A	-1,555	ADMINISTRATIVE & GENERAL	5.00	0	33.79
33.80	AHA LOBBYING EXPENSE	A	-5,265	ADMINISTRATIVE & GENERAL	5.00	0	33.80
33.81	PHY OFFICE BLDG	A	-486,875	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.81
33.82	PHY OFFICE BLDG	A	-9,521	ADMINISTRATIVE & GENERAL	5.00	0	33.82
33.83	PHY OFFICE BLDG	A	-1	ADMINISTRATIVE & GENERAL	5.00	0	33.83
33.84	PHY OFFICE BLDG	A	-17,925	RADIOLOGY-DIAGNOSTIC	54.00	0	33.84
33.85	PHY OFFICE BLDG	A	-6,670	RURAL HEALTH CLINIC	88.00	0	33.85
33.86	INTEREST REVENUE	B	-2,373	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.86
33.87	RENTAL PROPERTIES EXPENSE	A	-242,654	ADMINISTRATIVE & GENERAL	5.00	0	33.87
33.88	RENTAL PROPERTIES EXPENSE	A	-8,158	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.88
33.89	RENTAL PROPERTIES EXPENSE	A	-1,796	OPERATION OF PLANT	7.00	0	33.89
33.90	TELEPHONE SERVICES	A	-34,650	ADMINISTRATIVE & GENERAL	5.00	0	33.90
33.91	XRAY SCHOOL TUITION REVENUE	B	-60,105	PARAMED ED PRGM	23.00	0	33.91
33.92	HAF EXPENSE	A	-3,573,884	ADMINISTRATIVE & GENERAL	5.00	0	33.92
33.93	SELF INSURANCE CLAIM EXPENSE	A	-2,888,697	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.93
34.00	SUBURBAN EXPENSE	A	2,722,799	HOME HEALTH AGENCY	101.00	0	34.00
34.01	SALE OF USED EQUIPMENT	B	-19	RADIOLOGY-DIAGNOSTIC	54.00	0	34.01
34.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.02
34.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.03
34.04	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.04

ADJUSTMENTS TO EXPENSES | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/27/2015 11:52 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	
34.05	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.05
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-9,746,643				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-2 | Date/Time Prepared: 5/27/2015 11:52 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	362,327	362,327	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	7,829	7,829	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	96,000	96,000	0	0	0	3.00
4.00	41.00	SUBPROVIDER - IRF	36,000	36,000	0	0	0	4.00
5.00	50.00	OPERATING ROOM	388,298	388,298	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	130,587	130,587	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	87,500	87,500	0	0	0	7.00
8.00	60.00	LABORATORY	114,583	114,583	0	0	0	8.00
9.00	65.00	RESPIRATORY THERAPY	18,500	18,500	0	0	0	9.00
10.00	68.00	SPEECH PATHOLOGY	1,250	1,250	0	0	0	10.00
12.00	90.01	WOUND CLINIC	4,345	4,345	0	0	0	12.00
13.00	90.02	DIABETES CLINIC	350	350	0	0	0	13.00
14.00	90.04	ANDIS CLINIC	4,875	4,875	0	0	0	14.00
15.00	90.07	ONCOLOGY	520,077	520,077	0	0	0	15.00
16.00	91.00	EMERGENCY	60,000	60,000	0	0	0	16.00
200.00			1,832,521	1,832,521	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	13.00	NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	3.00
4.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	7.00
8.00	60.00	LABORATORY	0	0	0	0	0	8.00
9.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	9.00
10.00	68.00	SPEECH PATHOLOGY	0	0	0	0	0	10.00
12.00	90.01	WOUND CLINIC	0	0	0	0	0	12.00
13.00	90.02	DIABETES CLINIC	0	0	0	0	0	13.00
14.00	90.04	ANDIS 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	362,327		1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	7,829		2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	96,000		3.00
4.00	41.00	SUBPROVIDER - IRF	0	0	0	36,000		4.00
5.00	50.00	OPERATING ROOM	0	0	0	388,298		5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	130,587		6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	87,500		7.00
8.00	60.00	LABORATORY	0	0	0	114,583		8.00
9.00	65.00	RESPIRATORY THERAPY	0	0	0	18,500		9.00
10.00	68.00	SPEECH PATHOLOGY	0	0	0	1,250		10.00
12.00	90.01	WOUND CLINIC	0	0	0	4,345		12.00
13.00	90.02	DIABETES CLINIC	0	0	0	350		13.00
14.00	90.04	ANDIS CLINIC	0	0	0	4,875		14.00
15.00	90.07	ONCOLOGY	0	0	0	520,077		15.00
16.00	91.00	EMERGENCY	0	0	0	60,000		16.00
200.00			0	0	0	1,832,521		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/27/2015 11:52 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	4,892,735	4,892,735				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,348,290	15,883	5,364,173			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,535,988	353,049	876,712	13,765,749	13,765,749	5.00
7.00	00700	OPERATION OF PLANT	5,022,215	1,195,773	119,706	6,337,694	1,167,093	7.00
9.00	00900	HOUSEKEEPING	1,469,608	31,256	120,841	1,621,705	298,639	9.00
10.00	01000	DIETARY	330,509	49,104	54,820	434,433	80,001	10.00
11.00	01100	CAFETERIA	1,263,216	93,731	104,647	1,461,594	269,154	11.00
13.00	01300	NURSING ADMINISTRATION	1,625,080	13,298	186,212	1,824,590	336,000	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	89,159	0	9,456	98,615	18,160	14.00
15.00	01500	PHARMACY	7,046,437	71,685	202,112	7,320,234	1,347,994	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	792,713	42,698	85,606	921,017	169,606	16.00
23.00	02300	PARAMED ED PRGM	20,591	16,307	10,066	46,964	8,648	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,175,433	343,658	372,356	3,891,447	716,614	30.00
31.00	03100	INTENSIVE CARE UNIT	3,709,345	289,385	437,025	4,435,755	816,849	31.00
40.00	04000	SUBPROVIDER - IPF	1,270,065	77,363	163,531	1,510,959	278,245	40.00
41.00	04100	SUBPROVIDER - IRF	181,438	17,751	23,124	222,313	40,939	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,236,158	286,036	352,777	4,874,971	897,731	50.00
51.00	05100	RECOVERY ROOM	252,568	25,723	29,250	307,541	56,634	51.00
53.00	05300	ANESTHESIOLOGY	8,451	0	0	8,451	1,556	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,939,358	179,212	336,649	4,455,219	820,433	54.00
60.00	06000	LABORATORY	3,800,261	77,096	217,440	4,094,797	754,061	60.00
65.00	06500	RESPIRATORY THERAPY	1,282,780	28,053	163,675	1,474,508	271,532	65.00
66.00	06600	PHYSICAL THERAPY	1,128,753	52,744	133,501	1,314,998	242,158	66.00
67.00	06700	OCCUPATIONAL THERAPY	276,851	0	37,132	313,983	57,820	67.00
68.00	06800	SPEECH PATHOLOGY	198,693	6,091	25,595	230,379	42,425	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	972,390	84,352	66,859	1,123,601	206,912	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,189,177	0	0	3,189,177	587,290	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,649,055	0	0	1,649,055	303,675	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	03160	CARDIOPULMONARY	93,997	0	7,398	101,395	18,672	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	257,745	0	25,251	282,996	52,114	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	857,407	35,127	87,278	979,812	180,433	90.01
90.02	09002	DIABETES CLINIC	40,999	2,342	4,960	48,301	8,895	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	100,735	3,992	6,459	111,186	20,475	90.04
90.05	09005	PRIME TIME	108,748	0	0	108,748	20,026	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	262,452	0	18,783	281,235	51,790	90.06
90.07	04951	ONCOLOGY	936,318	0	66,745	1,003,063	184,715	90.07
90.08	04950	ANDERSON WOMENS CENTER	285,858	20,748	32,760	339,366	62,495	90.08
91.00	09100	EMERGENCY	2,646,738	328,539	320,511	3,295,788	606,923	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,283,579	0	117,549	3,401,128	626,321	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	2,134,882	112,114	153,346	2,400,342	442,025	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	80,716,775	3,853,110	4,970,132	79,283,109	12,065,053	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	505,544	687,437	0	1,192,981	219,689	190.01
190.02	19002	PHYSICIAN BUILDING	103,406	0	1	103,407	19,043	190.02
190.03	19003	PRIVATE DUTY	631,318	0	60,031	691,349	127,313	190.03
190.04	19004	MARKETING	669,074	5,351	13,433	687,858	126,670	190.04
190.05	19005	WATER LAB	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	181,914	0	17,959	199,873	36,807	190.06
190.07	19007	ASC	720	281,947	0	282,667	52,053	190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	3,554,363	0	157,639	3,712,002	683,569	190.09
190.10	19010	HANCOCK WELLNESS	1,981,841	0	124,165	2,106,006	387,823	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	1,700	0	14,099	15,799	2,909	190.12
190.13	19013	MCCORD WELLNESS	7,736	0	0	7,736	1,425	190.13
190.14	19014	3 WEST UNIT	128,046	64,890	6,714	199,650	36,766	190.14

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/27/2015 11:52 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
190.15	19015	NEUROLOGY PHYSICIAN	36,000	0	0	36,000	6,629	190.15
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	88,518,437	4,892,735	5,364,173	88,518,437	13,765,749	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/27/2015 11:52 am

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	7,504,787					7.00
9.00	00900	HOUSEKEEPING	70,483	1,990,827				9.00
10.00	01000	DIETARY	110,731	31,591	656,756			10.00
11.00	01100	CAFETERIA	211,367	52,058	0	1,994,173		11.00
13.00	01300	NURSING ADMINISTRATION	29,988	0	0	74,364	2,264,942	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	78,965	0	8,625	12,578	14.00
15.00	01500	PHARMACY	161,651	57,600	0	78,910	115,078	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	96,285	69,285	0	57,769	0	16.00
23.00	02300	PARAMED ED PRGM	36,774	79,810	0	4,432	6,463	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	774,956	529,507	207,320	171,056	249,459	30.00
31.00	03100	INTENSIVE CARE UNIT	652,569	109,165	284,489	233,062	339,887	31.00
40.00	04000	SUBPROVIDER - IPF	174,456	87,366	148,334	83,389	121,610	40.00
41.00	04100	SUBPROVIDER - IRF	40,030	30,244	16,613	14,274	20,817	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	645,017	211,958	0	36,961	53,902	50.00
51.00	05100	RECOVERY ROOM	58,006	78,048	0	11,376	16,591	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	404,127	77,589	0	172,051	248,900	54.00
60.00	06000	LABORATORY	173,854	74,040	0	140,091	204,302	60.00
65.00	06500	RESPIRATORY THERAPY	63,259	56,707	0	153,893	224,429	65.00
66.00	06600	PHYSICAL THERAPY	118,940	65,905	0	57,601	84,002	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	19,141	0	67.00
68.00	06800	SPEECH PATHOLOGY	13,735	0	0	9,091	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	190,216	128,502	0	32,917	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	03160	CARDIOPULMONARY	0	0	0	5,850	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	79,211	0	0	29,757	0	90.01
90.02	09002	DIABETES CLINIC	5,281	0	0	3,174	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	9,002	0	0	3,803	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	31,007	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	46,788	0	0	17,730	0	90.08
91.00	09100	EMERGENCY	740,864	113,535	0	143,304	208,986	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	58,952	0	134,931	196,777	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	252,819	0	0	77,385	106,370	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,160,409	1,990,827	656,756	1,805,944	2,210,151	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	1,550,187	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	37,571	54,791	190.03
190.04	19004	MARKETING	12,066	0	0	6,521	0	190.04
190.05	19005	WATER LAB	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	0	0	0	8,864	0	190.06
190.07	19007	ASC	635,796	0	0	0	0	190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	0	0	0	21,051	0	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	107,402	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	4,262	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	0	190.13
190.14	19014	3 WEST UNIT	146,329	0	0	2,558	0	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0	0	0	190.15
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	7,504,787	1,990,827	656,756	1,994,173	2,264,942	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/27/2015 11:52 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
			14.00	15.00	16.00	23.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS 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	216,943					14.00
15.00	01500	PHARMACY	3,022	9,084,489				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,313,962			16.00
23.00	02300	PARAMED ED PRGM	0	0	0	183,091		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,028	0	303,401	0	6,847,788	30.00
31.00	03100	INTENSIVE CARE UNIT	8,775	0	37,884	0	6,918,435	31.00
40.00	04000	SUBPROVIDER - IPF	520	0	31,237	0	2,436,116	40.00
41.00	04100	SUBPROVIDER - IRF	70	0	185,762	0	571,062	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,779	0	398,775	0	7,126,094	50.00
51.00	05100	RECOVERY ROOM	251	0	0	0	528,447	51.00
53.00	05300	ANESTHESIOLOGY	3	0	0	0	10,010	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,901	0	45,527	183,091	6,408,838	54.00
60.00	06000	LABORATORY	48,573	0	101,023	0	5,590,741	60.00
65.00	06500	RESPIRATORY THERAPY	536	0	0	0	2,244,864	65.00
66.00	06600	PHYSICAL THERAPY	53	0	0	0	1,883,657	66.00
67.00	06700	OCCUPATIONAL THERAPY	24	0	0	0	390,968	67.00
68.00	06800	SPEECH PATHOLOGY	155	0	0	0	295,785	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	1,371	0	51,841	0	1,735,360	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	128,208	0	0	0	3,904,675	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,952,730	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,084,489	2,326	0	9,086,815	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	27	0	0	0	125,944	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	105	0	0	0	335,215	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	662	0	0	0	1,269,875	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	65,651	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	2	0	0	0	144,468	90.04
90.05	09005	PRIME TIME	0	0	0	0	128,774	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	513	0	0	0	333,538	90.06
90.07	04951	ONCOLOGY	791	0	0	0	1,219,576	90.07
90.08	04950	ANDERSON WOMENS CENTER	169	0	0	0	466,548	90.08
91.00	09100	EMERGENCY	6,813	0	155,854	0	5,272,067	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	72	0	332	0	4,418,513	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	3,288	0	0	0	3,282,229	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	216,711	9,084,489	1,313,962	183,091	74,994,783	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0	0	2,962,857	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	122,450	190.02
190.03	19003	PRIVATE DUTY	71	0	0	0	911,095	190.03
190.04	19004	MARKETING	0	0	0	0	833,115	190.04
190.05	19005	WATER LAB	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	0	0	0	0	245,544	190.06
190.07	19007	ASC	0	0	0	0	970,516	190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	161	0	0	0	4,416,783	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	0	2,601,231	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	22,970	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	9,161	190.13
190.14	19014	3 WEST UNIT	0	0	0	0	385,303	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0	0	42,629	190.15
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	216,943	9,084,489	1,313,962	183,091	88,518,437	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/27/2015 11:52 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS 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
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	6,847,788		30.00
31.00	03100	INTENSIVE CARE UNIT	0	6,918,435		31.00
40.00	04000	SUBPROVIDER - IPF	0	2,436,116		40.00
41.00	04100	SUBPROVIDER - IRF	0	571,062		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	7,126,094		50.00
51.00	05100	RECOVERY ROOM	0	528,447		51.00
53.00	05300	ANESTHESIOLOGY	0	10,010		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,408,838		54.00
60.00	06000	LABORATORY	0	5,590,741		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,244,864		65.00
66.00	06600	PHYSICAL THERAPY	0	1,883,657		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	390,968		67.00
68.00	06800	SPEECH PATHOLOGY	0	295,785		68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	1,735,360		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,904,675		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,952,730		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,086,815		73.00
76.00	03020	CARDIAC	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	125,944		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	335,215		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	1,269,875		90.01
90.02	09002	DIABETES CLINIC	0	65,651		90.02
90.03	09003	ASTHMA CLINIC	0	0		90.03
90.04	09004	ANDIS CLINIC	0	144,468		90.04
90.05	09005	PRIME TIME	0	128,774		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	333,538		90.06
90.07	04951	ONCOLOGY	0	1,219,576		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	466,548		90.08
91.00	09100	EMERGENCY	0	5,272,067		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	4,418,513		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	3,282,229		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	74,994,783		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	2,962,857		190.01
190.02	19002	PHYSICIAN BUILDING	0	122,450		190.02
190.03	19003	PRIVATE DUTY	0	911,095		190.03
190.04	19004	MARKETING	0	833,115		190.04
190.05	19005	WATER LAB	0	0		190.05
190.06	19006	FOUNDATION	0	245,544		190.06
190.07	19007	ASC	0	970,516		190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.08
190.09	19009	HANCOCK OB	0	4,416,783		190.09
190.10	19010	HANCOCK WELLNESS	0	2,601,231		190.10
190.11	19011	MORRISTOWN CLINIC	0	0		190.11
190.12	19012	O3PUREMED	0	22,970		190.12
190.13	19013	MCCORD WELLNESS	0	9,161		190.13
190.14	19014	3 WEST UNIT	0	385,303		190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	42,629		190.15
200.00		Cross Foot Adjustments	0	0		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/27/2015 11:52 am

	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		25.00	26.00		
201.00	Negative Cost Centers	0	0		201.00
202.00	TOTAL (sum lines 118-201)	0	88,518,437		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/27/2015 11:52 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	15,883	15,883	15,883		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	353,049	353,049	2,596	355,645	5.00
7.00	00700	OPERATION OF PLANT	0	1,195,773	1,195,773	354	30,155	7.00
9.00	00900	HOUSEKEEPING	0	31,256	31,256	358	7,716	9.00
10.00	01000	DIETARY	0	49,104	49,104	162	2,067	10.00
11.00	01100	CAFETERIA	0	93,731	93,731	310	6,954	11.00
13.00	01300	NURSING ADMINISTRATION	0	13,298	13,298	551	8,681	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	28	469	14.00
15.00	01500	PHARMACY	0	71,685	71,685	598	34,804	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	42,698	42,698	253	4,382	16.00
23.00	02300	PARAMED ED PRGM	0	16,307	16,307	30	223	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	343,658	343,658	1,102	18,516	30.00
31.00	03100	INTENSIVE CARE UNIT	0	289,385	289,385	1,294	21,105	31.00
40.00	04000	SUBPROVIDER - IPF	0	77,363	77,363	484	7,189	40.00
41.00	04100	SUBPROVIDER - IRF	0	17,751	17,751	68	1,058	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	286,036	286,036	1,044	23,195	50.00
51.00	05100	RECOVERY ROOM	0	25,723	25,723	87	1,463	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	40	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	179,212	179,212	997	21,198	54.00
60.00	06000	LABORATORY	0	77,096	77,096	644	19,483	60.00
65.00	06500	RESPIRATORY THERAPY	0	28,053	28,053	485	7,016	65.00
66.00	06600	PHYSICAL THERAPY	0	52,744	52,744	395	6,257	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	110	1,494	67.00
68.00	06800	SPEECH PATHOLOGY	0	6,091	6,091	76	1,096	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	84,352	84,352	198	5,346	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	15,174	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	7,846	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	03160	CARDIOPULMONARY	0	0	0	22	482	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	75	1,346	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	35,127	35,127	258	4,662	90.01
90.02	09002	DIABETES CLINIC	0	2,342	2,342	15	230	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	3,992	3,992	19	529	90.04
90.05	09005	PRIME TIME	0	0	0	0	517	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	56	1,338	90.06
90.07	04951	ONCOLOGY	0	0	0	198	4,773	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	20,748	20,748	97	1,615	90.08
91.00	09100	EMERGENCY	0	328,539	328,539	949	15,681	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	348	16,183	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	112,114	112,114	454	11,421	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,853,110	3,853,110	14,715	311,704	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	687,437	687,437	0	5,676	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	492	190.02
190.03	19003	PRIVATE DUTY	0	0	0	178	3,289	190.03
190.04	19004	MARKETING	0	5,351	5,351	40	3,273	190.04
190.05	19005	WATER LAB	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	0	0	0	53	951	190.06
190.07	19007	ASC	0	281,947	281,947	0	1,345	190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	0	0	0	467	17,662	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	368	10,020	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	42	75	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	37	190.13
190.14	19014	3 WEST UNIT	0	64,890	64,890	20	950	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0	0	171	190.15

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/27/2015 11:52 am

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		0	1.00	2A	4.00	5.00	
200.00	Cross Foot Adjustments			0			200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	4,892,735	4,892,735	15,883	355,645	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/27/2015 11:52 am

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	1,226,282					7.00
9.00	00900	HOUSEKEEPING	11,517	50,847				9.00
10.00	01000	DIETARY	18,094	807	70,234			10.00
11.00	01100	CAFETERIA	34,537	1,330	0	136,862		11.00
13.00	01300	NURSING ADMINISTRATION	4,900	0	0	5,104	32,534	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,017	0	592	181	14.00
15.00	01500	PHARMACY	26,414	1,471	0	5,416	1,653	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,733	1,770	0	3,965	0	16.00
23.00	02300	PARAMED ED PRGM	6,009	2,038	0	304	93	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	126,628	13,524	22,171	11,740	3,583	30.00
31.00	03100	INTENSIVE CARE UNIT	106,630	2,788	30,423	15,992	4,881	31.00
40.00	04000	SUBPROVIDER - IPF	28,506	2,231	15,863	5,723	1,747	40.00
41.00	04100	SUBPROVIDER - IRF	6,541	772	1,777	980	299	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	105,396	5,414	0	2,537	774	50.00
51.00	05100	RECOVERY ROOM	9,478	1,993	0	781	238	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	66,034	1,982	0	11,808	3,575	54.00
60.00	06000	LABORATORY	28,408	1,891	0	9,615	2,935	60.00
65.00	06500	RESPIRATORY THERAPY	10,337	1,448	0	10,562	3,224	65.00
66.00	06600	PHYSICAL THERAPY	19,435	1,683	0	3,953	1,207	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,314	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,244	0	0	624	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	31,081	3,282	0	2,259	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	03160	CARDIOPULMONARY	0	0	0	402	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	12,943	0	0	2,042	0	90.01
90.02	09002	DIABETES CLINIC	863	0	0	218	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	1,471	0	0	261	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	2,128	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	7,645	0	0	1,217	0	90.08
91.00	09100	EMERGENCY	121,057	2,900	0	9,835	3,002	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,506	0	9,260	2,827	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	41,311	0	0	5,311	1,528	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	843,212	50,847	70,234	123,943	31,747	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	253,299	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	2,579	787	190.03
190.04	19004	MARKETING	1,972	0	0	448	0	190.04
190.05	19005	WATER LAB	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	0	0	0	608	0	190.06
190.07	19007	ASC	103,889	0	0	0	0	190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	0	0	0	1,445	0	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	7,371	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	292	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	0	190.13
190.14	19014	3 WEST UNIT	23,910	0	0	176	0	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0	0	0	190.15
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,226,282	50,847	70,234	136,862	32,534	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/27/2015 11:52 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
			14.00	15.00	16.00	23.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS 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	3,287					14.00
15.00	01500	PHARMACY	46	142,087				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	68,801			16.00
23.00	02300	PARAMED ED PRGM	0	0	0	25,004		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	61	0	15,887		556,870	30.00
31.00	03100	INTENSIVE CARE UNIT	133	0	1,984		474,615	31.00
40.00	04000	SUBPROVIDER - IPF	8	0	1,636		140,750	40.00
41.00	04100	SUBPROVIDER - IRF	1	0	9,727		38,974	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	103	0	20,879		445,378	50.00
51.00	05100	RECOVERY ROOM	4	0	0		39,767	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		40	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29	0	2,384		287,219	54.00
60.00	06000	LABORATORY	736	0	5,290		146,098	60.00
65.00	06500	RESPIRATORY THERAPY	8	0	0		61,133	65.00
66.00	06600	PHYSICAL THERAPY	1	0	0		85,675	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		2,918	67.00
68.00	06800	SPEECH PATHOLOGY	2	0	0		10,133	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0		0	68.01
69.00	06900	ELECTROCARDIOLOGY	21	0	2,714		129,253	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,942	0	0		17,116	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		7,846	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	142,087	122		142,209	73.00
76.00	03020	CARDIAC	0	0	0		0	76.00
76.01	03160	CARDIOPULMONARY	0	0	0		906	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2	0	0		1,423	88.00
90.00	09000	CLINIC	0	0	0		0	90.00
90.01	09001	WOUND CLINIC	10	0	0		55,042	90.01
90.02	09002	DIABETES CLINIC	0	0	0		3,668	90.02
90.03	09003	ASTHMA CLINIC	0	0	0		0	90.03
90.04	09004	ANDIS CLINIC	0	0	0		6,272	90.04
90.05	09005	PRIME TIME	0	0	0		517	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	8	0	0		1,402	90.06
90.07	04951	ONCOLOGY	12	0	0		7,111	90.07
90.08	04950	ANDERSON WOMENS CENTER	3	0	0		31,325	90.08
91.00	09100	EMERGENCY	103	0	8,161		490,227	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1	0	17		30,142	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	50	0	0		172,189	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,284	142,087	68,801	0	3,386,218	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0		946,412	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0		492	190.02
190.03	19003	PRIVATE DUTY	1	0	0		6,834	190.03
190.04	19004	MARKETING	0	0	0		11,084	190.04
190.05	19005	WATER LAB	0	0	0		0	190.05
190.06	19006	FOUNDATION	0	0	0		1,612	190.06
190.07	19007	ASC	0	0	0		387,181	190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0		0	190.08
190.09	19009	HANCOCK OB	2	0	0		19,576	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0		17,759	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0		0	190.11
190.12	19012	O3PUREMED	0	0	0		409	190.12
190.13	19013	MCCORD WELLNESS	0	0	0		37	190.13
190.14	19014	3 WEST UNIT	0	0	0		89,946	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0		171	190.15
200.00		Cross Foot Adjustments				25,004	25,004	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,287	142,087	68,801	25,004	4,892,735	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/27/2015 11:52 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS 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
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	556,870		30.00
31.00	03100	INTENSIVE CARE UNIT	0	474,615		31.00
40.00	04000	SUBPROVIDER - IPF	0	140,750		40.00
41.00	04100	SUBPROVIDER - IRF	0	38,974		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	445,378		50.00
51.00	05100	RECOVERY ROOM	0	39,767		51.00
53.00	05300	ANESTHESIOLOGY	0	40		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	287,219		54.00
60.00	06000	LABORATORY	0	146,098		60.00
65.00	06500	RESPIRATORY THERAPY	0	61,133		65.00
66.00	06600	PHYSICAL THERAPY	0	85,675		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,918		67.00
68.00	06800	SPEECH PATHOLOGY	0	10,133		68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	129,253		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17,116		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	7,846		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	142,209		73.00
76.00	03020	CARDIAC	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	906		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	1,423		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	55,042		90.01
90.02	09002	DIABETES CLINIC	0	3,668		90.02
90.03	09003	ASTHMA CLINIC	0	0		90.03
90.04	09004	ANDIS CLINIC	0	6,272		90.04
90.05	09005	PRIME TIME	0	517		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	1,402		90.06
90.07	04951	ONCOLOGY	0	7,111		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	31,325		90.08
91.00	09100	EMERGENCY	0	490,227		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	30,142		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	172,189		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,386,218		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	946,412		190.01
190.02	19002	PHYSICIAN BUILDING	0	492		190.02
190.03	19003	PRIVATE DUTY	0	6,834		190.03
190.04	19004	MARKETING	0	11,084		190.04
190.05	19005	WATER LAB	0	0		190.05
190.06	19006	FOUNDATION	0	1,612		190.06
190.07	19007	ASC	0	387,181		190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.08
190.09	19009	HANCOCK OB	0	19,576		190.09
190.10	19010	HANCOCK WELLNESS	0	17,759		190.10
190.11	19011	MORRISTOWN CLINIC	0	0		190.11
190.12	19012	O3PUREMED	0	409		190.12
190.13	19013	MCCORD WELLNESS	0	37		190.13
190.14	19014	3 WEST UNIT	0	89,946		190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	171		190.15
200.00		Cross Foot Adjustments	0	25,004		200.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/27/2015 11:52 am

	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		25.00	26.00		
201.00	Negative Cost Centers	0	0		201.00
202.00	TOTAL (sum lines 118-201)	0	4,892,735		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 11:52 am

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	403,241					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,309	36,338,315				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	29,097	5,939,174	-13,765,749	74,752,688		5.00
7.00	00700	OPERATION OF PLANT	98,551	810,917	0	6,337,694	274,284	7.00
9.00	00900	HOUSEKEEPING	2,576	818,608	0	1,621,705	2,576	9.00
10.00	01000	DIETARY	4,047	371,363	0	434,433	4,047	10.00
11.00	01100	CAFETERIA	7,725	708,906	0	1,461,594	7,725	11.00
13.00	01300	NURSING ADMINISTRATION	1,096	1,261,447	0	1,824,590	1,096	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	64,059	0	98,615	0	14.00
15.00	01500	PHARMACY	5,908	1,369,156	0	7,320,234	5,908	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,519	579,917	0	921,017	3,519	16.00
23.00	02300	PARAMED ED PRGM	1,344	68,188	0	46,964	1,344	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,323	2,522,427	0	3,891,447	28,323	30.00
31.00	03100	INTENSIVE CARE UNIT	23,850	2,960,513	0	4,435,755	23,850	31.00
40.00	04000	SUBPROVIDER - IPF	6,376	1,107,800	0	1,510,959	6,376	40.00
41.00	04100	SUBPROVIDER - IRF	1,463	156,648	0	222,313	1,463	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,574	2,389,797	0	4,874,971	23,574	50.00
51.00	05100	RECOVERY ROOM	2,120	198,149	0	307,541	2,120	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	8,451	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,770	2,280,541	0	4,455,219	14,770	54.00
60.00	06000	LABORATORY	6,354	1,472,994	0	4,094,797	6,354	60.00
65.00	06500	RESPIRATORY THERAPY	2,312	1,108,772	0	1,474,508	2,312	65.00
66.00	06600	PHYSICAL THERAPY	4,347	904,370	0	1,314,998	4,347	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	251,541	0	313,983	0	67.00
68.00	06800	SPEECH PATHOLOGY	502	173,388	0	230,379	502	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	6,952	452,917	0	1,123,601	6,952	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,189,177	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,649,055	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	03160	CARDIOPULMONARY	0	50,114	0	101,395	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	171,059	0	282,996	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	2,895	591,241	0	979,812	2,895	90.01
90.02	09002	DIABETES CLINIC	193	33,598	0	48,301	193	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	329	43,753	0	111,186	329	90.04
90.05	09005	PRIME TIME	0	0	0	108,748	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	127,238	0	281,235	0	90.06
90.07	04951	ONCOLOGY	0	452,144	0	1,003,063	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	1,710	221,923	0	339,366	1,710	90.08
91.00	09100	EMERGENCY	27,077	2,171,216	0	3,295,788	27,077	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	796,304	0	3,401,128	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	9,240	1,038,801	0	2,400,342	9,240	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	317,559	33,668,983	-13,765,749	65,517,360	188,602	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	56,656	0	0	1,192,981	56,656	190.01
190.02	19002	PHYSICIAN BUILDING	0	6	0	103,407	0	190.02
190.03	19003	PRIVATE DUTY	0	406,663	0	691,349	0	190.03
190.04	19004	MARKETING	441	91,001	0	687,858	441	190.04
190.05	19005	WATER LAB	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	0	121,658	0	199,873	0	190.06
190.07	19007	ASC	23,237	0	0	282,667	23,237	190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	0	1,067,887	0	3,712,002	0	190.09
190.10	19010	HANCOCK WELLNESS	0	841,127	0	2,106,006	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	95,508	0	15,799	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	7,736	0	190.13
190.14	19014	3 WEST UNIT	5,348	45,482	0	199,650	5,348	190.14

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 11:52 am

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0	36,000	0	190.15
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,892,735	5,364,173		13,765,749	7,504,787	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.133526	0.147618		0.184151	27.361374	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		15,883		355,645	1,226,282	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000437		0.004758	4.470848	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 11:52 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	
		GENERAL SERVICE COST CENTERS						
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	412,334					9.00
10.00	01000	DIETARY	6,543	11,702				10.00
11.00	01100	CAFETERIA	10,782	0	843,668			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	31,461	657,060		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,355	0	3,649	3,649	5,380,020	14.00
15.00	01500	PHARMACY	11,930	0	33,384	33,384	74,931	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,350	0	24,440	0	0	16.00
23.00	02300	PARAMED ED PRGM	16,530	0	1,875	1,875	6	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	109,670	3,694	72,368	72,368	99,888	30.00
31.00	03100	INTENSIVE CARE UNIT	22,610	5,069	98,601	98,601	217,615	31.00
40.00	04000	SUBPROVIDER - IPF	18,095	2,643	35,279	35,279	12,889	40.00
41.00	04100	SUBPROVIDER - IRF	6,264	296	6,039	6,039	1,736	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	43,900	0	15,637	15,637	168,104	50.00
51.00	05100	RECOVERY ROOM	16,165	0	4,813	4,813	6,217	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	70	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,070	0	72,789	72,206	47,147	54.00
60.00	06000	LABORATORY	15,335	0	59,268	59,268	1,204,579	60.00
65.00	06500	RESPIRATORY THERAPY	11,745	0	65,107	65,107	13,294	65.00
66.00	06600	PHYSICAL THERAPY	13,650	0	24,369	24,369	1,312	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	8,098	0	606	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	3,846	0	3,845	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	26,615	0	13,926	0	33,991	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,179,458	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	03160	CARDIOPULMONARY	0	0	2,475	0	678	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	2,612	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	12,589	0	16,417	90.01
90.02	09002	DIABETES CLINIC	0	0	1,343	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	1,609	0	50	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	12,725	90.06
90.07	04951	ONCOLOGY	0	0	13,118	0	19,623	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	7,501	0	4,197	90.08
91.00	09100	EMERGENCY	23,515	0	60,627	60,627	168,950	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	12,210	0	57,085	57,085	1,785	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	32,739	30,858	81,547	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	412,334	11,702	764,035	641,165	5,374,272	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0	0	0	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	15,895	15,895	1,755	190.03
190.04	19004	MARKETING	0	0	2,759	0	0	190.04
190.05	19005	WATER LAB	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	0	0	3,750	0	0	190.06
190.07	19007	ASC	0	0	0	0	0	190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	0	0	8,906	0	3,993	190.09
190.10	19010	HANCOCK WELLNESS	0	0	45,438	0	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	1,803	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	0	190.13
190.14	19014	3 WEST UNIT	0	0	1,082	0	0	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0	0	0	190.15
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 11:52 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	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,990,827	656,756	1,994,173	2,264,942	216,943	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	4.828190	56.123398	2.363694	3.447086	0.040324	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	50,847	70,234	136,862	32,534	3,287	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.123315	6.001880	0.162223	0.049515	0.000611	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 11:52 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	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	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,954			16.00
23.00	02300	PARAMED ED PRGM	0	0	100		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	913	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	114	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	94	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	559	0		41.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,200	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	137	100		54.00
60.00	06000	LABORATORY	0	304	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	156	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100	7	0		73.00
76.00	03020	CARDIAC	0	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	WOUND CLINIC	0	0	0		90.01
90.02	09002	DIABETES CLINIC	0	0	0		90.02
90.03	09003	ASTHMA CLINIC	0	0	0		90.03
90.04	09004	ANDIS CLINIC	0	0	0		90.04
90.05	09005	PRIME TIME	0	0	0		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0		90.06
90.07	04951	ONCOLOGY	0	0	0		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0		90.08
91.00	09100	EMERGENCY	0	469	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	1	0		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	3,954	100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	0	0		190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0		190.02
190.03	19003	PRIVATE DUTY	0	0	0		190.03
190.04	19004	MARKETING	0	0	0		190.04
190.05	19005	WATER LAB	0	0	0		190.05
190.06	19006	FOUNDATION	0	0	0		190.06
190.07	19007	ASC	0	0	0		190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0		190.08
190.09	19009	HANCOCK OB	0	0	0		190.09
190.10	19010	HANCOCK WELLNESS	0	0	0		190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0		190.11
190.12	19012	O3PUREMED	0	0	0		190.12
190.13	19013	MCCORD WELLNESS	0	0	0		190.13
190.14	19014	3 WEST UNIT	0	0	0		190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0		190.15
200.00		Cross Foot Adjustments					200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 11:52 am

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	PARAMED ED PRGM (ASSIGNED TIME)		
			15.00	16.00	23.00		
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	9,084,489	1,313,962	183,091		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	90,844.890000	332.312089	1,830.910000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	142,087	68,801	25,004		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1,420.870000	17.400354	250.040000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 11:52 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,847,788		6,847,788	0	6,847,788	30.00
31.00	03100	INTENSIVE CARE UNIT	6,918,435		6,918,435	0	6,918,435	31.00
40.00	04000	SUBPROVIDER - IPF	2,436,116		2,436,116	0	2,436,116	40.00
41.00	04100	SUBPROVIDER - IRF	571,062		571,062	0	571,062	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,126,094		7,126,094	0	7,126,094	50.00
51.00	05100	RECOVERY ROOM	528,447		528,447	0	528,447	51.00
53.00	05300	ANESTHESIOLOGY	10,010		10,010	0	10,010	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,408,838		6,408,838	0	6,408,838	54.00
60.00	06000	LABORATORY	5,590,741		5,590,741	0	5,590,741	60.00
65.00	06500	RESPIRATORY THERAPY	2,244,864	0	2,244,864	0	2,244,864	65.00
66.00	06600	PHYSICAL THERAPY	1,883,657	0	1,883,657	0	1,883,657	66.00
67.00	06700	OCCUPATIONAL THERAPY	390,968	0	390,968	0	390,968	67.00
68.00	06800	SPEECH PATHOLOGY	295,785	0	295,785	0	295,785	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	1,735,360		1,735,360	0	1,735,360	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,904,675		3,904,675	0	3,904,675	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,952,730		1,952,730	0	1,952,730	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,086,815		9,086,815	0	9,086,815	73.00
76.00	03020	CARDIAC	0		0	0	0	76.00
76.01	03160	CARDIOPULMONARY	125,944		125,944	0	125,944	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	335,215		335,215	0	335,215	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CLINIC	1,269,875		1,269,875	0	1,269,875	90.01
90.02	09002	DIABETES CLINIC	65,651		65,651	0	65,651	90.02
90.03	09003	ASTHMA CLINIC	0		0	0	0	90.03
90.04	09004	ANDIS CLINIC	144,468		144,468	0	144,468	90.04
90.05	09005	PRIME TIME	128,774		128,774	0	128,774	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	333,538		333,538	0	333,538	90.06
90.07	04951	ONCOLOGY	1,219,576		1,219,576	0	1,219,576	90.07
90.08	04950	ANDERSON WOMENS CENTER	466,548		466,548	0	466,548	90.08
91.00	09100	EMERGENCY	5,272,067		5,272,067	0	5,272,067	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,493,177		2,493,177		2,493,177	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	4,418,513		4,418,513		4,418,513	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	3,282,229		3,282,229		3,282,229	116.00
200.00		Subtotal (see instructions)	77,487,960	0	77,487,960	0	77,487,960	200.00
201.00		Less Observation Beds	2,493,177		2,493,177		2,493,177	201.00
202.00		Total (see instructions)	74,994,783	0	74,994,783	0	74,994,783	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 11:52 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,317,566		6,317,566			30.00
31.00	03100	INTENSIVE CARE UNIT	7,802,674		7,802,674			31.00
40.00	04000	SUBPROVIDER - IPF	3,071,585		3,071,585			40.00
41.00	04100	SUBPROVIDER - IRF	363,156		363,156			41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,701,063	9,034,522	14,735,585	0.483598	0.000000	50.00
51.00	05100	RECOVERY ROOM	846,533	1,077,119	1,923,652	0.274710	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	14,202	753	14,955	0.669341	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,596,027	39,627,790	44,223,817	0.144918	0.000000	54.00
60.00	06000	LABORATORY	5,750,655	27,851,253	33,601,908	0.166382	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,743,609	4,440,658	7,184,267	0.312469	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	862,792	3,261,781	4,124,573	0.456691	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	582,873	540,662	1,123,535	0.347980	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	169,896	417,821	587,717	0.503278	0.000000	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0.000000	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	3,441,942	7,909,248	11,351,190	0.152879	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,331,591	3,104,441	5,436,032	0.718295	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,248,643	1,095,588	6,344,231	0.307796	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,136,668	29,243,756	39,380,424	0.230744	0.000000	73.00
76.00	03020	CARDIAC	0	0	0	0.000000	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0	283,291	283,291	0.444575	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	347,836	347,836			88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	WOUND CLINIC	8,171	3,814,002	3,822,173	0.332239	0.000000	90.01
90.02	09002	DIABETES CLINIC	0	55,080	55,080	1.191921	0.000000	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	ANDIS CLINIC	0	56,227	56,227	2.569371	0.000000	90.04
90.05	09005	PRIME TIME	53	265,476	265,529	0.484972	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	1,610,003	1,610,003	0.207166	0.000000	90.06
90.07	04951	ONCOLOGY	19,601	2,496,663	2,516,264	0.484677	0.000000	90.07
90.08	04950	ANDERSON WOMENS CENTER	6,334	2,910,155	2,916,489	0.159969	0.000000	90.08
91.00	09100	EMERGENCY	2,897,473	18,590,777	21,488,250	0.245347	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	203,117	1,946,264	2,149,381	1.159951	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	672,614	672,614			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	621,437	1,230,587	1,852,024			116.00
200.00		Subtotal (see instructions)	63,737,661	161,884,367	225,622,028			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	63,737,661	161,884,367	225,622,028			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 11:52 am

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.483598	50.00
51.00	05100	RECOVERY ROOM	0.274710	51.00
53.00	05300	ANESTHESIOLOGY	0.669341	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.144918	54.00
60.00	06000	LABORATORY	0.166382	60.00
65.00	06500	RESPIRATORY THERAPY	0.312469	65.00
66.00	06600	PHYSICAL THERAPY	0.456691	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.347980	67.00
68.00	06800	SPEECH PATHOLOGY	0.503278	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	0.152879	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.718295	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.307796	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.230744	73.00
76.00	03020	CARDIAC	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0.444575	76.01
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	WOUND CLINIC	0.332239	90.01
90.02	09002	DIABETES CLINIC	1.191921	90.02
90.03	09003	ASTHMA CLINIC	0.000000	90.03
90.04	09004	ANDIS CLINIC	2.569371	90.04
90.05	09005	PRIME TIME	0.484972	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.207166	90.06
90.07	04951	ONCOLOGY	0.484677	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.159969	90.08
91.00	09100	EMERGENCY	0.245347	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.159951	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
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 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 11:52 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,847,788		6,847,788	0	6,847,788	30.00
31.00	03100	INTENSIVE CARE UNIT	6,918,435		6,918,435	0	6,918,435	31.00
40.00	04000	SUBPROVIDER - IPF	2,436,116		2,436,116	0	2,436,116	40.00
41.00	04100	SUBPROVIDER - IRF	571,062		571,062	0	571,062	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,126,094		7,126,094	0	7,126,094	50.00
51.00	05100	RECOVERY ROOM	528,447		528,447	0	528,447	51.00
53.00	05300	ANESTHESIOLOGY	10,010		10,010	0	10,010	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,408,838		6,408,838	0	6,408,838	54.00
60.00	06000	LABORATORY	5,590,741		5,590,741	0	5,590,741	60.00
65.00	06500	RESPIRATORY THERAPY	2,244,864	0	2,244,864	0	2,244,864	65.00
66.00	06600	PHYSICAL THERAPY	1,883,657	0	1,883,657	0	1,883,657	66.00
67.00	06700	OCCUPATIONAL THERAPY	390,968	0	390,968	0	390,968	67.00
68.00	06800	SPEECH PATHOLOGY	295,785	0	295,785	0	295,785	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	1,735,360		1,735,360	0	1,735,360	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,904,675		3,904,675	0	3,904,675	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,952,730		1,952,730	0	1,952,730	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,086,815		9,086,815	0	9,086,815	73.00
76.00	03020	CARDIAC	0		0	0	0	76.00
76.01	03160	CARDIOPULMONARY	125,944		125,944	0	125,944	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	335,215		335,215	0	335,215	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CLINIC	1,269,875		1,269,875	0	1,269,875	90.01
90.02	09002	DIABETES CLINIC	65,651		65,651	0	65,651	90.02
90.03	09003	ASTHMA CLINIC	0		0	0	0	90.03
90.04	09004	ANDIS CLINIC	144,468		144,468	0	144,468	90.04
90.05	09005	PRIME TIME	128,774		128,774	0	128,774	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	333,538		333,538	0	333,538	90.06
90.07	04951	ONCOLOGY	1,219,576		1,219,576	0	1,219,576	90.07
90.08	04950	ANDERSON WOMENS CENTER	466,548		466,548	0	466,548	90.08
91.00	09100	EMERGENCY	5,272,067		5,272,067	0	5,272,067	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,493,177		2,493,177		2,493,177	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	4,418,513		4,418,513		4,418,513	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	3,282,229		3,282,229		3,282,229	116.00
200.00		Subtotal (see instructions)	77,487,960	0	77,487,960	0	77,487,960	200.00
201.00		Less Observation Beds	2,493,177		2,493,177		2,493,177	201.00
202.00		Total (see instructions)	74,994,783	0	74,994,783	0	74,994,783	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 11:52 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,317,566		6,317,566			30.00
31.00	03100	INTENSIVE CARE UNIT	7,802,674		7,802,674			31.00
40.00	04000	SUBPROVIDER - IPF	3,071,585		3,071,585			40.00
41.00	04100	SUBPROVIDER - IRF	363,156		363,156			41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,701,063	9,034,522	14,735,585	0.483598	0.000000	50.00
51.00	05100	RECOVERY ROOM	846,533	1,077,119	1,923,652	0.274710	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	14,202	753	14,955	0.669341	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,596,027	39,627,790	44,223,817	0.144918	0.000000	54.00
60.00	06000	LABORATORY	5,750,655	27,851,253	33,601,908	0.166382	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,743,609	4,440,658	7,184,267	0.312469	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	862,792	3,261,781	4,124,573	0.456691	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	582,873	540,662	1,123,535	0.347980	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	169,896	417,821	587,717	0.503278	0.000000	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0.000000	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	3,441,942	7,909,248	11,351,190	0.152879	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,331,591	3,104,441	5,436,032	0.718295	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,248,643	1,095,588	6,344,231	0.307796	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,136,668	29,243,756	39,380,424	0.230744	0.000000	73.00
76.00	03020	CARDIAC	0	0	0	0.000000	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0	283,291	283,291	0.444575	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	347,836	347,836	0.963716	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	WOUND CLINIC	8,171	3,814,002	3,822,173	0.332239	0.000000	90.01
90.02	09002	DIABETES CLINIC	0	55,080	55,080	1.191921	0.000000	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	ANDIS CLINIC	0	56,227	56,227	2.569371	0.000000	90.04
90.05	09005	PRIME TIME	53	265,476	265,529	0.484972	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	1,610,003	1,610,003	0.207166	0.000000	90.06
90.07	04951	ONCOLOGY	19,601	2,496,663	2,516,264	0.484677	0.000000	90.07
90.08	04950	ANDERSON WOMENS CENTER	6,334	2,910,155	2,916,489	0.159969	0.000000	90.08
91.00	09100	EMERGENCY	2,897,473	18,590,777	21,488,250	0.245347	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	203,117	1,946,264	2,149,381	1.159951	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	672,614	672,614			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	621,437	1,230,587	1,852,024			116.00
200.00		Subtotal (see instructions)	63,737,661	161,884,367	225,622,028			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	63,737,661	161,884,367	225,622,028			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 11:52 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
		ANCILLARY SERVICE COST CENTERS			
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	03160	CARDIOPULMONARY	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS			
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
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
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 01/01/2014 To 12/31/2014 | Worksheet D Part I Date/Time Prepared: 5/27/2015 11:52 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	556,870	0	556,870	5,658	98.42	30.00
31.00	INTENSIVE CARE UNIT	474,615		474,615	5,037	94.23	31.00
40.00	SUBPROVIDER - IPF	140,750	0	140,750	2,643	53.25	40.00
41.00	SUBPROVIDER - IRF	38,974	0	38,974	296	131.67	41.00
200.00	Total (lines 30-199)	1,211,209		1,211,209	13,634		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	1,269	124,895	30.00
31.00	INTENSIVE CARE UNIT	2,309	217,577	31.00
40.00	SUBPROVIDER - IPF	2,434	129,611	40.00
41.00	SUBPROVIDER - IRF	186	24,491	41.00
200.00	Total (lines 30-199)	6,198	496,574	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/27/2015 11:52 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	445,378	14,735,585	0.030225	2,389,376	72,219	50.00
51.00	05100	RECOVERY ROOM	39,767	1,923,652	0.020673	310,243	6,414	51.00
53.00	05300	ANESTHESIOLOGY	40	14,955	0.002675	1,470	4	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	287,219	44,223,817	0.006495	2,399,655	15,586	54.00
60.00	06000	LABORATORY	146,098	33,601,908	0.004348	2,860,458	12,437	60.00
65.00	06500	RESPIRATORY THERAPY	61,133	7,184,267	0.008509	1,455,808	12,387	65.00
66.00	06600	PHYSICAL THERAPY	85,675	4,124,573	0.020772	377,279	7,837	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,918	1,123,535	0.002597	212,680	552	67.00
68.00	06800	SPEECH PATHOLOGY	10,133	587,717	0.017241	92,999	1,603	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	129,253	11,351,190	0.011387	1,628,585	18,545	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,116	5,436,032	0.003149	966,398	3,043	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,846	6,344,231	0.001237	2,235,426	2,765	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	142,209	39,380,424	0.003611	4,372,578	15,789	73.00
76.00	03020	CARDIAC	0	0	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	906	283,291	0.003198	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,423	347,836	0.004091	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	55,042	3,822,173	0.014401	3,268	47	90.01
90.02	09002	DIABETES CLINIC	3,668	55,080	0.066594	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	6,272	56,227	0.111548	0	0	90.04
90.05	09005	PRIME TIME	517	265,529	0.001947	47	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	1,402	1,610,003	0.000871	0	0	90.06
90.07	04951	ONCOLOGY	7,111	2,516,264	0.002826	2,306	7	90.07
90.08	04950	ANDERSON WOMENS CENTER	31,325	2,916,489	0.010741	5,343	57	90.08
91.00	09100	EMERGENCY	490,227	21,488,250	0.022814	1,697,624	38,730	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	202,748	2,149,381	0.094329	287	27	92.00
200.00		Total (lines 50-199)	2,175,426	205,542,409		21,011,830	208,049	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part III Date/Time Prepared: 5/27/2015 11:52 am

Title XVIII | Hospital | PPS

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

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,658	0.00	1,269	0		30.00
31.00	03100	INTENSIVE CARE UNIT	5,037	0.00	2,309	0		31.00
40.00	04000	SUBPROVIDER - IPF	2,643	0.00	2,434	0		40.00
41.00	04100	SUBPROVIDER - IRF	296	0.00	186	0		41.00
200.00		Total (lines 30-199)	13,634		6,198	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 11:52 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	183,091	0	183,091	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	03160	CARDIOPULMONARY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	0	0	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	0	0	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
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	183,091	0	183,091	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 11:52 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	14,735,585	0.000000	0.000000	2,389,376	50.00
51.00	05100	RECOVERY ROOM	0	1,923,652	0.000000	0.000000	310,243	51.00
53.00	05300	ANESTHESIOLOGY	0	14,955	0.000000	0.000000	1,470	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	183,091	44,223,817	0.004140	0.004140	2,399,655	54.00
60.00	06000	LABORATORY	0	33,601,908	0.000000	0.000000	2,860,458	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,184,267	0.000000	0.000000	1,455,808	65.00
66.00	06600	PHYSICAL THERAPY	0	4,124,573	0.000000	0.000000	377,279	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,123,535	0.000000	0.000000	212,680	67.00
68.00	06800	SPEECH PATHOLOGY	0	587,717	0.000000	0.000000	92,999	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0.000000	0.000000	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	11,351,190	0.000000	0.000000	1,628,585	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,436,032	0.000000	0.000000	966,398	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	6,344,231	0.000000	0.000000	2,235,426	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	39,380,424	0.000000	0.000000	4,372,578	73.00
76.00	03020	CARDIAC	0	0	0.000000	0.000000	0	76.00
76.01	03160	CARDIOPULMONARY	0	283,291	0.000000	0.000000	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	347,836	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	3,822,173	0.000000	0.000000	3,268	90.01
90.02	09002	DIABETES CLINIC	0	55,080	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	56,227	0.000000	0.000000	0	90.04
90.05	09005	PRIME TIME	0	265,529	0.000000	0.000000	47	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	1,610,003	0.000000	0.000000	0	90.06
90.07	04951	ONCOLOGY	0	2,516,264	0.000000	0.000000	2,306	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	2,916,489	0.000000	0.000000	5,343	90.08
91.00	09100	EMERGENCY	0	21,488,250	0.000000	0.000000	1,697,624	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,149,381	0.000000	0.000000	287	92.00
200.00		Total (lines 50-199)	183,091	205,542,409			21,011,830	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/27/2015 11:52 am

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,129,281	0		50.00
51.00	05100	RECOVERY ROOM	0	286,663	0		51.00
53.00	05300	ANESTHESIOLOGY	0	753	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,935	11,414,026	47,254		54.00
60.00	06000	LABORATORY	0	3,823,726	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,263,881	0		65.00
66.00	06600	PHYSICAL THERAPY	0	6,218	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,814	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	52,642	0		68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	3,064,386	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	844,570	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	379,796	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,670,236	0		73.00
76.00	03020	CARDIAC	0	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	109,804	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	WOUND CLINIC	0	2,389,649	0		90.01
90.02	09002	DIABETES CLINIC	0	39	0		90.02
90.03	09003	ASTHMA CLINIC	0	0	0		90.03
90.04	09004	ANDIS CLINIC	0	2,944	0		90.04
90.05	09005	PRIME TIME	0	17,004	0		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	294,048	0		90.06
90.07	04951	ONCOLOGY	0	354,464	0		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	617	0		90.08
91.00	09100	EMERGENCY	0	4,127,173	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,164,082	0		92.00
200.00		Total (lines 50-199)	9,935	42,399,816	47,254		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/27/2015 11:52 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.483598	2,129,281	0	0	1,029,716	50.00
51.00	05100	RECOVERY ROOM	0.274710	286,663	0	0	78,749	51.00
53.00	05300	ANESTHESIOLOGY	0.669341	753	0	0	504	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.144918	11,414,026	0	0	1,654,098	54.00
60.00	06000	LABORATORY	0.166382	3,823,726	365	0	636,199	60.00
65.00	06500	RESPIRATORY THERAPY	0.312469	1,263,881	0	0	394,924	65.00
66.00	06600	PHYSICAL THERAPY	0.456691	6,218	0	0	2,840	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.347980	3,814	0	0	1,327	67.00
68.00	06800	SPEECH PATHOLOGY	0.503278	52,642	0	0	26,494	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.152879	3,064,386	0	0	468,480	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.718295	844,570	0	0	606,650	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.307796	379,796	0	0	116,900	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.230744	10,670,236	0	17,043	2,462,093	73.00
76.00	03020	CARDIAC	0.000000	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.444575	109,804	0	0	48,816	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.332239	2,389,649	0	0	793,935	90.01
90.02	09002	DIABETES CLINIC	1.191921	39	0	0	46	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	2.569371	2,944	0	0	7,564	90.04
90.05	09005	PRIME TIME	0.484972	17,004	0	0	8,246	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.207166	294,048	0	0	60,917	90.06
90.07	04951	ONCOLOGY	0.484677	354,464	0	0	171,801	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.159969	617	0	0	99	90.08
91.00	09100	EMERGENCY	0.245347	4,127,173	0	0	1,012,590	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.159951	1,164,082	0	0	1,350,278	92.00
200.00		Subtotal (see instructions)		42,399,816	365	17,043	10,933,266	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		42,399,816	365	17,043	10,933,266	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/27/2015 11:52 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	61	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	3,933		73.00
76.00	03020	CARDIAC	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	0		90.01
90.02	09002	DIABETES CLINIC	0	0		90.02
90.03	09003	ASTHMA CLINIC	0	0		90.03
90.04	09004	ANDIS CLINIC	0	0		90.04
90.05	09005	PRIME TIME	0	0		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0		90.06
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)	61	3,933		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	61	3,933		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150037 | Component CCN: 15S037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/27/2015 11:52 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	445,378	14,735,585	0.030225	11,137	337	50.00
51.00	05100	RECOVERY ROOM	39,767	1,923,652	0.020673	1,119	23	51.00
53.00	05300	ANESTHESIOLOGY	40	14,955	0.002675	18	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	287,219	44,223,817	0.006495	108,489	705	54.00
60.00	06000	LABORATORY	146,098	33,601,908	0.004348	355,057	1,544	60.00
65.00	06500	RESPIRATORY THERAPY	61,133	7,184,267	0.008509	100,720	857	65.00
66.00	06600	PHYSICAL THERAPY	85,675	4,124,573	0.020772	54,854	1,139	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,918	1,123,535	0.002597	75,074	195	67.00
68.00	06800	SPEECH PATHOLOGY	10,133	587,717	0.017241	9,112	157	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	129,253	11,351,190	0.011387	10,842	123	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,116	5,436,032	0.003149	52,874	167	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,846	6,344,231	0.001237	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	142,209	39,380,424	0.003611	317,639	1,147	73.00
76.00	03020	CARDIAC	0	0	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	906	283,291	0.003198	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,423	347,836	0.004091	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	55,042	3,822,173	0.014401	534	8	90.01
90.02	09002	DIABETES CLINIC	3,668	55,080	0.066594	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	6,272	56,227	0.111548	0	0	90.04
90.05	09005	PRIME TIME	517	265,529	0.001947	6	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	1,402	1,610,003	0.000871	0	0	90.06
90.07	04951	ONCOLOGY	7,111	2,516,264	0.002826	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	31,325	2,916,489	0.010741	991	11	90.08
91.00	09100	EMERGENCY	490,227	21,488,250	0.022814	63,089	1,439	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,149,381	0.000000	0	0	92.00
200.00		Total (lines 50-199)	1,972,678	205,542,409		1,161,555	7,852	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150037 | Component CCN: 15S037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 11:52 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	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	183,091	0	183,091	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	03160	CARDIOPULMONARY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	0	0	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	0	0	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
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	183,091	0	183,091	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150037 | Component CCN: 15S037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/27/2015 11:52 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	14,735,585	0.000000	0.000000	11,137	50.00
51.00	05100	RECOVERY ROOM	0	1,923,652	0.000000	0.000000	1,119	51.00
53.00	05300	ANESTHESIOLOGY	0	14,955	0.000000	0.000000	18	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	183,091	44,223,817	0.004140	0.004140	108,489	54.00
60.00	06000	LABORATORY	0	33,601,908	0.000000	0.000000	355,057	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,184,267	0.000000	0.000000	100,720	65.00
66.00	06600	PHYSICAL THERAPY	0	4,124,573	0.000000	0.000000	54,854	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,123,535	0.000000	0.000000	75,074	67.00
68.00	06800	SPEECH PATHOLOGY	0	587,717	0.000000	0.000000	9,112	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0.000000	0.000000	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	11,351,190	0.000000	0.000000	10,842	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,436,032	0.000000	0.000000	52,874	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	6,344,231	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	39,380,424	0.000000	0.000000	317,639	73.00
76.00	03020	CARDIAC	0	0	0.000000	0.000000	0	76.00
76.01	03160	CARDIOPULMONARY	0	283,291	0.000000	0.000000	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	347,836	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	3,822,173	0.000000	0.000000	534	90.01
90.02	09002	DIABETES CLINIC	0	55,080	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	56,227	0.000000	0.000000	0	90.04
90.05	09005	PRIME TIME	0	265,529	0.000000	0.000000	6	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	1,610,003	0.000000	0.000000	0	90.06
90.07	04951	ONCOLOGY	0	2,516,264	0.000000	0.000000	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	2,916,489	0.000000	0.000000	991	90.08
91.00	09100	EMERGENCY	0	21,488,250	0.000000	0.000000	63,089	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,149,381	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	183,091	205,542,409			1,161,555	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150037 | Component CCN: 15S037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 11:52 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	449	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	CARDIAC	0	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	WOUND CLINIC	0	0	0		90.01
90.02	09002	DIABETES CLINIC	0	0	0		90.02
90.03	09003	ASTHMA CLINIC	0	0	0		90.03
90.04	09004	ANDIS CLINIC	0	0	0		90.04
90.05	09005	PRIME TIME	0	0	0		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0		90.06
90.07	04951	ONCOLOGY	0	0	0		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0		90.08
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	449	0	0		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150037 | Component CCN: 15T037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II | Date/Time Prepared: 5/27/2015 11:52 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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	445,378	14,735,585	0.030225	4,354	132	50.00
51.00	05100	RECOVERY ROOM	39,767	1,923,652	0.020673	0	0	51.00
53.00	05300	ANESTHESIOLOGY	40	14,955	0.002675	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	287,219	44,223,817	0.006495	8,367	54	54.00
60.00	06000	LABORATORY	146,098	33,601,908	0.004348	21,988	96	60.00
65.00	06500	RESPIRATORY THERAPY	61,133	7,184,267	0.008509	4,144	35	65.00
66.00	06600	PHYSICAL THERAPY	85,675	4,124,573	0.020772	83,373	1,732	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,918	1,123,535	0.002597	87,071	226	67.00
68.00	06800	SPEECH PATHOLOGY	10,133	587,717	0.017241	16,586	286	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	129,253	11,351,190	0.011387	183	2	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,116	5,436,032	0.003149	5,376	17	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,846	6,344,231	0.001237	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	142,209	39,380,424	0.003611	32,748	118	73.00
76.00	03020	CARDIAC	0	0	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	906	283,291	0.003198	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,423	347,836	0.004091	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	55,042	3,822,173	0.014401	0	0	90.01
90.02	09002	DIABETES CLINIC	3,668	55,080	0.066594	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	6,272	56,227	0.111548	0	0	90.04
90.05	09005	PRIME TIME	517	265,529	0.001947	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	1,402	1,610,003	0.000871	0	0	90.06
90.07	04951	ONCOLOGY	7,111	2,516,264	0.002826	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	31,325	2,916,489	0.010741	0	0	90.08
91.00	09100	EMERGENCY	490,227	21,488,250	0.022814	1,205	27	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,149,381	0.000000	0	0	92.00
200.00		Total (lines 50-199)	1,972,678	205,542,409		265,395	2,725	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150037 | Component CCN: 15T037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 11:52 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	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	183,091	0	183,091	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	03160	CARDIOPULMONARY	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	0	0	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	0	0	0	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
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	183,091	0	183,091	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150037 | Component CCN: 15T037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/27/2015 11:52 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	14,735,585	0.000000	0.000000	4,354	50.00
51.00	05100	RECOVERY ROOM	0	1,923,652	0.000000	0.000000	0	51.00
53.00	05300	ANESTHESIOLOGY	0	14,955	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	183,091	44,223,817	0.004140	0.004140	8,367	54.00
60.00	06000	LABORATORY	0	33,601,908	0.000000	0.000000	21,988	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,184,267	0.000000	0.000000	4,144	65.00
66.00	06600	PHYSICAL THERAPY	0	4,124,573	0.000000	0.000000	83,373	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,123,535	0.000000	0.000000	87,071	67.00
68.00	06800	SPEECH PATHOLOGY	0	587,717	0.000000	0.000000	16,586	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0.000000	0.000000	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	11,351,190	0.000000	0.000000	183	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,436,032	0.000000	0.000000	5,376	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	6,344,231	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	39,380,424	0.000000	0.000000	32,748	73.00
76.00	03020	CARDIAC	0	0	0.000000	0.000000	0	76.00
76.01	03160	CARDIOPULMONARY	0	283,291	0.000000	0.000000	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	347,836	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	3,822,173	0.000000	0.000000	0	90.01
90.02	09002	DIABETES CLINIC	0	55,080	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	56,227	0.000000	0.000000	0	90.04
90.05	09005	PRIME TIME	0	265,529	0.000000	0.000000	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	1,610,003	0.000000	0.000000	0	90.06
90.07	04951	ONCOLOGY	0	2,516,264	0.000000	0.000000	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	2,916,489	0.000000	0.000000	0	90.08
91.00	09100	EMERGENCY	0	21,488,250	0.000000	0.000000	1,205	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,149,381	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	183,091	205,542,409			265,395	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150037 | Component CCN: 15T037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 11:52 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	CARDIAC	0	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	WOUND CLINIC	0	0	0		90.01
90.02	09002	DIABETES CLINIC	0	0	0		90.02
90.03	09003	ASTHMA CLINIC	0	0	0		90.03
90.04	09004	ANDIS CLINIC	0	0	0		90.04
90.05	09005	PRIME TIME	0	0	0		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0		90.06
90.07	04951	ONCOLOGY	0	0	0		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0		90.08
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	35	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 11:52 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,658	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,658	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)	3,598	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)	1,269	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,847,788	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)	6,847,788	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,847,788	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,210.28	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,535,845	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)	1,535,845	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 11:52 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	6,918,435	5,037	1,373.52	2,309	3,171,458	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)	5,873,455	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	10,580,758	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)	342,472	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	217,984	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	560,456	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	10,020,302	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)	2,060	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,210.28	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,493,177	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 11:52 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	556,870	6,847,788	0.081321	2,493,177	202,748	90.00
91.00	Nursing School cost	0	6,847,788	0.000000	2,493,177	0	91.00
92.00	Allied health cost	0	6,847,788	0.000000	2,493,177	0	92.00
93.00	All other Medical Education	0	6,847,788	0.000000	2,493,177	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150037 Component CCN: 15S037	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/27/2015 11:52 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,643	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,643	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)	2,643	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)	2,434	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,436,116	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)	2,436,116	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,436,116	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	921.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,243,466	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)	2,243,466	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150037 | Component CCN: 15S037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 11:52 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)	296,483	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,539,949	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)	129,611	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	8,301	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	137,912	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,402,037	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 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 11:52 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	140,750	2,436,116	0.057776	0	0	90.00
91.00	Nursing School cost	0	2,436,116	0.000000	0	0	91.00
92.00	Allied health cost	0	2,436,116	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,436,116	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150037 Component CCN: 15T037	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/27/2015 11:52 am
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	296	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	296	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)	296	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)	186	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	571,062	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)	571,062	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	571,062	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,929.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	358,842	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)	358,842	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150037 | Component CCN: 15T037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 11:52 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)	96,736	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	455,578	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)	24,491	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	2,760	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	27,251	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	428,327	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 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 11:52 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	38,974	571,062	0.068248	0	0	90.00
91.00	Nursing School cost	0	571,062	0.000000	0	0	91.00
92.00	Allied health cost	0	571,062	0.000000	0	0	92.00
93.00	All other Medical Education	0	571,062	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 11:52 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,658	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,658	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)	3,598	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)	426	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,847,788	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)	6,847,788	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,847,788	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,210.28	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	515,579	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)	515,579	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 11:52 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	6,918,435	5,037	1,373.52	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)	413,872	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	929,451	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)	2,060	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,210.28	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,493,177	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 11:52 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	556,870	6,847,788	0.081321	2,493,177	202,748	90.00
91.00	Nursing School cost	0	6,847,788	0.000000	2,493,177	0	91.00
92.00	Allied health cost	0	6,847,788	0.000000	2,493,177	0	92.00
93.00	All other Medical Education	0	6,847,788	0.000000	2,493,177	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/27/2015 11:52 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		923,479		30.00
31.00	03100	INTENSIVE CARE UNIT		3,708,289		31.00
40.00	04000	SUBPROVIDER - IPF		14,203		40.00
41.00	04100	SUBPROVIDER - IRF		4,298		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.483598	2,389,376	1,155,497	50.00
51.00	05100	RECOVERY ROOM	0.274710	310,243	85,227	51.00
53.00	05300	ANESTHESIOLOGY	0.669341	1,470	984	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.144918	2,399,655	347,753	54.00
60.00	06000	LABORATORY	0.166382	2,860,458	475,929	60.00
65.00	06500	RESPIRATORY THERAPY	0.312469	1,455,808	454,895	65.00
66.00	06600	PHYSICAL THERAPY	0.456691	377,279	172,300	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.347980	212,680	74,008	67.00
68.00	06800	SPEECH PATHOLOGY	0.503278	92,999	46,804	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.152879	1,628,585	248,976	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.718295	966,398	694,159	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.307796	2,235,426	688,055	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.230744	4,372,578	1,008,946	73.00
76.00	03020	CARDIAC	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.444575	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.332239	3,268	1,086	90.01
90.02	09002	DIABETES CLINIC	1.191921	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	2.569371	0	0	90.04
90.05	09005	PRIME TIME	0.484972	47	23	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.207166	0	0	90.06
90.07	04951	ONCOLOGY	0.484677	2,306	1,118	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.159969	5,343	855	90.08
91.00	09100	EMERGENCY	0.245347	1,697,624	416,507	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.159951	287	333	92.00
200.00		Total (sum of lines 50-94 and 96-98)		21,011,830	5,873,455	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)		21,011,830		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150037 | Component CCN: 15S037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/27/2015 11:52 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		2,852,565		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.483598	11,137	5,386	50.00
51.00	05100	RECOVERY ROOM	0.274710	1,119	307	51.00
53.00	05300	ANESTHESIOLOGY	0.669341	18	12	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.144918	108,489	15,722	54.00
60.00	06000	LABORATORY	0.166382	355,057	59,075	60.00
65.00	06500	RESPIRATORY THERAPY	0.312469	100,720	31,472	65.00
66.00	06600	PHYSICAL THERAPY	0.456691	54,854	25,051	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.347980	75,074	26,124	67.00
68.00	06800	SPEECH PATHOLOGY	0.503278	9,112	4,586	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.152879	10,842	1,658	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.718295	52,874	37,979	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.307796	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.230744	317,639	73,293	73.00
76.00	03020	CARDIAC	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.444575	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.332239	534	177	90.01
90.02	09002	DIABETES CLINIC	1.191921	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	2.569371	0	0	90.04
90.05	09005	PRIME TIME	0.484972	6	3	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.207166	0	0	90.06
90.07	04951	ONCOLOGY	0.484677	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.159969	991	159	90.08
91.00	09100	EMERGENCY	0.245347	63,089	15,479	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.159951	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,161,555	296,483	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)		1,161,555		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150037 | Component CCN: 15T037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/27/2015 11:52 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	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		226,917		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.483598	4,354	2,106	50.00
51.00	05100	RECOVERY ROOM	0.274710	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.669341	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.144918	8,367	1,213	54.00
60.00	06000	LABORATORY	0.166382	21,988	3,658	60.00
65.00	06500	RESPIRATORY THERAPY	0.312469	4,144	1,295	65.00
66.00	06600	PHYSICAL THERAPY	0.456691	83,373	38,076	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.347980	87,071	30,299	67.00
68.00	06800	SPEECH PATHOLOGY	0.503278	16,586	8,347	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.152879	183	28	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.718295	5,376	3,862	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.307796	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.230744	32,748	7,556	73.00
76.00	03020	CARDIAC	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.444575	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.332239	0	0	90.01
90.02	09002	DIABETES CLINIC	1.191921	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	2.569371	0	0	90.04
90.05	09005	PRIME TIME	0.484972	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.207166	0	0	90.06
90.07	04951	ONCOLOGY	0.484677	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.159969	0	0	90.08
91.00	09100	EMERGENCY	0.245347	1,205	296	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.159951	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		265,395	96,736	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)		265,395		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/27/2015 11:52 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		632,802		30.00
31.00	03100	INTENSIVE CARE UNIT		199,286		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.483598	236,513	114,377	50.00
51.00	05100	RECOVERY ROOM	0.274710	26,510	7,283	51.00
53.00	05300	ANESTHESIOLOGY	0.669341	1,468	983	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.144918	154,583	22,402	54.00
60.00	06000	LABORATORY	0.166382	205,305	34,159	60.00
65.00	06500	RESPIRATORY THERAPY	0.312469	78,873	24,645	65.00
66.00	06600	PHYSICAL THERAPY	0.456691	8,250	3,768	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.347980	4,886	1,700	67.00
68.00	06800	SPEECH PATHOLOGY	0.503278	3,274	1,648	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.152879	61,388	9,385	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.718295	117,056	84,081	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.307796	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.230744	371,893	85,812	73.00
76.00	03020	CARDIAC	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.444575	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.963716	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.332239	0	0	90.01
90.02	09002	DIABETES CLINIC	1.191921	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	2.569371	0	0	90.04
90.05	09005	PRIME TIME	0.484972	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.207166	0	0	90.06
90.07	04951	ONCOLOGY	0.484677	1,193	578	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.159969	0	0	90.08
91.00	09100	EMERGENCY	0.245347	93,954	23,051	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.159951	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,365,146	413,872	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)		1,365,146		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time Prepared: 5/27/2015 11:52 am

Title XVIII | Hospital | PPS

		0	1.00	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		6,117,662		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		2,039,220		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0		1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0		1.04
2.00	Outlier payments for discharges. (see instructions)		53,369		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)		53.45		4.00
	Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjusment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0		22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		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
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0		28.01
29.00	Total IME payment (sum of lines 22 and 28)		0		29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0		29.01
	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		1.61		30.00
31.00	Percentage of Medicaid patient days (see instructions)		15.56		31.00
32.00	Sum of lines 30 and 31		17.17		32.00
33.00	Allowable disproportionate share percentage (see instructions)		3.91		33.00
34.00	Disproportionate share adjustment (see instructions)		79,734		34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time Prepared: 5/27/2015 11:52 am

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			Prior to October 1	On/After October 1	
		0	1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		9,046,380,143	7,647,644,855	35.00
35.01	Factor 3 (see instructions)		0.000046089	0.000039112	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		416,939	299,115	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		311,847	75,393	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		387,240		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		8,677,225		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		0		48.00
49.00	Total payment for inpatient operating costs (see instructions)		8,677,225		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		653,126		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		5,549		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		9,935		58.00
59.00	Total (sum of amounts on lines 49 through 58)		9,345,835		59.00
60.00	Primary payer payments		4,289		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		9,341,546		61.00
62.00	Deductibles billed to program beneficiaries		1,075,680		62.00
63.00	Coinsurance billed to program beneficiaries		6,384		63.00
64.00	Allowable bad debts (see instructions)		0		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		0		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		8,259,482		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		15,006		70.93
70.94	HRR adjustment amount (see instructions)		0		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time Prepared: 5/27/2015 11:52 am

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			Prior to October 1	On/After October 1	
		0	1.00	2.00	
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)	2014	191,771		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		8,466,259		71.00
71.01	Sequestration adjustment (see instructions)		169,325		71.01
72.00	Interim payments		8,251,616		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)		45,318		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		526,292		75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00

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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/27/2015 11:52 am

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		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	1.01	6,117,662	0	6,117,662	0	6,117,662	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,039,220	0	0	2,039,220	2,039,220	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	53,369	0	40,027	13,342	53,369	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
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0391	0.0391	0.0391	0.0391		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	79,734	0	59,800	19,934	79,734	11.00
11.01	Uncompensated care payments	36.00	387,240	0	311,847	75,393	387,240	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	8,677,225	0	6,529,336	2,147,889	8,677,225	13.00
14.00	Hospital specific payments (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 (see instructions)	49.00	8,677,225	0	6,529,336	2,147,889	8,677,225	15.00
16.00	Payment for inpatient program capital	50.00	653,126	0	489,845	163,281	653,126	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	0	17.01
17.02	Capital received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/27/2015 11:52 am

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		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	
19.00	SUBTOTAL			0	7,019,181	2,311,170	9,330,351	19.00
		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	652,113	0	489,085	163,028	652,113	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	1,013	0	760	253	1,013	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 (see instructions)	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 (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	653,126	0	489,845	163,281	653,126	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				0.027321	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			191,771		191,771	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/27/2015 11:52 am

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	6,117,662	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,039,220		8,156,882	8,156,882	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	53,369	0	53,369	53,369	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0391	0.0391	0.0391		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	79,734	0	79,734	79,734	11.00
11.01	Uncompensated care payments	36.00	387,240	311,847	75,393	387,240	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	8,677,225	311,847	8,365,378	8,677,225	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	8,677,225	311,847	8,365,378	8,677,225	15.00
16.00	Payment for inpatient program capital	50.00	653,126	0	653,126	653,126	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	17.01
17.02	Capital received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			311,847	9,018,504	9,330,351	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/27/2015 11:52 am

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	652,113	0	652,113	652,113	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	1,013	0	1,013	1,013	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	653,126	0	653,126	653,126	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	191,771	191,771		191,771	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	15,006	0	15,006	15,006	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150037	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/27/2015 11:52 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,994	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	10,886,012	2.00
3.00	PPS payments	7,899,574	3.00
4.00	Outlier payment (see instructions)	41,992	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	47,254	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,994	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	17,408	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	17,408	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	17,408	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	13,414	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)	3,994	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	7,988,820	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,761,027	26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	6,231,787	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	6,231,787	30.00
31.00	Primary payer payments	589	31.00
32.00	Subtotal (line 30 minus line 31)	6,231,198	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	161,311	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	104,852	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	161,311	36.00
37.00	Subtotal (see instructions)	6,336,050	37.00
38.00	MSP-LCC reconciliation amount from PS&R	39	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	6,336,011	40.00
40.01	Sequestration adjustment (see instructions)	126,720	40.01
41.00	Interim payments	6,172,112	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	37,179	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I Date/Time Prepared: 5/27/2015 11:52 am

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		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		8,196,816		6,057,742	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	12/31/2014	27,300	12/31/2014	114,370	3.01
3.02		07/18/2014	27,500		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)		54,800		114,370	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)		8,251,616		6,172,112	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		45,318		37,179	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		8,296,934		6,209,291	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 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/27/2015 11:52 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		2,020,818		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,020,818		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		440		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,021,258		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 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/27/2015 11:52 am

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		268,688		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		268,688		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		35		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		268,723		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 01/01/2014 To 12/31/2014	Worksheet E-1 Part II Date/Time Prepared: 5/27/2015 11:52 am
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	2,579	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	3,578	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	834	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	8,635	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	225,622,028	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	4,686,211	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	596,418	8.00
9.00	Sequestration adjustment amount (see instructions)	11,928	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	584,490	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	631,557	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)	-47,067	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150037 Component CCN: 15S037	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part II Date/Time Prepared: 5/27/2015 11:52 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	2,221,884	1.00
2.00	Net IPF PPS Outlier Payments	2,479	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 42 CFR §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 instuctions)	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 instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	7.241096	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) 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)	2,224,363	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 physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	2,224,363	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	2,224,363	18.00
19.00	Deductibles	161,696	19.00
20.00	Subtotal (line 18 minus line 19)	2,062,667	20.00
21.00	Coinsurance	608	21.00
22.00	Subtotal (line 20 minus line 21)	2,062,059	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	2,062,059	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	449	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	2,062,508	31.00
31.01	Sequestration adjustment (see instructions)	41,250	31.01
32.00	Interim payments	2,020,818	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)	440	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	2,479	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 01/01/2014 To 12/31/2014	Worksheet E-3 Part III Date/Time Prepared: 5/27/2015 11:52 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	280,220	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0000	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	0	3.00
4.00	Outlier Payments	0	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 42 CFR §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 instructions)	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 instructions)	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)	0.810959	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	280,220	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 physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	280,220	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	280,220	19.00
20.00	Deductibles	6,048	20.00
21.00	Subtotal (line 19 minus line 20)	274,172	21.00
22.00	Coinsurance	0	22.00
23.00	Subtotal (line 21 minus line 22)	274,172	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)	274,172	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	35	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	274,207	32.00
32.01	Sequestration adjustment (see instructions)	5,484	32.01
33.00	Interim payments	268,688	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	35	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150037	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Prepared: 5/27/2015 11:52 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	929,451		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)	929,451	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)	929,451	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	832,088		8.00
9.00	Ancillary service charges	1,365,146	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)	2,197,234	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	2,197,234	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,267,783	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 physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	929,451	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	929,451	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	929,451	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	929,451	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	929,451	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)	929,451	0	40.00
41.00	Interim payments	1,364,324	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-434,873	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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 01/01/2014 To 12/31/2014 | Worksheet G | Date/Time Prepared: 5/27/2015 11:52 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	19,243,114	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	10,854,003	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	4,497,605	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)	34,594,722	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	6,747,145	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	102,565,981	0	0	0	15.00
16.00	Accumulated depreciation	-112,513,047	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	62,233,410	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)	59,033,489	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	55,014,784	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	55,014,784	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	148,642,995	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	21,051,221	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,500,843	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,845,168	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	29,397,232	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	0	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	29,397,232	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	119,245,763				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)	119,245,763	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	148,642,995	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-1 | Date/Time Prepared: 5/27/2015 11:52 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		110,054,293		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		9,191,470				2.00
3.00	Total (sum of line 1 and line 2)		119,245,763		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		119,245,763		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		119,245,763		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 01/01/2014 To 12/31/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/27/2015 11:52 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	7,330,859		7,330,859	1.00
2.00	SUBPROVIDER - IPF	3,071,585		3,071,585	2.00
3.00	SUBPROVIDER - IRF	363,156		363,156	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)	10,765,600		10,765,600	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	9,133,755		9,133,755	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)	9,133,755		9,133,755	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	19,899,355		19,899,355	17.00
18.00	Ancillary services	43,393,997	129,888,211	173,282,208	18.00
19.00	Outpatient services	2,945,347	30,119,465	33,064,812	19.00
20.00	RURAL HEALTH CLINIC	0	349,787	349,787	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		672,614	672,614	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	623,222	1,249,942	1,873,164	26.00
27.00	DIETARY/PRIVATE DUTY	0	270,038	270,038	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	66,861,921	162,550,057	229,411,978	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		98,265,080		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)		98,265,080		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-3 | Date/Time Prepared: 5/27/2015 11:52 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	229,411,978	1.00
2.00	Less contractual allowances and discounts on patients' accounts	137,638,346	2.00
3.00	Net patient revenues (line 1 minus line 2)	91,773,632	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	98,265,080	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-6,491,448	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER/NONOPER	15,606,835	24.00
25.00	Total other income (sum of lines 6-24)	15,606,835	25.00
26.00	Total (line 5 plus line 25)	9,115,387	26.00
27.00	GAIN/LOSS INVENTORY	-76,083	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-76,083	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	9,191,470	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 150037 | HHA CCN: 157092 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H | Date/Time Prepared: 5/27/2015 11:52 am

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	527,253	602,704	205,169	0	3,036	1,338,162	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	673,782	0	0	0	0	673,782	6.00
7.00	Physical Therapy	418,964	0	0	0	0	418,964	7.00
8.00	Occupational Therapy	543,450	0	0	0	0	543,450	8.00
9.00	Speech Pathology	20,623	0	0	0	0	20,623	9.00
10.00	Medical Social Services	33,018	0	0	0	0	33,018	10.00
11.00	Home Health Aide	111,301	0	0	0	0	111,301	11.00
12.00	Supplies (see instructions)	0	0	0	0	45,935	45,935	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	2,328,391	602,704	205,169	0	48,971	3,185,235	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	1,338,162	98,344	1,436,506			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	673,782	0	673,782			6.00
7.00	Physical Therapy	0	418,964	0	418,964			7.00
8.00	Occupational Therapy	0	543,450	0	543,450			8.00
9.00	Speech Pathology	0	20,623	0	20,623			9.00
10.00	Medical Social Services	0	33,018	0	33,018			10.00
11.00	Home Health Aide	0	111,301	0	111,301			11.00
12.00	Supplies (see instructions)	0	45,935	0	45,935			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	0	3,185,235	98,344	3,283,579			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 | HHA CCN: 157092 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-1 Part I | Date/Time Prepared: 5/27/2015 11:52 am

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	1,436,506	0	0	0	0	1,436,506	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	673,782	0	0	0	0	673,782	6.00
7.00	Physical Therapy	418,964	0	0	0	0	418,964	7.00
8.00	Occupational Therapy	543,450	0	0	0	0	543,450	8.00
9.00	Speech Pathology	20,623	0	0	0	0	20,623	9.00
10.00	Medical Social Services	33,018	0	0	0	0	33,018	10.00
11.00	Home Health Aide	111,301	0	0	0	0	111,301	11.00
12.00	Supplies (see instructions)	45,935	0	0	0	0	45,935	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	3,283,579	0	0	0	0	3,283,579	24.00

		Administrative & General	Total (cols. 4A + 5)		
		5.00	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures				1.00
2.00	Capital Related - Movable Equipment				2.00
3.00	Plant Operation & Maintenance				3.00
4.00	Transportation				4.00
5.00	Administrative and General	1,436,506			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	524,013	1,197,795		6.00
7.00	Physical Therapy	325,837	744,801		7.00
8.00	Occupational Therapy	422,652	966,102		8.00
9.00	Speech Pathology	16,039	36,662		9.00
10.00	Medical Social Services	25,679	58,697		10.00
11.00	Home Health Aide	86,561	197,862		11.00
12.00	Supplies (see instructions)	35,725	81,660		12.00
13.00	Drugs	0	0		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	0	0		22.00
23.00	All Others (specify)	0	0		23.00
24.00	Total (sum of lines 1-23)		3,283,579		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 150037 | HHA CCN: 157092 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-1 Part II | Date/Time Prepared: 5/27/2015 11:52 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-1,436,506	1,847,073	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	673,782	6.00
7.00	Physical Therapy	0	0	0	0	0	418,964	7.00
8.00	Occupational Therapy	0	0	0	0	0	543,450	8.00
9.00	Speech Pathology	0	0	0	0	0	20,623	9.00
10.00	Medical Social Services	0	0	0	0	0	33,018	10.00
11.00	Home Health Aide	0	0	0	0	0	111,301	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	45,935	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-1,436,506	1,847,073	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		1,436,506	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.777720	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150037 | HHA CCN: 157092 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-2 Part I | Date/Time Prepared: 5/27/2015 11:52 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		0	1.00	4.00	4A	5.00	7.00	
1.00	Administrative and General	0	0	117,549	117,549	21,647	0	1.00
2.00	Skilled Nursing Care	1,197,795	0	0	1,197,795	220,575	0	2.00
3.00	Physical Therapy	744,801	0	0	744,801	137,156	0	3.00
4.00	Occupational Therapy	966,102	0	0	966,102	177,909	0	4.00
5.00	Speech Pathology	36,662	0	0	36,662	6,751	0	5.00
6.00	Medical Social Services	58,697	0	0	58,697	10,809	0	6.00
7.00	Home Health Aide	197,862	0	0	197,862	36,436	0	7.00
8.00	Supplies (see instructions)	81,660	0	0	81,660	15,038	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)	3,283,579	0	117,549	3,401,128	626,321	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	58,952	0	134,931	196,777	72	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	58,952	0	134,931	196,777	72	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150037 HHA CCN: 157092 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-2 Part I Date/Time Prepared: 5/27/2015 11:52 am

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	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	332	0	530,260	0	530,260		1.00
2.00	Skilled Nursing Care	0	0	1,418,370	0	1,418,370	193,430	2.00
3.00	Physical Therapy	0	0	881,957	0	881,957	120,277	3.00
4.00	Occupational Therapy	0	0	1,144,011	0	1,144,011	156,015	4.00
5.00	Speech Pathology	0	0	43,413	0	43,413	5,920	5.00
6.00	Medical Social Services	0	0	69,506	0	69,506	9,479	6.00
7.00	Home Health Aide	0	0	234,298	0	234,298	31,952	7.00
8.00	Supplies (see instructions)	0	0	96,698	0	96,698	13,187	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)	332	0	4,418,513	0	4,418,513	530,260	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.						0.136375	21.00

	Cost Center Description	Total HHA Costs	
		28.00	
1.00	Administrative and General		1.00
2.00	Skilled Nursing Care	1,611,800	2.00
3.00	Physical Therapy	1,002,234	3.00
4.00	Occupational Therapy	1,300,026	4.00
5.00	Speech Pathology	49,333	5.00
6.00	Medical Social Services	78,985	6.00
7.00	Home Health Aide	266,250	7.00
8.00	Supplies (see instructions)	109,885	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)	4,418,513	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 01/01/2014 To 12/31/2014 | Worksheet H-2 Part II | Date/Time Prepared: 5/27/2015 11:52 am

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	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	HOUSEKEEPING (HOURS OF SERVICE)	
		1.00	4.00	5A	5.00	7.00	9.00	
1.00	Administrative and General	0	796,304	0	117,549	0	12,210	1.00
2.00	Skilled Nursing Care	0	0	0	1,197,795	0	0	2.00
3.00	Physical Therapy	0	0	0	744,801	0	0	3.00
4.00	Occupational Therapy	0	0	0	966,102	0	0	4.00
5.00	Speech Pathology	0	0	0	36,662	0	0	5.00
6.00	Medical Social Services	0	0	0	58,697	0	0	6.00
7.00	Home Health Aide	0	0	0	197,862	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	81,660	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	796,304		3,401,128	0	12,210	20.00
21.00	Total cost to be allocated	0	117,549		626,321	0	58,952	21.00
22.00	Unit cost multiplier	0.000000	0.147618		0.184151	0.000000	4.828174	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	57,085	57,085	1,785	0	1	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	57,085	57,085	1,785	0	1	20.00
21.00	Total cost to be allocated	0	134,931	196,777	72	0	332	21.00
22.00	Unit cost multiplier	0.000000	2.363686	3.447088	0.040336	0.000000	332.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150037
HHA CCN: 157092

Period:
From 01/01/2014
To 12/31/2014

Worksheet H-2
Part II
Date/Time Prepared:
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	Cost Center Description	PARAMED ED PRGM (ASSIGNED TIME)		
		23.00		
1.00	Administrative and General	0		1.00
2.00	Skilled Nursing Care	0		2.00
3.00	Physical Therapy	0		3.00
4.00	Occupational Therapy	0		4.00
5.00	Speech Pathology	0		5.00
6.00	Medical Social Services	0		6.00
7.00	Home Health Aide	0		7.00
8.00	Supplies (see instructions)	0		8.00
9.00	Drugs	0		9.00
10.00	DME	0		10.00
11.00	Home Dialysis Aide Services	0		11.00
12.00	Respiratory Therapy	0		12.00
13.00	Private Duty Nursing	0		13.00
14.00	Clinic	0		14.00
15.00	Health Promotion Activities	0		15.00
16.00	Day Care Program	0		16.00
17.00	Home Delivered Meals Program	0		17.00
18.00	Homemaker Service	0		18.00
19.00	All Others (specify)	0		19.00
20.00	Total (sum of lines 1-19)	0		20.00
21.00	Total cost to be allocated	0		21.00
22.00	Unit cost multiplier	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-3 Part I | Date/Time Prepared: 5/27/2015 11:52 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	1,611,800		1,611,800	6,922	232.85	1.00
2.00	Physical Therapy	3.00	1,002,234	0	1,002,234	6,046	165.77	2.00
3.00	Occupational Therapy	4.00	1,300,026	0	1,300,026	2,675	485.99	3.00
4.00	Speech Pathology	5.00	49,333	0	49,333	290	170.11	4.00
5.00	Medical Social Services	6.00	78,985		78,985	156	506.31	5.00
6.00	Home Health Aide	7.00	266,250		266,250	2,351	113.25	6.00
7.00	Total (sum of lines 1-6)		4,308,628	0	4,308,628	18,440		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	0	793			8.00
8.01	Skilled Nursing Care		26900	0	3,321			8.01
8.02	Skilled Nursing Care		11300	0	155			8.02
8.03	Skilled Nursing Care		34620	0	0			8.03
8.04	Skilled Nursing Care		29020	0	36			8.04
9.00	Physical Therapy		99915	0	672			9.00
9.01	Physical Therapy		26900	0	2,778			9.01
9.02	Physical Therapy		11300	0	189			9.02
9.03	Physical Therapy		34620	0	0			9.03
9.04	Physical Therapy		29020	0	50			9.04
10.00	Occupational Therapy		99915	0	320			10.00
10.01	Occupational Therapy		26900	0	1,289			10.01
10.02	Occupational Therapy		11300	0	87			10.02
10.03	Occupational Therapy		34620	0	0			10.03
10.04	Occupational Therapy		29020	0	2			10.04
11.00	Speech Pathology		99915	0	11			11.00
11.01	Speech Pathology		26900	0	133			11.01
11.02	Speech Pathology		11300	0	6			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	0	15			12.00
12.01	Medical Social Services		26900	0	87			12.01
12.02	Medical Social Services		11300	0	1			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	0	201			13.00
13.01	Home Health Aide		26900	0	1,077			13.01
13.02	Home Health Aide		11300	0	41			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)			0	11,264			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	109,885	0	109,885	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 01/01/2014 To 12/31/2014 | Worksheet H-3 Part I | Date/Time Prepared: 5/27/2015 11:52 am

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	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Cost of Services Part B Not Subject to Deductibles & Coinsurance	Cost of Services Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	4,305		0	1,002,419		1.00
2.00	Physical Therapy	0	3,689		0	611,526		2.00
3.00	Occupational Therapy	0	1,698		0	825,211		3.00
4.00	Speech Pathology	0	150		0	25,517		4.00
5.00	Medical Social Services	0	103		0	52,150		5.00
6.00	Home Health Aide	0	1,319		0	149,377		6.00
7.00	Total (sum of lines 1-6)	0	11,264		0	2,666,200		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

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-3 Part I | Date/Time Prepared: 5/27/2015 11:52 am

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	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	1,002,419		1.00
2.00	Physical Therapy	611,526		2.00
3.00	Occupational Therapy	825,211		3.00
4.00	Speech Pathology	25,517		4.00
5.00	Medical Social Services	52,150		5.00
6.00	Home Health Aide	149,377		6.00
7.00	Total (sum of lines 1-6)	2,666,200		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: From 01/01/2014 To 12/31/2014 | Worksheet H-3 Part II | Date/Time Prepared: 5/27/2015 11:52 am

HHA CCN: 157092 | Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.456691	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.347980	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.503278	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	0.718295	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.230744	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-4 Part I-II

HHA CCN: 157092 | Date/Time Prepared: 5/27/2015 11:52 am

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	1,233	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	-1,233	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	1,949,560	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	6,406	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	20,231	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	20,427	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	853	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	207	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	1,996,451	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	1,996,451	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	1,996,451	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	1,996,451	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
31.00	Subtotal (see instructions)	0	1,996,451	31.00
31.01	Sequestration adjustment (see instructions)	0	39,929	31.01
32.00	Interim payments (see instructions)	0	1,956,522	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	0	0	35.00

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

Provider CCN: 150037 HHA CCN: 157092

Period: From 01/01/2014 To 12/31/2014

Worksheet H-5

Date/Time Prepared: 5/27/2015 11:52 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		0		1,956,522	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)		0		1,956,522	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		1,956,522	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 Hospice CCN: 151547 | Period: From 01/01/2014 To 12/31/2014 | Worksheet K | Date/Time Prepared: 5/27/2015 11:52 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	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	158,190	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	194,230	0	0	0	0	9.00
10.00	Nursing Care	514,647	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	68,637	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	103,097	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	1,140,921	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	1,038,801	0	0	0	1,140,921	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150037 Hospice CCN: 151547 | Period: From 01/01/2014 To 12/31/2014 | Worksheet K | Date/Time Prepared: 5/27/2015 11:52 am

Hospice I

		Total (cols. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	158,190	0	158,190	0	158,190	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	194,230	0	194,230	0	194,230	9.00
10.00	Nursing Care	514,647	0	514,647	0	514,647	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	68,637	0	68,637	0	68,637	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	103,097	0	103,097	0	103,097	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	1,140,921	0	1,140,921	-44,840	1,096,081	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	2,179,722	0	2,179,722	-44,840	2,134,882	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150037 Hospice CCN: 151547 | Period: From 01/01/2014 To 12/31/2014 | Worksheet K-1 | Date/Time Prepared: 5/27/2015 11:52 am

Hospice I

		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	158,190	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	194,230	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	514,647	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	68,637	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	352,420	0	68,637	0	514,647	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150037 Hospice CCN: 151547

Period: From 01/01/2014 To 12/31/2014

Worksheet K-1

Date/Time Prepared: 5/27/2015 11:52 am

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	0	158,190		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	194,230		9.00
10.00	Nursing Care		0	0	514,647		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	68,637		15.00
16.00	Spiritual Counseling		0	0	0		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		103,097	0	103,097		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	103,097	0	1,038,801		39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 150037 Hospice CCN: 151547

Period: From 01/01/2014 To 12/31/2014

Worksheet K-4 Part I Date/Time Prepared: 5/27/2015 11:52 am

Hospice I

		NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COST		PLANT OPERATION & MAINT.	TRANSPORTATION	
			BUILDINGS & FIXTURES	MOVABLE EQUIPMENT			
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	158,190	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	194,230	0	0	0	0	9.00
10.00	Nursing Care	514,647	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	68,637	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	103,097	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	1,096,081	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	2,134,882	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 150037 Hospice CCN: 151547

Period: From 01/01/2014 To 12/31/2014

Worksheet K-4 Part I Date/Time Prepared: 5/27/2015 11:52 am

Hospice I

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (cols. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A ± col. 6)		
		5.00	5A	6.00	7.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance						3.00
4.00	Transportation - Staff						4.00
5.00	Volunteer Service Coordination	0					5.00
6.00	Administrative and General	0	158,190	158,190			6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0		7.00
8.00	Inpatient - Respite Care	0	0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services	0	194,230	15,544	209,774		9.00
10.00	Nursing Care	0	514,647	41,186	555,833		10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services	0	68,637	5,493	74,130		15.00
16.00	Spiritual Counseling	0	0	0	0		16.00
17.00	Dietary Counseling	0	0	0	0		17.00
18.00	Counseling - Other	0	0	0	0		18.00
19.00	Home Health Aide and Homemaker	0	103,097	8,251	111,348		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		20.00
21.00	Other	0	0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0		22.00
23.00	Analgesics	0	0	0	0		23.00
24.00	Sedatives / Hypnotics	0	0	0	0		24.00
25.00	Other - Specify	0	0	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0		26.00
27.00	Patient Transportation	0	0	0	0		27.00
28.00	Imaging Services	0	0	0	0		28.00
29.00	Labs and Diagnostics	0	0	0	0		29.00
30.00	Medical Supplies	0	0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0		31.00
32.00	Radiation Therapy	0	0	0	0		32.00
33.00	Chemotherapy	0	0	0	0		33.00
34.00	Other	0	1,096,081	87,716	1,183,797		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0		35.00
36.00	Volunteer Program Costs	0	0	0	0		36.00
37.00	Fundraising	0	0	0	0		37.00
38.00	Other Program Costs	0	0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	2,134,882		2,134,882		39.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150037 Hospice CCN: 151547 | Period: From 01/01/2014 To 12/31/2014 | Worksheet K-4 Part II Date/Time Prepared: 5/27/2015 11:52 am

Hospice I

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

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150037 Hospice CCN: 151547 | Period: From 01/01/2014 To 12/31/2014 | Worksheet K-4 Part II Date/Time Prepared: 5/27/2015 11:52 am

Hospice I

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)		
		6A	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0			1.00
2.00	Capital Related Costs-Movable Equip.	0			2.00
3.00	Plant Operation and Maintenance	0			3.00
4.00	Transportation - Staff	0			4.00
5.00	Volunteer Service Coordination				5.00
6.00	Administrative and General	-158,190	1,976,692		6.00
	INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	0		7.00
8.00	Inpatient - Respite Care	0	0		8.00
	VISITING SERVICES				
9.00	Physician Services	0	194,230		9.00
10.00	Nursing Care	0	514,647		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	68,637		15.00
16.00	Spiritual Counseling	0	0		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	103,097		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		20.00
21.00	Other	0	0		21.00
	OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	0		22.00
23.00	Analgesics	0	0		23.00
24.00	Sedatives / Hypnotics	0	0		24.00
25.00	Other - Specify	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0		26.00
27.00	Patient Transportation	0	0		27.00
28.00	Imaging Services	0	0		28.00
29.00	Labs and Diagnostics	0	0		29.00
30.00	Medical Supplies	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		31.00
32.00	Radiation Therapy	0	0		32.00
33.00	Chemotherapy	0	0		33.00
34.00	Other	0	1,096,081		34.00
	HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0		35.00
36.00	Volunteer Program Costs	0	0		36.00
37.00	Fundraising	0	0		37.00
38.00	Other Program Costs	0	0		38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		158,190		39.00
40.00	Unit Cost Multiplier		0.080028		40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150037 Hospice CCN: 151547

Period: From 01/01/2014 To 12/31/2014

Worksheet K-5 Part I Date/Time Prepared: 5/27/2015 11:52 am

Hospice I

	Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	4.00	4A	5.00	
1.00	Administrative and General		112,114	153,346	265,460	48,885	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	209,774	0	0	209,774	38,630	4.00
5.00	Nursing Care	555,833	0	0	555,833	102,357	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	74,130	0	0	74,130	13,651	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	111,348	0	0	111,348	20,505	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	1,183,797	0	0	1,183,797	217,997	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)	2,134,882	112,114	153,346	2,400,342	442,025	34.00
35.00	Unit Cost Multiplier (see instructions)				0.000000		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150037 Hospice CCN: 151547

Period: From 01/01/2014 To 12/31/2014

Worksheet K-5 Part I Date/Time Prepared: 5/27/2015 11:52 am

Hospice I

	Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	252,819	0	0	77,385	106,370	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)	252,819	0	0	77,385	106,370	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150037
Hospice CCN: 151547

Period:
From 01/01/2014
To 12/31/2014

Worksheet K-5
Part I
Date/Time Prepared:
5/27/2015 11:52 am

Hospice I

	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal (cols. 4A-23)	
		14.00	15.00	16.00	23.00	24.00	
1.00	Administrative and General	3,288	0	0	0	754,207	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	248,404	4.00
5.00	Nursing Care	0	0	0	0	658,190	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	87,781	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	131,853	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	1,401,794	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)	3,288	0	0	0	3,282,229	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150037 Hospice CCN: 151547

Period: From 01/01/2014 To 12/31/2014

Worksheet K-5 Part I Date/Time Prepared: 5/27/2015 11:52 am

Hospice I

	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (cols. 26 ± 27)		
		25.00	26.00	27.00	28.00		
1.00	Administrative and General						1.00
2.00	Inpatient - General Care	0	0	0	0		2.00
3.00	Inpatient - Respite Care	0	0	0	0		3.00
4.00	Physician Services	0	248,404	74,109	322,513		4.00
5.00	Nursing Care	0	658,190	196,364	854,554		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	87,781	26,188	113,969		10.00
11.00	Spiritual Counseling	0	0	0	0		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	131,853	39,337	171,190		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	1,401,794	418,209	1,820,003		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	3,282,229		3,282,229		34.00
35.00	Unit Cost Multiplier (see instructions)			0.298339			35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150037
Hospice CCN: 151547

Period:
From 01/01/2014
To 12/31/2014

Worksheet K-5
Part II
Date/Time Prepared:
5/27/2015 11:52 am

Hospice I

	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	9,240	2,403,900	0	265,460	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	209,774	0	4.00
5.00	Nursing Care	0	0	0	555,833	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	74,130	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	111,348	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	1,183,797	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	2,403,900		2,400,342	9,240	34.00
35.00	Total cost to be allocated	112,114	153,346		442,025	252,819	35.00
36.00	Unit Cost Multiplier (see instructions)	12.133550	0.063791		0.184151	27.361364	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150037
Hospice CCN: 151547

Period:
From 01/01/2014
To 12/31/2014

Worksheet K-5
Part II
Date/Time Prepared:
5/27/2015 11:52 am

Hospice I

	Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	0	32,739	30,858	81,547	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	32,739	30,858	81,547	34.00
35.00	Total cost to be allocated	0	0	77,385	106,370	3,288	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	2.363695	3.447080	0.040320	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150037
Hospice CCN: 151547

Period:
From 01/01/2014
To 12/31/2014

Worksheet K-5
Part II
Date/Time Prepared:
5/27/2015 11:52 am

Hospice I

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

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 150037 Hospice CCN: 151547

Period: From 01/01/2014 To 12/31/2014

Worksheet K-5 Part III Date/Time Prepared: 5/27/2015 11:52 am

Hospice I

	Cost Center Description	Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1.00	2.00	3.00	
	ANCILLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.456691	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.347980	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.503278	0	0	3.00
3.01	OCCUPATIONAL HEALTH	68.01	0.000000	0	0	3.01
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.230744	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00
6.00	LABORATORY	60.00	0.166382	0	0	6.00
6.01	BLOOD LABORATORY	60.01				6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.718295	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	CARDIOPULMONARY	76.01	0.444575	0	0	10.01
11.00	Totals (sum of lines 1-10)				0	11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 150037 Hospice CCN: 151547

Period: From 01/01/2014 To 12/31/2014

Worksheet K-6

Date/Time Prepared: 5/27/2015 11:52 am

Hospice I

		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				3,282,229	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				4,495	2.00
3.00	Average cost per diem (line 1 divided by line 2)				730.20	3.00
4.00	Updduplicated Medicare Days (Worksheet S-9, column 1, line 5)	4,175				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	3,048,585				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		31			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		22,636			7.00
8.00	Updduplicated 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)			289		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			211,028		13.00

CALCULATION OF CAPITAL PAYMENT | Provider CCN: 150037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet L Parts I-III Date/Time Prepared: 5/27/2015 11:52 am

Title XVIII | Hospital | PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	652,113	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	1,013	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)	24.12	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)	653,126	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

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

Provider CCN: 150037 Component CCN: 153987 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-1 | Date/Time Prepared: 5/27/2015 11:52 am

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	14,280	0	14,280	0	14,280	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	118,193	0	118,193	0	118,193	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	23,540	0	23,540	0	23,540	9.00
10.00	Subtotal (sum of lines 1 through 9)	156,013	0	156,013	0	156,013	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	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 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	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 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	156,013	0	156,013	0	156,013	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	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 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	79,076	79,076	0	79,076	29.00
30.00	Administrative Costs	29,326	0	29,326	0	29,326	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	29,326	79,076	108,402	0	108,402	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	185,339	79,076	264,415	0	264,415	32.00

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

Provider CCN: 150037 | Component CCN: 153987 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-1 | Date/Time Prepared: 5/27/2015 11:52 am

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	14,280		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	118,193		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	23,540		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	156,013		10.00
11.00	Physician Services Under Agreement	0	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 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		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 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	156,013		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		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 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	79,076		29.00
30.00	Administrative Costs	-6,670	22,656		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-6,670	101,732		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-6,670	257,745		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 150037 | Component CCN: 153987 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-2 | Date/Time Prepared: 5/27/2015 11:52 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	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	0	0		1.00
2.00	Physician Assistant	0.00	0	0	0		2.00
3.00	Nurse Practitioner	1.06	1,547	2,100	2,226		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.06	1,547		2,226	2,226	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 through 7)	1.06	1,547			2,226	8.00
9.00	Physician Services Under Agreements		22			22	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					156,013	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					156,013	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)					101,732	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					77,470	15.00
16.00	Total overhead (sum of lines 14 and 15)					179,202	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					179,202	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					179,202	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					335,215	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 150037 Component CCN: 153987	Period: From 01/01/2014 To 12/31/2014	Worksheet M-3 Date/Time Prepared: 5/27/2015 11:52 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		335,215	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		10,196	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		325,019	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		2,226	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		22	5.00
6.00	Total adjusted visits (line 4 plus line 5)		2,248	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		144.58	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	79.80	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	269	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	21,466	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) *		21,466	16.00
16.01	Total program charges (see instructions)(from contractor's records)		56,568	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.)		13,087	16.04
16.05	Total program cost (see instructions)		13,087	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		5,107	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		10,292	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		13,087	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		2,193	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		15,280	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
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		15,280	26.00
26.01	Sequestration adjustment (see instructions)		306	26.01
27.00	Interim payments		12,339	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)		2,635	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 150037 Component CCN: 153987	Period: From 01/01/2014 To 12/31/2014	Worksheet M-4 Date/Time Prepared: 5/27/2015 11:52 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	156,013	156,013	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001276	0.010338	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	199	1,613	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,239	1,694	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,438	3,307	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	156,013	156,013	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	179,202	179,202	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.009217	0.021197	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,652	3,799	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	3,090	7,106	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	19	154	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	162.63	46.14	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	1	44	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	163	2,030	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		10,196	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		2,193	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 01/01/2014 To 12/31/2014	Worksheet M-5 Date/Time Prepared: 5/27/2015 11:52 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		12,339	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)		12,339	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		2,635	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		14,974	7.00

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