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 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 5/26/2016 2:54 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/26/2016 Time: 2:54 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 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	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	35,607	-8,047	268,684	391,421	1.00
2.00	Subprovider - IPF	0	469	0		0	2.00
3.00	Subprovider - IRF	0	0	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		3,720		0	10.00
200.00	Total	0	36,076	-4,327	268,684	391,421	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 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2016 2:22 pm

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

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	HANCOCK REGIONAL HOSPITAL	150037	26900	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	HANCOCK REGIONAL GERO PSYCH UNIT	15S037	26900	4	12/01/1996	N	P	N	4.00
5.00	Subprovider - IRF									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									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:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2015	12/31/2015	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.	177	584	0	0	559	25	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2016 2:22 pm

		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 is in effect in the cost reporting period.	0		37.00
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the 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, chapter 21, §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

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		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 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/26/2016 2:22 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name 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, indicate which program year began during this cost reporting period. (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.	N			75.00
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, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00

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		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
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.	N	87.00

		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/IID 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	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 is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	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, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	558,042	0	0	118.01

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		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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N		145.00
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, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
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 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/26/2016 2:22 pm

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (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 §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
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
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)	0.25	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)	10/01/2014	09/30/2015	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 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/26/2016 2:22 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	06/30/2016	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 Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	02/09/2016	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II Date/Time Prepared: 5/26/2016 2:22 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions					22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.					28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					31.00
	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.					32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.					34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.					35.00
			Y/N	Date		
			1.00	2.00		
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?					36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
			1.00	2.00		
	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 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/26/2016 2:22 pm

		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)				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)	02/09/2016			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 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 5/26/2016 2:22 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(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	0	0		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)		78				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 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2016 2:22 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
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)	1,237	177	3,348			1.00
2.00	HMO and other (see instructions)	351	1,143				2.00
3.00	HMO IPF Subprovider	0	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)	1,237	177	3,348			7.00
8.00	INTENSIVE CARE UNIT	2,466	0	5,230			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)	3,703	177	8,578	0.00	596.11	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,562	0	2,610	0.00	18.64	16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	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	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	1,009	0.00	18.27	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	289	0	1,698	0.00	3.03	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	636.05	27.00
28.00	Observation Bed Days		0	2,098			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			72			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	25	46			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2016 2:22 pm

	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	1,183	40	2,556	1.00
2.00	HMO and other (see instructions)			98	288		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		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	1,183	40	2,556	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	213	0	222	16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	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	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 01/01/2015 To 12/31/2015 | Worksheet S-3 Part II Date/Time Prepared: 5/26/2016 2:22 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	37,540,824	0	37,540,824	1,181,434.76	31.78	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		175,440	0	175,440	5,912.56	29.67	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)		5,052,593	103,971	5,156,564	144,939.00	35.58	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		283,759	0	283,759	5,140.00	55.21	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		377,685	0	377,685	3,112.00	121.36	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)		7,316,302	0	7,316,302			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,294,280	0	1,294,280			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		40,313	0	40,313			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	317,830	0	317,830	7,773.00	40.89	26.00
27.00	Administrative & General	5.00	6,686,229	-103,971	6,582,258	196,300.00	33.53	27.00
28.00	Administrative & General under contract (see inst.)		870,210	0	870,210	4,583.00	189.88	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	902,194	0	902,194	30,655.00	29.43	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	861,408	0	861,408	60,820.00	14.16	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,098,122	-733,832	364,290	22,118.00	16.47	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	733,832	733,832	45,490.00	16.13	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	918,199	0	918,199	21,852.00	42.02	38.00
39.00	Central Services and Supply	14.00	60,848	0	60,848	3,417.00	17.81	39.00
40.00	Pharmacy	15.00	1,463,372	-15,950	1,447,422	37,721.00	38.37	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part II Date/Time Prepared: 5/26/2016 2:22 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	591,131	0	591,131	23,815.00	24.82	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 01/01/2015 To 12/31/2015 | Worksheet S-3 Part III Date/Time Prepared: 5/26/2016 2:22 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		38,235,594	0	38,235,594	1,180,105.20	32.40	1.00
2.00	Excluded area salaries (see instructions)		5,052,593	103,971	5,156,564	144,939.00	35.58	2.00
3.00	Subtotal salaries (line 1 minus line 2)		33,183,001	-103,971	33,079,030	1,035,166.20	31.96	3.00
4.00	Subtotal other wages & related costs (see inst.)		661,444	0	661,444	8,252.00	80.16	4.00
5.00	Subtotal wage-related costs (see inst.)		7,316,302	0	7,316,302	0.00	22.12	5.00
6.00	Total (sum of lines 3 thru 5)		41,160,747	-103,971	41,056,776	1,043,418.20	39.35	6.00
7.00	Total overhead cost (see instructions)		13,769,543	-119,921	13,649,622	454,544.00	30.03	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part IV Date/Time Prepared: 5/26/2016 2:22 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1,266,053	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	4,860	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)	4,111,358	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	197,349	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	158,754	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)	62,219	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	48,017	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,680,300	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	23,302	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	9,113	22.00
23.00	Tuition Reimbursement	77,069	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	8,638,394	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 01/01/2015 To 12/31/2015 | Worksheet S-3 Part V Date/Time Prepared: 5/26/2016 2:22 pm

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

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

Provider CCN: 150037 Component CCN: 153987 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-8 Date/Time Prepared: 5/26/2016 2:22 pm

		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	46148	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)	137,632	07/01/2015	4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00

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

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

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		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)						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	16:00	08:00	16:00	08:00	16:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 150037 Component CCN: 153987	Period: From 01/01/2015 To 12/31/2015	Worksheet S-8 Date/Time Prepared: 5/26/2016 2:22 pm
		Rural Health Clinic (RHC) I	Cost

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

HOSPITAL IDENTIFICATION DATA | Provider CCN: 150037 | Component CCN: 151547 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-9 Parts I & II | Date/Time Prepared: 5/26/2016 2:22 pm

Hospice I

		Unduplicated Days Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Routine Home Care	4,734	0	270	0	129	4,863	2.00
3.00	Inpatient Respite Care	278	0	5	0	14	292	3.00
4.00	General Inpatient Care	528	0	0	0	27	555	4.00
5.00	Total Hospice Days	5,540	0	275	0	170	5,710	5.00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving Hospice Care	247	0	6	0	18	265	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)	22.43	0.00	45.83	0.00	9.44	21.55	8.00
9.00	Unduplicated Census Count	233	0	6	0	18	251	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-10 | Date/Time Prepared: 5/26/2016 2:22 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.291566	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	10,220,233	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	12,578,583	6.00
7.00	Medicaid cost (line 1 times line 6)	3,667,487	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	4,253,653	0	4,253,653	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,240,221	0	1,240,221	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)	1,240,221	0	1,240,221	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	9,655,240	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	135,503	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	9,519,737	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	2,775,632	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,015,853	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,015,853	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/26/2016 2:22 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		8,719,372	8,719,372	0	8,719,372	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	317,830	6,332,293	6,650,123	0	6,650,123	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,686,229	10,426,279	17,112,508	-584,592	16,527,916	5.00
7.00	00700	OPERATION OF PLANT	902,194	3,999,085	4,901,279	3,379	4,904,658	7.00
9.00	00900	HOUSEKEEPING	861,408	692,604	1,554,012	0	1,554,012	9.00
10.00	01000	DIETARY	1,098,122	919,457	2,017,579	-1,348,269	669,310	10.00
11.00	01100	CAFETERIA	0	0	0	1,348,269	1,348,269	11.00
13.00	01300	NURSING ADMINISTRATION	918,199	164,967	1,083,166	0	1,083,166	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	60,848	50,513	111,361	0	111,361	14.00
15.00	01500	PHARMACY	1,463,372	6,746,713	8,210,085	-16,482	8,193,603	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	591,131	302,433	893,564	10,982	904,546	16.00
23.00	02300	PARAMED ED PRGM	75,985	14,666	90,651	0	90,651	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,491,534	583,972	3,075,506	0	3,075,506	30.00
31.00	03100	INTENSIVE CARE UNIT	3,017,324	652,001	3,669,325	0	3,669,325	31.00
40.00	04000	SUBPROVIDER - IPF	1,149,395	223,548	1,372,943	0	1,372,943	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,776,698	2,057,653	4,834,351	0	4,834,351	50.00
51.00	05100	RECOVERY ROOM	222,953	33,427	256,380	0	256,380	51.00
53.00	05300	ANESTHESIOLOGY	0	138,838	138,838	0	138,838	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,475,821	1,572,296	4,048,117	0	4,048,117	54.00
60.00	06000	LABORATORY	1,568,564	2,444,688	4,013,252	5,571	4,018,823	60.00
65.00	06500	RESPIRATORY THERAPY	1,134,178	258,543	1,392,721	7,176	1,399,897	65.00
66.00	06600	PHYSICAL THERAPY	946,390	203,449	1,149,839	0	1,149,839	66.00
67.00	06700	OCCUPATIONAL THERAPY	265,128	23,568	288,696	0	288,696	67.00
68.00	06800	SPEECH PATHOLOGY	159,111	19,302	178,413	0	178,413	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	498,355	184,844	683,199	23,422	706,621	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,162,361	3,162,361	-1,709	3,160,652	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,290,960	2,290,960	0	2,290,960	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	52,839	33,833	86,672	0	86,672	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	175,440	93,344	268,784	0	268,784	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	617,220	253,155	870,375	0	870,375	90.01
90.02	09002	DIABETES CLINIC	39,768	8,585	48,353	0	48,353	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	42,375	48,887	91,262	0	91,262	90.04
90.05	09005	PRIME TIME	0	102,303	102,303	0	102,303	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	195,115	176,533	371,648	0	371,648	90.06
90.07	04951	ONCOLOGY	500,884	1,027,770	1,528,654	0	1,528,654	90.07
90.08	04950	ANDERSON WOMENS CENTER	254,104	32,720	286,824	0	286,824	90.08
91.00	09100	EMERGENCY	2,155,097	519,515	2,674,612	0	2,674,612	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	1,098,036	1,639,714	2,737,750	0	2,737,750	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	34,811,647	56,154,191	90,965,838	-552,253	90,413,585	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	587,218	587,218	-32,339	554,879	190.01
190.02	19002	PHYSICIAN BUILDING	0	50,185	50,185	0	50,185	190.02
190.03	19003	PRIVATE DUTY	144,151	199,405	343,556	0	343,556	190.03
190.04	19004	MARKETING	0	0	0	584,592	584,592	190.04
190.05	19005	SPORTS PHYSICALS	23,937	4,528	28,465	0	28,465	190.05
190.06	19006	FOUNDATION	127,827	53,094	180,921	0	180,921	190.06
190.07	19007	ASC	0	806	806	0	806	190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	1,261,258	2,305,317	3,566,575	0	3,566,575	190.09
190.10	19010	HANCOCK WELLNESS	900,938	563,931	1,464,869	0	1,464,869	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	57,189	-51,662	5,527	0	5,527	190.12
190.13	19013	MCCORD WELLNESS	59,817	144,753	204,570	0	204,570	190.13
190.14	19014	3 WEST UNIT	154,060	189,437	343,497	0	343,497	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	78,000	78,000	0	78,000	190.15
200.00		TOTAL (SUM OF LINES 118-199)	37,540,824	60,279,203	97,820,027	0	97,820,027	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/26/2016 2:22 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-1,036,303	7,683,069		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,613,654	5,036,469		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,370,885	12,157,031		5.00
7.00	00700	OPERATION OF PLANT	-43,909	4,860,749		7.00
9.00	00900	HOUSEKEEPING	-67,600	1,486,412		9.00
10.00	01000	DIETARY	-378,054	291,256		10.00
11.00	01100	CAFETERIA	-32,896	1,315,373		11.00
13.00	01300	NURSING ADMINISTRATION	-18,615	1,064,551		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-28,995	82,366		14.00
15.00	01500	PHARMACY	-708,005	7,485,598		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-69,173	835,373		16.00
23.00	02300	PARAMED ED PRGM	-53,132	37,519		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,337	3,074,169		30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,669,325		31.00
40.00	04000	SUBPROVIDER - IPF	-96,000	1,276,943		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-8,435	4,825,916		50.00
51.00	05100	RECOVERY ROOM	0	256,380		51.00
53.00	05300	ANESTHESIOLOGY	0	138,838		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-527,420	3,520,697		54.00
60.00	06000	LABORATORY	-214,469	3,804,354		60.00
65.00	06500	RESPIRATORY THERAPY	-196,925	1,202,972		65.00
66.00	06600	PHYSICAL THERAPY	41	1,149,880		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	288,696		67.00
68.00	06800	SPEECH PATHOLOGY	-375	178,038		68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	-341	706,280		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,160,652		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,290,960		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	86,672		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-6,757	262,027		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	-719	869,656		90.01
90.02	09002	DIABETES CLINIC	0	48,353		90.02
90.03	09003	ASTHMA CLINIC	0	0		90.03
90.04	09004	ANDIS CLINIC	-3,375	87,887		90.04
90.05	09005	PRIME TIME	0	102,303		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	-26,487	345,161		90.06
90.07	04951	ONCOLOGY	-474,877	1,053,777		90.07
90.08	04950	ANDERSON WOMENS CENTER	-1,071	285,753		90.08
91.00	09100	EMERGENCY	-60,962	2,613,650		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	-1,166	2,736,584		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-10,041,896	80,371,689		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	554,879		190.01
190.02	19002	PHYSICIAN BUILDING	0	50,185		190.02
190.03	19003	PRIVATE DUTY	0	343,556		190.03
190.04	19004	MARKETING	0	584,592		190.04
190.05	19005	SPORTS PHYSICALS	0	28,465		190.05
190.06	19006	FOUNDATION	0	180,921		190.06
190.07	19007	ASC	0	806		190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.08
190.09	19009	HANCOCK OB	0	3,566,575		190.09
190.10	19010	HANCOCK WELLNESS	0	1,464,869		190.10
190.11	19011	MORRISTOWN CLINIC	0	0		190.11
190.12	19012	O3PUREMED	0	5,527		190.12
190.13	19013	MCCORD WELLNESS	0	204,570		190.13
190.14	19014	3 WEST UNIT	0	343,497		190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	78,000		190.15
200.00		TOTAL (SUM OF LINES 118-199)	-10,041,896	87,778,131		200.00

RECLASSIFICATIONS | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/26/2016 2:22 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	733,832	614,437		1.00
	TOTALS		733,832	614,437		
	B - PLANT					
1.00	OPERATION OF PLANT	7.00	0	3,379		1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	10,982		2.00
3.00	ELECTROCARDIOLOGY	69.00	0	10,802		3.00
4.00	RESPIRATORY THERAPY	65.00	0	7,176		4.00
	TOTALS		0	32,339		
	C - MARKETING					
1.00	MARKETING	190.04	103,971	480,621		1.00
	TOTALS		103,971	480,621		
	D - OUTPATIENT PROCEDURES					
1.00	LABORATORY	60.00	4,885	686		1.00
2.00	ELECTROCARDIOLOGY	69.00	11,065	1,555		2.00
	TOTALS		15,950	2,241		
500.00	Grand Total: Increases		853,753	1,129,638		500.00

RECLASSIFICATIONS | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/26/2016 2:22 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	733,832	614,437	0		1.00
	TOTALS		733,832	614,437			
	B - PLANT						
1.00	PROFESSIONAL BUILDING	190.01	0	32,339	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	32,339			
	C - MARKETING						
1.00	ADMINISTRATIVE & GENERAL	5.00	103,971	480,621	0		1.00
	TOTALS		103,971	480,621			
	D - OUTPATIENT PROCEDURES						
1.00	PHARMACY	15.00	15,950	532	0		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,709	0		2.00
	TOTALS		15,950	2,241			
500.00	Grand Total: Decreases		853,753	1,129,638			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part I | Date/Time Prepared: 5/26/2016 2:22 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,241,194	0	0	0	0	1.00
2.00	Land Improvements	5,505,951	1,072,303	0	1,072,303	0	2.00
3.00	Buildings and Fixtures	43,186,865	2,195,256	0	2,195,256	126,052	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	56,277,169	3,005,519	0	3,005,519	26,900	5.00
6.00	Movable Equipment	62,233,410	9,426,740	0	9,426,740	125,199	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	168,444,589	15,699,818	0	15,699,818	278,151	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	168,444,589	15,699,818	0	15,699,818	278,151	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	6,578,254	0	2.00
3.00	Buildings and Fixtures	45,256,069	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	59,255,788	0	5.00
6.00	Movable Equipment	71,534,951	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	183,866,256	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	183,866,256	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part II | Date/Time Prepared: 5/26/2016 2:22 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	8,719,372	0	0	0	0	1.00
3.00	Total (sum of lines 1-2)	8,719,372	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	8,719,372		1.00
3.00	Total (sum of lines 1-2)	0	8,719,372		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part III | Date/Time Prepared: 5/26/2016 2:22 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	45,256,069	0	45,256,069	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	45,256,069	0	45,256,069	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	8,719,372	-663,271	1.00
3.00	Total (sum of lines 1-2)	0	0	0	8,719,372	-663,271	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	-373,032	0	0	0	7,683,069	1.00
3.00	Total (sum of lines 1-2)	-373,032	0	0	0	7,683,069	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/26/2016 2:22 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,362,595			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 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/26/2016 2:22 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	HRH MMO RENTAL INCOME	B	-652,525	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.00
33.01	HRH OTHER REVENUE SALES TAX	B	41,126	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	HRH OTHER REVENUE MISCELLANEOUS REVE	B	-19,650	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	HRH OTHER REVENUE CHARGE CARD-OTHER	B	-40	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	HRH MED STAFF SERV QA APPLICATION FE	B	-15,750	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	HRH MEDICAL DUES MEDICAL STAFF DUES	B	-18,100	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	HRH PAT FIN. SERV. BUSINESS SERV-COP	B	-1,790	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	HRH PAT FIN. SERV. EXPENSE REIMBURSE	B	-47,639	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	HRH INFO SERVICES MISCELLANEOUS REVE	B	-373,772	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	HRH ACCOUNTING MISCELLANEOUS REVENUE	B	-9,567	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	HRH ACCOUNTING MANAGEMENT FEES	B	-18,233	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	HRH EXEC ADMIN MISCELLANEOUS REVENUE	B	-932	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	HRH COMMUNICATIONS MISCELLANEOUS REV	B	-8,925	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	HRH COMMUNICATIONS PHONE LEASE REVEN	B	-184,747	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	HRH COMM EDUCATION MISCELLANEOUS REV	B	-315	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	HRH COMM EDUCATION EDUCATION SERVICE	B	-9,799	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	HRH GAIN/LOSS INVENTORY	B	-246,161	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	HRH GAIN/LOSS GROSS VARIANCE INVENTO	B	74,686	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	HRH SECURITY MISCELLANEOUS REVENUE	B	-1,200	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	HRH HPN IT DEPT MISC REVENUE	B	-222,769	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	HRH PLANT OFFSITE SERVICES	B	-32,126	OPERATION OF PLANT	7.00	0	33.20
33.21	HRH HOUSEKEEPING ENVIRONMENTAL SERVI	B	-67,600	HOUSEKEEPING	9.00	0	33.21
33.22	HRH NUTRITIONAL SER REBATES/REFUNDS	B	-2,623	DIETARY	10.00	0	33.22
33.23	HRH NUTRITIONAL SER LTACH REVENUE	B	-62,639	DIETARY	10.00	0	33.23
33.24	HRH CLINICAL EDUCAT AHA COURSE REVEN	B	-18,495	NURSING ADMINISTRATION	13.00	0	33.24
33.25	HRH CLINICAL EDUCAT EDUCATION SERVIC	B	-120	NURSING ADMINISTRATION	13.00	0	33.25
33.26	HRH OTHER REVENUE REBATES/REFUNDS	B	-22,104	CENTRAL SERVICES & SUPPLY	14.00	0	33.26
33.27	HRH OTHER REVENUE DISCOUNTS EARNED O	B	-6,891	CENTRAL SERVICES & SUPPLY	14.00	0	33.27
33.28	HRH PHARMACY MISCELLANEOUS REVENUE	B	-3,829	PHARMACY	15.00	0	33.28
33.29	HRH PHARMACY REBATES/REFUNDS	B	-17,277	PHARMACY	15.00	0	33.29
33.30	HRH ASSOCIATE PHARM RETAIL PHARMACY-	B	-602,196	PHARMACY	15.00	0	33.30
33.31	HRH ASSOCIATE PHARM HOSPICE PHARMACY	B	-71,847	PHARMACY	15.00	0	33.31
33.32	HRH ASSOCIATE PHARM MISCELLANEOUS RE	B	-12,856	PHARMACY	15.00	0	33.32
33.33	HRH HEALTH INFO SER MEDICAL RECORDS-	B	-2,966	MEDICAL RECORDS & LIBRARY	16.00	0	33.33
33.34	HRH HEALTH INFO SER MISCELLANEOUS RE	B	-66,207	MEDICAL RECORDS & LIBRARY	16.00	0	33.34
33.35	XRAY SCHOOL TUITION REVENUE	B	-53,132	PARAMED ED PRGM	23.00	0	33.35
33.36	HRH ANDIS UNIT REBATES/REFUNDS	B	-840	ADULTS & PEDIATRICS	30.00	0	33.36
33.37	HRH SURGERY REBATES/REFUNDS	B	-4,945	OPERATING ROOM	50.00	0	33.37
33.38	SALE OF USED EQUIP	B	-25,630	RADIOLOGY-DIAGNOSTIC	54.00	0	33.38
33.39	HRH DIAG IMAGING HEARTBEATS REVENUE	B	-6,476	RADIOLOGY-DIAGNOSTIC	54.00	0	33.39
33.40	HRH MMO-RAD HEARTBEATS REVENUE	B	-198	RADIOLOGY-DIAGNOSTIC	54.00	0	33.40

ADJUSTMENTS TO EXPENSES | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/26/2016 2:22 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.41	HRH MMO EXPENSE REIMBURSEMENT	B	-176,483	RADIOLOGY-DIAGNOSTIC	54.00	0	33.41
33.42	HRH MMO-DEXA HEARTBEATS REVENUE	B	-420	RADIOLOGY-DIAGNOSTIC	54.00	0	33.42
33.43	HRH LAB WATER TESTING	B	-64,535	LABORATORY	60.00	0	33.43
33.44	HRH LAB HEARTBEATS REVENUE	B	-40,044	LABORATORY	60.00	0	33.44
33.45	HRH SLEEP STUDY CLINIC MANAGMENT	B	-80,790	RESPIRATORY THERAPY	65.00	0	33.45
33.46	HRH SLEEP STUDY SLEEP STUDY FEES	B	-98,135	RESPIRATORY THERAPY	65.00	0	33.46
33.47	HRH WELLNESS PT WELLNESS REVENUE	B	41	PHYSICAL THERAPY	66.00	0	33.47
33.48	HRH CARDIO SERV HEARTBEATS REVENUE	B	-341	ELECTROCARDIOLOGY	69.00	0	33.48
33.49	HRH SHELBY WOUND PHYS OTHER REVENUE	B	-25,144	SHELBYVILLE WOUND CLINIC	90.06	0	33.49
33.50	HRH AWC GENERAL BOUTIQUE SERVICES	B	-581	ANDERSON WOMENS CENTER	90.08	0	33.50
33.51	HRH MMO-US HEARTBEATS REVENUE	B	-490	ANDERSON WOMENS CENTER	90.08	0	33.51
33.52	HRH E R REBATES/REFUNDS	B	-962	EMERGENCY	91.00	0	33.52
33.53	HRH HOSPICE MISCELLANEOUS REVENUE	B	-20	HOSPICE	116.00	0	33.53
33.54	MOW	A	-312,792	DIETARY	10.00	0	33.54
33.55	CAFETERIA GUEST MEALS	A	-32,896	CAFETERIA	11.00	0	33.55
33.56	PHYSICIAN RECRUITMENT FEES	A	-4,744	ADMINISTRATIVE & GENERAL	5.00	0	33.56
33.57	DONATIONS & SPONSORSHIPS	A	-59,018	ADMINISTRATIVE & GENERAL	5.00	0	33.57
33.58	ADVERTISING FEE	A	-244,649	ADMINISTRATIVE & GENERAL	5.00	0	33.58
33.59	ADVERTISING FEE	A	-1,957	OPERATION OF PLANT	7.00	0	33.59
33.60	ADVERTISING FEE	A	-719	WOUND CLINIC	90.01	0	33.60
33.61	ADVERTISING FEE	A	-1,343	SHELBYVILLE WOUND CLINIC	90.06	0	33.61
33.62	ADVERTISING FEE	A	-300	ONCOLOGY	90.07	0	33.62
33.63	IHA LOBBYING EXPENSE	A	-1,636	ADMINISTRATIVE & GENERAL	5.00	0	33.63
33.64	AHA LOBBYING EXPENSE	A	-5,185	ADMINISTRATIVE & GENERAL	5.00	0	33.64
33.65	PHY OFFICE BLDG	A	-373,032	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.65
33.66	PHY OFFICE BLDG	A	-14,596	RADIOLOGY-DIAGNOSTIC	54.00	0	33.66
33.67	PHY OFFICE BLDG	A	-6,757	RURAL HEALTH CLINIC	88.00	0	33.67
33.68	RENTAL PROPERTIES EXPENSE	A	-194,695	ADMINISTRATIVE & GENERAL	5.00	0	33.68
33.69	RENTAL PROPERTIES EXPENSE	A	-10,746	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.69
33.70	RENTAL PROPERTIES EXPENSE	A	-9,826	OPERATION OF PLANT	7.00	0	33.70
33.71	TELEPHONE SERVICES	A	-34,115	ADMINISTRATIVE & GENERAL	5.00	0	33.71
33.72	HAF EXPENSE	A	-2,474,784	ADMINISTRATIVE & GENERAL	5.00	0	33.72
33.73	SELF INSURANCE CLAIM EXPENSE	A	-1,613,654	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.73
33.74	HRH MARKETING MOVING EXPENSES	A	4,500	ADMINISTRATIVE & GENERAL	5.00	0	33.74
33.75	ADVERTISING FEE	A	-208	ADMINISTRATIVE & GENERAL	5.00	0	33.75
33.76	ADVERTISING FEE	A	-1,146	HOSPICE	116.00	0	33.76
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-10,041,896				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 01/01/2015 To 12/31/2015 | Worksheet A-8-2 | Date/Time Prepared: 5/26/2016 2:22 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	292,774	292,774	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	497	497	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	96,000	96,000	0	0	0	3.00
4.00	50.00	OPERATING ROOM	3,490	3,490	0	0	0	4.00
5.00	0.00	AGGREGATE-	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	303,617	303,617	0	0	0	6.00
7.00	60.00	LABORATORY	145,833	109,890	35,943	253,900	401	7.00
8.00	65.00	RESPIRATORY THERAPY	18,000	18,000	0	0	0	8.00
9.00	68.00	SPEECH PATHOLOGY	375	375	0	0	0	9.00
10.00	90.04	ANDIS CLINIC	3,375	3,375	0	0	0	10.00
11.00	90.07	ONCOLOGY	474,577	474,577	0	0	0	11.00
12.00	91.00	EMERGENCY	60,000	60,000	0	0	0	12.00
200.00			1,398,538	1,362,595	35,943		401	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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	0.00	AGGREGATE-	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	48,949	2,447	0	0	0	7.00
8.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	8.00
9.00	68.00	SPEECH PATHOLOGY	0	0	0	0	0	9.00
10.00	90.04	ANDIS CLINIC	0	0	0	0	0	10.00
11.00	90.07	ONCOLOGY	0	0	0	0	0	11.00
12.00	91.00	EMERGENCY	0	0	0	0	0	12.00
200.00			48,949	2,447	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	292,774		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	497		2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	96,000		3.00
4.00	50.00	OPERATING ROOM	0	0	0	3,490		4.00
5.00	0.00	AGGREGATE-	0	0	0	0		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	303,617		6.00
7.00	60.00	LABORATORY	0	48,949	0	109,890		7.00
8.00	65.00	RESPIRATORY THERAPY	0	0	0	18,000		8.00
9.00	68.00	SPEECH PATHOLOGY	0	0	0	375		9.00
10.00	90.04	ANDIS CLINIC	0	0	0	3,375		10.00
11.00	90.07	ONCOLOGY	0	0	0	474,577		11.00
12.00	91.00	EMERGENCY	0	0	0	60,000		12.00
200.00			0	48,949	0	1,362,595		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/26/2016 2:22 pm

		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	7,683,069	7,683,069				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,036,469	35,483	5,071,952			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,157,031	555,189	896,874	13,609,094	13,609,094	5.00
7.00	00700	OPERATION OF PLANT	4,860,749	1,059,622	122,932	6,043,303	1,108,874	7.00
9.00	00900	HOUSEKEEPING	1,486,412	50,500	117,375	1,654,287	303,542	9.00
10.00	01000	DIETARY	291,256	76,338	49,638	417,232	76,557	10.00
11.00	01100	CAFETERIA	1,315,373	150,834	99,991	1,566,198	287,379	11.00
13.00	01300	NURSING ADMINISTRATION	1,064,551	8,057	125,113	1,197,721	219,767	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	82,366	0	8,291	90,657	16,634	14.00
15.00	01500	PHARMACY	7,485,598	37,013	197,224	7,719,835	1,416,463	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	835,373	72,182	80,547	988,102	181,305	16.00
23.00	02300	PARAMED ED PRGM	37,519	26,348	10,354	74,221	13,619	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,074,169	438,113	339,494	3,851,776	706,755	30.00
31.00	03100	INTENSIVE CARE UNIT	3,669,325	467,558	411,138	4,548,021	834,507	31.00
40.00	04000	SUBPROVIDER - IPF	1,276,943	124,996	156,615	1,558,554	285,976	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,825,916	493,024	378,350	5,697,290	1,045,384	50.00
51.00	05100	RECOVERY ROOM	256,380	41,561	30,379	328,320	60,243	51.00
53.00	05300	ANESTHESIOLOGY	138,838	0	0	138,838	25,475	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,520,697	509,589	337,353	4,367,639	801,409	54.00
60.00	06000	LABORATORY	3,804,354	114,566	214,397	4,133,317	758,414	60.00
65.00	06500	RESPIRATORY THERAPY	1,202,972	46,148	154,542	1,403,662	257,555	65.00
66.00	06600	PHYSICAL THERAPY	1,149,880	76,240	128,954	1,355,074	248,640	66.00
67.00	06700	OCCUPATIONAL THERAPY	288,696	0	36,126	324,822	59,601	67.00
68.00	06800	SPEECH PATHOLOGY	178,038	0	21,680	199,718	36,646	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	706,280	146,894	69,413	922,587	169,284	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,160,652	131,269	0	3,291,921	604,028	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,290,960	0	0	2,290,960	420,364	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	86,672	44,678	7,200	138,550	25,422	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	262,027	0	23,905	285,932	52,465	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	869,656	56,872	84,102	1,010,630	185,438	90.01
90.02	09002	DIABETES CLINIC	48,353	0	5,419	53,772	9,867	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	87,887	51,049	5,774	144,710	26,553	90.04
90.05	09005	PRIME TIME	102,303	0	0	102,303	18,771	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	345,161	0	26,586	371,747	68,211	90.06
90.07	04951	ONCOLOGY	1,053,777	272,360	68,250	1,394,387	255,853	90.07
90.08	04950	ANDERSON WOMENS CENTER	285,753	0	34,624	320,377	58,785	90.08
91.00	09100	EMERGENCY	2,613,650	433,349	293,651	3,340,650	612,969	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	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	2,736,584	173,026	149,617	3,059,227	561,331	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	80,371,689	5,692,858	4,685,908	77,995,434	11,814,086	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	554,879	1,655,040	0	2,209,919	405,494	190.01
190.02	19002	PHYSICIAN BUILDING	50,185	0	0	50,185	9,208	190.02
190.03	19003	PRIVATE DUTY	343,556	0	19,642	363,198	66,642	190.03
190.04	19004	MARKETING	584,592	0	14,167	598,759	109,865	190.04
190.05	19005	SPORTS PHYSICALS	28,465	0	3,262	31,727	5,822	190.05
190.06	19006	FOUNDATION	180,921	0	17,418	198,339	36,393	190.06
190.07	19007	ASC	806	0	0	806	148	190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	3,566,575	89,022	171,858	3,827,455	702,292	190.09
190.10	19010	HANCOCK WELLNESS	1,464,869	0	122,761	1,587,630	291,311	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	5,527	0	7,793	13,320	2,444	190.12
190.13	19013	MCCORD WELLNESS	204,570	0	8,151	212,721	39,032	190.13
190.14	19014	3 WEST UNIT	343,497	246,149	20,992	610,638	112,045	190.14

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/26/2016 2:22 pm

		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	78,000	0	0	78,000	14,312	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)	87,778,131	7,683,069	5,071,952	87,778,131	13,609,094	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/26/2016 2:22 pm

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	7,152,177					7.00
9.00	00900	HOUSEKEEPING	59,969	2,017,798				9.00
10.00	01000	DIETARY	90,652	33,521	617,962			10.00
11.00	01100	CAFETERIA	179,115	55,238	0	2,087,930		11.00
13.00	01300	NURSING ADMINISTRATION	9,568	0	0	60,644	1,487,700	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	83,789	0	9,479	0	14.00
15.00	01500	PHARMACY	43,952	61,119	0	105,113	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	85,716	73,517	0	66,061	0	16.00
23.00	02300	PARAMED ED PRGM	31,288	84,685	0	5,409	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	521,096	561,854	173,621	207,718	0	30.00
31.00	03100	INTENSIVE CARE UNIT	555,225	115,834	262,741	288,783	767,953	31.00
40.00	04000	SUBPROVIDER - IPF	148,432	92,703	130,969	100,830	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	585,465	224,906	0	138,833	0	50.00
51.00	05100	RECOVERY ROOM	49,353	82,815	0	15,509	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	605,137	82,329	0	194,731	0	54.00
60.00	06000	LABORATORY	136,047	78,563	0	170,486	0	60.00
65.00	06500	RESPIRATORY THERAPY	54,801	60,171	0	93,834	0	65.00
66.00	06600	PHYSICAL THERAPY	90,535	69,931	0	72,156	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	22,910	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	12,652	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	174,436	136,352	0	40,888	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	155,882	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	53,055	0	0	6,854	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	67,535	0	0	38,416	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	4,497	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	60,621	0	0	4,402	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	323,427	0	0	42,247	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	23,817	0	90.08
91.00	09100	EMERGENCY	514,601	120,471	0	171,843	456,976	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	192,897	0	50,631	98,813	262,771	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,788,805	2,017,798	617,962	1,996,925	1,487,700	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	1,965,356	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	21,135	0	190.03
190.04	19004	MARKETING	0	0	0	7,376	0	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	0	0	0	10,818	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	105,714	0	0	27,049	0	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	0	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	555	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	10,552	0	190.13
190.14	19014	3 WEST UNIT	292,302	0	0	13,520	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)	7,152,177	2,017,798	617,962	2,087,930	1,487,700	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/26/2016 2:22 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
			14.00	15.00	16.00	23.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS 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	200,559					14.00
15.00	01500	PHARMACY	3,693	9,350,175				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,394,701			16.00
23.00	02300	PARAMED ED PRGM	0	0	0	209,222		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,779	0	375,180	0	6,401,779	30.00
31.00	03100	INTENSIVE CARE UNIT	8,176	0	46,846	0	7,428,086	31.00
40.00	04000	SUBPROVIDER - IPF	589	0	38,628	0	2,356,681	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,927	0	493,117	0	8,192,922	50.00
51.00	05100	RECOVERY ROOM	250	0	0	0	536,490	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	164,313	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,609	0	56,298	209,222	6,319,374	54.00
60.00	06000	LABORATORY	44,563	0	124,923	0	5,446,313	60.00
65.00	06500	RESPIRATORY THERAPY	671	0	0	0	1,870,694	65.00
66.00	06600	PHYSICAL THERAPY	70	0	0	0	1,836,406	66.00
67.00	06700	OCCUPATIONAL THERAPY	45	0	0	0	407,378	67.00
68.00	06800	SPEECH PATHOLOGY	178	0	0	0	249,194	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	1,555	0	64,105	0	1,509,207	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	116,443	0	0	0	4,168,274	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	2,711,324	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,350,175	2,877	0	9,353,052	73.00
76.00	03020	CARDIAC	0	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	31	0	0	0	223,912	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	72	0	0	0	338,469	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	591	0	0	0	1,302,610	90.01
90.02	09002	DIABETES CLINIC	1	0	0	0	68,137	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	11	0	0	0	236,297	90.04
90.05	09005	PRIME TIME	0	0	0	0	121,074	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	228	0	0	0	440,186	90.06
90.07	04951	ONCOLOGY	1	0	0	0	2,015,915	90.07
90.08	04950	ANDERSON WOMENS CENTER	125	0	0	0	403,104	90.08
91.00	09100	EMERGENCY	6,755	0	192,727	0	5,416,992	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	1,995	0	0	0	4,227,665	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	200,358	9,350,175	1,394,701	209,222	73,745,848	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	4,580,769	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	59,393	190.02
190.03	19003	PRIVATE DUTY	68	0	0	0	451,043	190.03
190.04	19004	MARKETING	0	0	0	0	716,000	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	0	37,549	190.05
190.06	19006	FOUNDATION	0	0	0	0	245,550	190.06
190.07	19007	ASC	2	0	0	0	956	190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	124	0	0	0	4,662,634	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	0	1,878,941	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	0	16,319	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	0	262,305	190.13
190.14	19014	3 WEST UNIT	7	0	0	0	1,028,512	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0	0	92,312	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)	200,559	9,350,175	1,394,701	209,222	87,778,131	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/26/2016 2:22 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS 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	6,401,779		30.00
31.00	03100	INTENSIVE CARE UNIT	0	7,428,086		31.00
40.00	04000	SUBPROVIDER - IPF	0	2,356,681		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	8,192,922		50.00
51.00	05100	RECOVERY ROOM	0	536,490		51.00
53.00	05300	ANESTHESIOLOGY	0	164,313		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,319,374		54.00
60.00	06000	LABORATORY	0	5,446,313		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,870,694		65.00
66.00	06600	PHYSICAL THERAPY	0	1,836,406		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	407,378		67.00
68.00	06800	SPEECH PATHOLOGY	0	249,194		68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	1,509,207		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,168,274		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,711,324		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,353,052		73.00
76.00	03020	CARDIAC	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	223,912		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	338,469		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	1,302,610		90.01
90.02	09002	DIABETES CLINIC	0	68,137		90.02
90.03	09003	ASTHMA CLINIC	0	0		90.03
90.04	09004	ANDIS CLINIC	0	236,297		90.04
90.05	09005	PRIME TIME	0	121,074		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	440,186		90.06
90.07	04951	ONCOLOGY	0	2,015,915		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	403,104		90.08
91.00	09100	EMERGENCY	0	5,416,992		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		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	4,227,665		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	73,745,848		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	4,580,769		190.01
190.02	19002	PHYSICIAN BUILDING	0	59,393		190.02
190.03	19003	PRIVATE DUTY	0	451,043		190.03
190.04	19004	MARKETING	0	716,000		190.04
190.05	19005	SPORTS PHYSICALS	0	37,549		190.05
190.06	19006	FOUNDATION	0	245,550		190.06
190.07	19007	ASC	0	956		190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.08
190.09	19009	HANCOCK OB	0	4,662,634		190.09
190.10	19010	HANCOCK WELLNESS	0	1,878,941		190.10
190.11	19011	MORRISTOWN CLINIC	0	0		190.11
190.12	19012	O3PUREMED	0	16,319		190.12
190.13	19013	MCCORD WELLNESS	0	262,305		190.13
190.14	19014	3 WEST UNIT	0	1,028,512		190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	92,312		190.15
200.00		Cross Foot Adjustments	0	0		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/26/2016 2:22 pm

	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	87,778,131		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 5/26/2016 2:22 pm

		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	35,483	35,483	35,483		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	555,189	555,189	6,286	561,475	5.00
7.00	00700	OPERATION OF PLANT	0	1,059,622	1,059,622	860	45,748	7.00
9.00	00900	HOUSEKEEPING	0	50,500	50,500	821	12,523	9.00
10.00	01000	DIETARY	0	76,338	76,338	347	3,158	10.00
11.00	01100	CAFETERIA	0	150,834	150,834	699	11,856	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,057	8,057	875	9,067	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	58	686	14.00
15.00	01500	PHARMACY	0	37,013	37,013	1,379	58,456	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	72,182	72,182	563	7,480	16.00
23.00	02300	PARAMED ED PRGM	0	26,348	26,348	72	562	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	438,113	438,113	2,374	29,158	30.00
31.00	03100	INTENSIVE CARE UNIT	0	467,558	467,558	2,876	34,429	31.00
40.00	04000	SUBPROVIDER - IPF	0	124,996	124,996	1,095	11,798	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	493,024	493,024	2,646	43,128	50.00
51.00	05100	RECOVERY ROOM	0	41,561	41,561	212	2,485	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	1,051	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	509,589	509,589	2,359	33,063	54.00
60.00	06000	LABORATORY	0	114,566	114,566	1,499	31,289	60.00
65.00	06500	RESPIRATORY THERAPY	0	46,148	46,148	1,081	10,626	65.00
66.00	06600	PHYSICAL THERAPY	0	76,240	76,240	902	10,258	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	253	2,459	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	152	1,512	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	146,894	146,894	485	6,984	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	131,269	131,269	0	24,920	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	17,343	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	44,678	44,678	50	1,049	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	167	2,165	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	56,872	56,872	588	7,650	90.01
90.02	09002	DIABETES CLINIC	0	0	0	38	407	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	51,049	51,049	40	1,095	90.04
90.05	09005	PRIME TIME	0	0	0	0	774	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	186	2,814	90.06
90.07	04951	ONCOLOGY	0	272,360	272,360	477	10,556	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	242	2,425	90.08
91.00	09100	EMERGENCY	0	433,349	433,349	2,054	25,289	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	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	173,026	173,026	1,046	23,158	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	5,692,858	5,692,858	32,782	487,421	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	1,655,040	1,655,040	0	16,729	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	0	380	190.02
190.03	19003	PRIVATE DUTY	0	0	0	137	2,749	190.03
190.04	19004	MARKETING	0	0	0	99	4,533	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	23	240	190.05
190.06	19006	FOUNDATION	0	0	0	122	1,501	190.06
190.07	19007	ASC	0	0	0	0	6	190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	0	89,022	89,022	1,202	28,974	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	859	12,018	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	55	101	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	57	1,610	190.13
190.14	19014	3 WEST UNIT	0	246,149	246,149	147	4,623	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0	0	590	190.15

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 5/26/2016 2:22 pm

	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	7,683,069	7,683,069	35,483	561,475	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/26/2016 2:22 pm

		Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			7.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	1,106,230					7.00
9.00	00900	HOUSEKEEPING	9,275	73,119				9.00
10.00	01000	DIETARY	14,021	1,215	95,079			10.00
11.00	01100	CAFETERIA	27,704	2,002	0	193,095		11.00
13.00	01300	NURSING ADMINISTRATION	1,480	0	0	5,608	25,087	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,036	0	877	0	14.00
15.00	01500	PHARMACY	6,798	2,215	0	9,721	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,258	2,664	0	6,109	0	16.00
23.00	02300	PARAMED ED PRGM	4,839	3,069	0	500	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	80,598	20,361	26,713	19,210	0	30.00
31.00	03100	INTENSIVE CARE UNIT	85,877	4,197	40,425	26,709	12,950	31.00
40.00	04000	SUBPROVIDER - IPF	22,958	3,359	20,151	9,325	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	90,554	8,150	0	12,839	0	50.00
51.00	05100	RECOVERY ROOM	7,633	3,001	0	1,434	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	93,597	2,983	0	18,009	0	54.00
60.00	06000	LABORATORY	21,043	2,847	0	15,767	0	60.00
65.00	06500	RESPIRATORY THERAPY	8,476	2,180	0	8,678	0	65.00
66.00	06600	PHYSICAL THERAPY	14,003	2,534	0	6,673	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,119	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,170	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	26,980	4,941	0	3,781	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,110	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	8,206	0	0	634	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	10,446	0	0	3,553	0	90.01
90.02	09002	DIABETES CLINIC	0	0	0	416	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	9,376	0	0	407	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	50,025	0	0	3,907	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	0	2,203	0	90.08
91.00	09100	EMERGENCY	79,594	4,365	0	15,892	7,706	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	29,835	0	7,790	9,138	4,431	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	740,686	73,119	95,079	184,679	25,087	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	303,983	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	1,955	0	190.03
190.04	19004	MARKETING	0	0	0	682	0	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	0	0	0	1,000	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	16,351	0	0	2,502	0	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	0	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	0	51	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	0	976	0	190.13
190.14	19014	3 WEST UNIT	45,210	0	0	1,250	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)	1,106,230	73,119	95,079	193,095	25,087	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/26/2016 2:22 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	
			14.00	15.00	16.00	23.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS 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	4,657					14.00
15.00	01500	PHARMACY	86	115,668				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	102,256			16.00
23.00	02300	PARAMED ED PRGM	0	0	0	35,390		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	88	0	27,507		644,122	30.00
31.00	03100	INTENSIVE CARE UNIT	190	0	3,435		678,646	31.00
40.00	04000	SUBPROVIDER - IPF	14	0	2,832		196,528	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	184	0	36,154		686,679	50.00
51.00	05100	RECOVERY ROOM	6	0	0		56,332	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		1,051	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	61	0	4,128		663,789	54.00
60.00	06000	LABORATORY	1,034	0	9,159		197,204	60.00
65.00	06500	RESPIRATORY THERAPY	16	0	0		77,205	65.00
66.00	06600	PHYSICAL THERAPY	2	0	0		110,612	66.00
67.00	06700	OCCUPATIONAL THERAPY	1	0	0		4,832	67.00
68.00	06800	SPEECH PATHOLOGY	4	0	0		2,838	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0		0	68.01
69.00	06900	ELECTROCARDIOLOGY	36	0	4,700		194,801	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,702	0	0		183,001	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		17,343	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	115,668	211		115,879	73.00
76.00	03020	CARDIAC	0	0	0		0	76.00
76.01	03160	CARDIOPULMONARY	1	0	0		54,618	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2	0	0		2,334	88.00
90.00	09000	CLINIC	0	0	0		0	90.00
90.01	09001	WOUND CLINIC	14	0	0		79,123	90.01
90.02	09002	DIABETES CLINIC	0	0	0		861	90.02
90.03	09003	ASTHMA CLINIC	0	0	0		0	90.03
90.04	09004	ANDIS CLINIC	0	0	0		61,967	90.04
90.05	09005	PRIME TIME	0	0	0		774	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	5	0	0		3,005	90.06
90.07	04951	ONCOLOGY	0	0	0		337,325	90.07
90.08	04950	ANDERSON WOMENS CENTER	3	0	0		4,873	90.08
91.00	09100	EMERGENCY	157	0	14,130		582,536	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	46	0	0		248,470	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,652	115,668	102,256	0	5,206,748	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		1,975,752	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0		380	190.02
190.03	19003	PRIVATE DUTY	2	0	0		4,843	190.03
190.04	19004	MARKETING	0	0	0		5,314	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0		263	190.05
190.06	19006	FOUNDATION	0	0	0		2,623	190.06
190.07	19007	ASC	0	0	0		6	190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0		0	190.08
190.09	19009	HANCOCK OB	3	0	0		138,054	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0		12,877	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0		0	190.11
190.12	19012	O3PUREMED	0	0	0		207	190.12
190.13	19013	MCCORD WELLNESS	0	0	0		2,643	190.13
190.14	19014	3 WEST UNIT	0	0	0		297,379	190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	0	0		590	190.15
200.00		Cross Foot Adjustments				35,390	35,390	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,657	115,668	102,256	35,390	7,683,069	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/26/2016 2:22 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS 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	644,122		30.00
31.00	03100	INTENSIVE CARE UNIT	0	678,646		31.00
40.00	04000	SUBPROVIDER - IPF	0	196,528		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	686,679		50.00
51.00	05100	RECOVERY ROOM	0	56,332		51.00
53.00	05300	ANESTHESIOLOGY	0	1,051		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	663,789		54.00
60.00	06000	LABORATORY	0	197,204		60.00
65.00	06500	RESPIRATORY THERAPY	0	77,205		65.00
66.00	06600	PHYSICAL THERAPY	0	110,612		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,832		67.00
68.00	06800	SPEECH PATHOLOGY	0	2,838		68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	194,801		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	183,001		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	17,343		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	115,879		73.00
76.00	03020	CARDIAC	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	54,618		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	2,334		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	79,123		90.01
90.02	09002	DIABETES CLINIC	0	861		90.02
90.03	09003	ASTHMA CLINIC	0	0		90.03
90.04	09004	ANDIS CLINIC	0	61,967		90.04
90.05	09005	PRIME TIME	0	774		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	3,005		90.06
90.07	04951	ONCOLOGY	0	337,325		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	4,873		90.08
91.00	09100	EMERGENCY	0	582,536		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		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	248,470		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	5,206,748		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	PROFESSIONAL BUILDING	0	1,975,752		190.01
190.02	19002	PHYSICIAN BUILDING	0	380		190.02
190.03	19003	PRIVATE DUTY	0	4,843		190.03
190.04	19004	MARKETING	0	5,314		190.04
190.05	19005	SPORTS PHYSICALS	0	263		190.05
190.06	19006	FOUNDATION	0	2,623		190.06
190.07	19007	ASC	0	6		190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.08
190.09	19009	HANCOCK OB	0	138,054		190.09
190.10	19010	HANCOCK WELLNESS	0	12,877		190.10
190.11	19011	MORRISTOWN CLINIC	0	0		190.11
190.12	19012	O3PUREMED	0	207		190.12
190.13	19013	MCCORD WELLNESS	0	2,643		190.13
190.14	19014	3 WEST UNIT	0	297,379		190.14
190.15	19015	NEUROLOGY PHYSICIAN	0	590		190.15
200.00		Cross Foot Adjustments	0	35,390		200.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/26/2016 2:22 pm

	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	7,683,069		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/26/2016 2:22 pm

		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	391,911					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,810	37,222,994				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	28,320	6,582,258	-13,609,094	74,169,037		5.00
7.00	00700	OPERATION OF PLANT	54,051	902,194	0	6,043,303	307,226	7.00
9.00	00900	HOUSEKEEPING	2,576	861,408	0	1,654,287	2,576	9.00
10.00	01000	DIETARY	3,894	364,290	0	417,232	3,894	10.00
11.00	01100	CAFETERIA	7,694	733,832	0	1,566,198	7,694	11.00
13.00	01300	NURSING ADMINISTRATION	411	918,199	0	1,197,721	411	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	60,848	0	90,657	0	14.00
15.00	01500	PHARMACY	1,888	1,447,422	0	7,719,835	1,888	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,682	591,131	0	988,102	3,682	16.00
23.00	02300	PARAMED ED PRGM	1,344	75,985	0	74,221	1,344	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,348	2,491,534	0	3,851,776	22,384	30.00
31.00	03100	INTENSIVE CARE UNIT	23,850	3,017,324	0	4,548,021	23,850	31.00
40.00	04000	SUBPROVIDER - IPF	6,376	1,149,395	0	1,558,554	6,376	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,149	2,776,698	0	5,697,290	25,149	50.00
51.00	05100	RECOVERY ROOM	2,120	222,953	0	328,320	2,120	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	138,838	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,994	2,475,821	0	4,367,639	25,994	54.00
60.00	06000	LABORATORY	5,844	1,573,449	0	4,133,317	5,844	60.00
65.00	06500	RESPIRATORY THERAPY	2,354	1,134,178	0	1,403,662	2,354	65.00
66.00	06600	PHYSICAL THERAPY	3,889	946,390	0	1,355,074	3,889	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	265,128	0	324,822	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	159,111	0	199,718	0	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	7,493	509,420	0	922,587	7,493	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,696	0	0	3,291,921	6,696	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,290,960	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	2,279	52,839	0	138,550	2,279	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	175,440	0	285,932	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	2,901	617,220	0	1,010,630	2,901	90.01
90.02	09002	DIABETES CLINIC	0	39,768	0	53,772	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	2,604	42,375	0	144,710	2,604	90.04
90.05	09005	PRIME TIME	0	0	0	102,303	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	195,115	0	371,747	0	90.06
90.07	04951	ONCOLOGY	13,893	500,884	0	1,394,387	13,893	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	254,104	0	320,377	0	90.08
91.00	09100	EMERGENCY	22,105	2,155,097	0	3,340,650	22,105	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	8,826	1,098,036	0	3,059,227	8,286	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	290,391	34,389,846	-13,609,094	64,386,340	205,706	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	84,423	0	0	2,209,919	84,423	190.01
190.02	19002	PHYSICIAN BUILDING	0	0	0	50,185	0	190.02
190.03	19003	PRIVATE DUTY	0	144,151	0	363,198	0	190.03
190.04	19004	MARKETING	0	103,971	0	598,759	0	190.04
190.05	19005	SPORTS PHYSICALS	0	23,937	0	31,727	0	190.05
190.06	19006	FOUNDATION	0	127,827	0	198,339	0	190.06
190.07	19007	ASC	0	0	0	806	0	190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	4,541	1,261,258	0	3,827,455	4,541	190.09
190.10	19010	HANCOCK WELLNESS	0	900,938	0	1,587,630	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	57,189	0	13,320	0	190.12
190.13	19013	MCCORD WELLNESS	0	59,817	0	212,721	0	190.13
190.14	19014	3 WEST UNIT	12,556	154,060	0	610,638	12,556	190.14

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/26/2016 2:22 pm

		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	78,000	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)	7,683,069	5,071,952		13,609,094	7,152,177	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.604117	0.136259		0.183488	23.279856	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		35,483		561,475	1,106,230	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000953		0.007570	3.600704	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/26/2016 2:22 pm

		Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
9.00	00900	HOUSEKEEPING	393,860					9.00
10.00	01000	DIETARY	6,543	12,315				10.00
11.00	01100	CAFETERIA	10,782	0	752,695			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	21,862	201,677		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,355	0	3,417	0	5,450,180	14.00
15.00	01500	PHARMACY	11,930	0	37,893	0	100,365	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,350	0	23,815	0	0	16.00
23.00	02300	PARAMED ED PRGM	16,530	0	1,950	0	8	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	109,670	3,460	74,882	0	102,703	30.00
31.00	03100	INTENSIVE CARE UNIT	22,610	5,236	104,106	104,106	222,175	31.00
40.00	04000	SUBPROVIDER - IPF	18,095	2,610	36,349	0	15,994	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	43,900	0	50,049	0	215,403	50.00
51.00	05100	RECOVERY ROOM	16,165	0	5,591	0	6,801	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,070	0	70,200	0	70,907	54.00
60.00	06000	LABORATORY	15,335	0	61,460	0	1,210,971	60.00
65.00	06500	RESPIRATORY THERAPY	11,745	0	33,827	0	18,238	65.00
66.00	06600	PHYSICAL THERAPY	13,650	0	26,012	0	1,894	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	8,259	0	1,210	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	4,561	0	4,836	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	26,615	0	14,740	0	42,253	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,164,404	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	2,471	0	850	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	1,957	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	13,849	0	16,058	90.01
90.02	09002	DIABETES CLINIC	0	0	1,621	0	21	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	0	0	1,587	0	303	90.04
90.05	09005	PRIME TIME	0	0	0	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	0	0	0	6,203	90.06
90.07	04951	ONCOLOGY	0	0	15,230	0	33	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	0	8,586	0	3,398	90.08
91.00	09100	EMERGENCY	23,515	0	61,949	61,949	183,559	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	1,009	35,622	35,622	54,205	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	393,860	12,315	719,888	201,677	5,444,749	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	7,619	0	1,852	190.03
190.04	19004	MARKETING	0	0	2,659	0	0	190.04
190.05	19005	SPORTS PHYSICALS	0	0	0	0	0	190.05
190.06	19006	FOUNDATION	0	0	3,900	0	0	190.06
190.07	19007	ASC	0	0	0	0	42	190.07
190.08	19008	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.08
190.09	19009	HANCOCK OB	0	0	9,751	0	3,358	190.09
190.10	19010	HANCOCK WELLNESS	0	0	0	0	0	190.10
190.11	19011	MORRISTOWN CLINIC	0	0	0	0	0	190.11
190.12	19012	O3PUREMED	0	0	200	0	0	190.12
190.13	19013	MCCORD WELLNESS	0	0	3,804	0	0	190.13
190.14	19014	3 WEST UNIT	0	0	4,874	0	179	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 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/26/2016 2:22 pm

		Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,017,798	617,962	2,087,930	1,487,700	200,559	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.123135	50.179618	2.773939	7.376647	0.036799	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	73,119	95,079	193,095	25,087	4,657	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.185647	7.720585	0.256538	0.124392	0.000854	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/26/2016 2:22 pm

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	PARAMED ED PRGM (ASSIGNED TIME)		
			15.00	16.00	23.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS 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	3,394			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	0	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	0	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	3,394	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	SPORTS PHYSICALS	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 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/26/2016 2:22 pm

		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)	9,350,175	1,394,701	209,222		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	93,501.750000	410.931349	2,092.220000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	115,668	102,256	35,390		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1,156.680000	30.128462	353.900000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/26/2016 2:22 pm

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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	6,401,779		6,401,779	0	6,401,779	30.00
31.00	03100	INTENSIVE CARE UNIT	7,428,086		7,428,086	0	7,428,086	31.00
40.00	04000	SUBPROVIDER - IPF	2,356,681		2,356,681	0	2,356,681	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,192,922		8,192,922	0	8,192,922	50.00
51.00	05100	RECOVERY ROOM	536,490		536,490	0	536,490	51.00
53.00	05300	ANESTHESIOLOGY	164,313		164,313	0	164,313	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,319,374		6,319,374	0	6,319,374	54.00
60.00	06000	LABORATORY	5,446,313		5,446,313	0	5,446,313	60.00
65.00	06500	RESPIRATORY THERAPY	1,870,694	0	1,870,694	0	1,870,694	65.00
66.00	06600	PHYSICAL THERAPY	1,836,406	0	1,836,406	0	1,836,406	66.00
67.00	06700	OCCUPATIONAL THERAPY	407,378	0	407,378	0	407,378	67.00
68.00	06800	SPEECH PATHOLOGY	249,194	0	249,194	0	249,194	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	1,509,207		1,509,207	0	1,509,207	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,168,274		4,168,274	0	4,168,274	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,711,324		2,711,324	0	2,711,324	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,353,052		9,353,052	0	9,353,052	73.00
76.00	03020	CARDIAC	0		0	0	0	76.00
76.01	03160	CARDIOPULMONARY	223,912		223,912	0	223,912	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	338,469		338,469	0	338,469	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CLINIC	1,302,610		1,302,610	0	1,302,610	90.01
90.02	09002	DIABETES CLINIC	68,137		68,137	0	68,137	90.02
90.03	09003	ASTHMA CLINIC	0		0	0	0	90.03
90.04	09004	ANDIS CLINIC	236,297		236,297	0	236,297	90.04
90.05	09005	PRIME TIME	121,074		121,074	0	121,074	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	440,186		440,186	0	440,186	90.06
90.07	04951	ONCOLOGY	2,015,915		2,015,915	0	2,015,915	90.07
90.08	04950	ANDERSON WOMENS CENTER	403,104		403,104	0	403,104	90.08
91.00	09100	EMERGENCY	5,416,992		5,416,992	0	5,416,992	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,466,199		2,466,199		2,466,199	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	4,227,665		4,227,665		4,227,665	116.00
200.00		Subtotal (see instructions)	76,212,047	0	76,212,047	0	76,212,047	200.00
201.00		Less Observation Beds	2,466,199		2,466,199		2,466,199	201.00
202.00		Total (see instructions)	73,745,848	0	73,745,848	0	73,745,848	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I | Date/Time Prepared: 5/26/2016 2:22 pm

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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	6,178,359		6,178,359			30.00
31.00	03100	INTENSIVE CARE UNIT	9,704,524		9,704,524			31.00
40.00	04000	SUBPROVIDER - IPF	3,214,429		3,214,429			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,130,433	8,498,377	15,628,810	0.524219	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,013,815	1,192,674	2,206,489	0.243142	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	15,901	1,010	16,911	9.716338	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,584,387	45,819,268	50,403,655	0.125375	0.000000	54.00
60.00	06000	LABORATORY	6,232,901	29,588,765	35,821,666	0.152040	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,025,557	4,930,296	7,955,853	0.235134	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	820,120	3,529,051	4,349,171	0.422243	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	502,595	594,925	1,097,520	0.371180	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	107,532	375,811	483,343	0.515563	0.000000	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0.000000	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	3,380,544	10,664,231	14,044,775	0.107457	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,250,439	3,233,961	5,484,400	0.760024	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,819,505	1,224,884	7,044,389	0.384891	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,173,548	33,939,847	44,113,395	0.212023	0.000000	73.00
76.00	03020	CARDIAC	0	0	0	0.000000	0.000000	76.00
76.01	03160	CARDIOPULMONARY	259	316,757	317,016	0.706311	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	354,794	354,794			88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	WOUND CLINIC	24,711	4,792,390	4,817,101	0.270414	0.000000	90.01
90.02	09002	DIABETES CLINIC	0	76,281	76,281	0.893237	0.000000	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	ANDIS CLINIC	0	49,336	49,336	4.789545	0.000000	90.04
90.05	09005	PRIME TIME	54	352,453	352,507	0.343466	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	1,784,052	1,784,052	0.246734	0.000000	90.06
90.07	04951	ONCOLOGY	27,473	3,352,659	3,380,132	0.596401	0.000000	90.07
90.08	04950	ANDERSON WOMENS CENTER	6,964	3,155,099	3,162,063	0.127481	0.000000	90.08
91.00	09100	EMERGENCY	3,802,157	22,151,620	25,953,777	0.208717	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	253,510	2,409,237	2,662,747	0.926186	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	893,280	1,379,647	2,272,927			116.00
200.00		Subtotal (see instructions)	69,162,997	183,767,425	252,930,422			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	69,162,997	183,767,425	252,930,422			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/26/2016 2:22 pm

Title XVIII | Hospital | PPS

		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	0.524219	50.00
51.00	05100	RECOVERY ROOM	0.243142	51.00
53.00	05300	ANESTHESIOLOGY	9.716338	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.125375	54.00
60.00	06000	LABORATORY	0.152040	60.00
65.00	06500	RESPIRATORY THERAPY	0.235134	65.00
66.00	06600	PHYSICAL THERAPY	0.422243	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.371180	67.00
68.00	06800	SPEECH PATHOLOGY	0.515563	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	0.107457	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.760024	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.384891	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.212023	73.00
76.00	03020	CARDIAC	0.000000	76.00
76.01	03160	CARDIOPULMONARY	0.706311	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	0.270414	90.01
90.02	09002	DIABETES CLINIC	0.893237	90.02
90.03	09003	ASTHMA CLINIC	0.000000	90.03
90.04	09004	ANDIS CLINIC	4.789545	90.04
90.05	09005	PRIME TIME	0.343466	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.246734	90.06
90.07	04951	ONCOLOGY	0.596401	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.127481	90.08
91.00	09100	EMERGENCY	0.208717	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.926186	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 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/26/2016 2:22 pm

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	6,401,779		6,401,779	0	6,401,779	30.00
31.00	03100	INTENSIVE CARE UNIT	7,428,086		7,428,086	0	7,428,086	31.00
40.00	04000	SUBPROVIDER - IPF	2,356,681		2,356,681	0	2,356,681	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,192,922		8,192,922	0	8,192,922	50.00
51.00	05100	RECOVERY ROOM	536,490		536,490	0	536,490	51.00
53.00	05300	ANESTHESIOLOGY	164,313		164,313	0	164,313	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,319,374		6,319,374	0	6,319,374	54.00
60.00	06000	LABORATORY	5,446,313		5,446,313	0	5,446,313	60.00
65.00	06500	RESPIRATORY THERAPY	1,870,694	0	1,870,694	0	1,870,694	65.00
66.00	06600	PHYSICAL THERAPY	1,836,406	0	1,836,406	0	1,836,406	66.00
67.00	06700	OCCUPATIONAL THERAPY	407,378	0	407,378	0	407,378	67.00
68.00	06800	SPEECH PATHOLOGY	249,194	0	249,194	0	249,194	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	1,509,207		1,509,207	0	1,509,207	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,168,274		4,168,274	0	4,168,274	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,711,324		2,711,324	0	2,711,324	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,353,052		9,353,052	0	9,353,052	73.00
76.00	03020	CARDIAC	0		0	0	0	76.00
76.01	03160	CARDIOPULMONARY	223,912		223,912	0	223,912	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	338,469		338,469	0	338,469	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CLINIC	1,302,610		1,302,610	0	1,302,610	90.01
90.02	09002	DIABETES CLINIC	68,137		68,137	0	68,137	90.02
90.03	09003	ASTHMA CLINIC	0		0	0	0	90.03
90.04	09004	ANDIS CLINIC	236,297		236,297	0	236,297	90.04
90.05	09005	PRIME TIME	121,074		121,074	0	121,074	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	440,186		440,186	0	440,186	90.06
90.07	04951	ONCOLOGY	2,015,915		2,015,915	0	2,015,915	90.07
90.08	04950	ANDERSON WOMENS CENTER	403,104		403,104	0	403,104	90.08
91.00	09100	EMERGENCY	5,416,992		5,416,992	0	5,416,992	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,466,199		2,466,199		2,466,199	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	4,227,665		4,227,665		4,227,665	116.00
200.00		Subtotal (see instructions)	76,212,047	0	76,212,047	0	76,212,047	200.00
201.00		Less Observation Beds	2,466,199		2,466,199		2,466,199	201.00
202.00		Total (see instructions)	73,745,848	0	73,745,848	0	73,745,848	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/26/2016 2:22 pm

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	6,178,359		6,178,359			30.00
31.00	03100	INTENSIVE CARE UNIT	9,704,524		9,704,524			31.00
40.00	04000	SUBPROVIDER - IPF	3,214,429		3,214,429			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,130,433	8,498,377	15,628,810	0.524219	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,013,815	1,192,674	2,206,489	0.243142	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	15,901	1,010	16,911	9.716338	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,584,387	45,819,268	50,403,655	0.125375	0.000000	54.00
60.00	06000	LABORATORY	6,232,901	29,588,765	35,821,666	0.152040	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,025,557	4,930,296	7,955,853	0.235134	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	820,120	3,529,051	4,349,171	0.422243	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	502,595	594,925	1,097,520	0.371180	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	107,532	375,811	483,343	0.515563	0.000000	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0	0.000000	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	3,380,544	10,664,231	14,044,775	0.107457	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,250,439	3,233,961	5,484,400	0.760024	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,819,505	1,224,884	7,044,389	0.384891	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,173,548	33,939,847	44,113,395	0.212023	0.000000	73.00
76.00	03020	CARDIAC	0	0	0	0.000000	0.000000	76.00
76.01	03160	CARDIOPULMONARY	259	316,757	317,016	0.706311	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	354,794	354,794	0.953987	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	WOUND CLINIC	24,711	4,792,390	4,817,101	0.270414	0.000000	90.01
90.02	09002	DIABETES CLINIC	0	76,281	76,281	0.893237	0.000000	90.02
90.03	09003	ASTHMA CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	ANDIS CLINIC	0	49,336	49,336	4.789545	0.000000	90.04
90.05	09005	PRIME TIME	54	352,453	352,507	0.343466	0.000000	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	1,784,052	1,784,052	0.246734	0.000000	90.06
90.07	04951	ONCOLOGY	27,473	3,352,659	3,380,132	0.596401	0.000000	90.07
90.08	04950	ANDERSON WOMENS CENTER	6,964	3,155,099	3,162,063	0.127481	0.000000	90.08
91.00	09100	EMERGENCY	3,802,157	22,151,620	25,953,777	0.208717	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	253,510	2,409,237	2,662,747	0.926186	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	893,280	1,379,647	2,272,927			116.00
200.00		Subtotal (see instructions)	69,162,997	183,767,425	252,930,422			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	69,162,997	183,767,425	252,930,422			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/26/2016 2:22 pm

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 01/01/2015 To 12/31/2015 | Worksheet D Part I Date/Time Prepared: 5/26/2016 2:22 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	644,122	0	644,122	5,446	118.27	30.00
31.00	INTENSIVE CARE UNIT	678,646		678,646	5,230	129.76	31.00
40.00	SUBPROVIDER - IPF	196,528	0	196,528	2,610	75.30	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
200.00	Total (lines 30-199)	1,519,296		1,519,296	13,286		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	1,237	146,300	30.00
31.00	INTENSIVE CARE UNIT	2,466	319,988	31.00
40.00	SUBPROVIDER - IPF	2,562	192,919	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
200.00	Total (lines 30-199)	6,265	659,207	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/26/2016 2:22 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	686,679	15,628,810	0.043937	2,427,583	106,661	50.00
51.00	05100	RECOVERY ROOM	56,332	2,206,489	0.025530	356,568	9,103	51.00
53.00	05300	ANESTHESIOLOGY	1,051	16,911	0.062149	1,398	87	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	663,789	50,403,655	0.013169	2,390,663	31,483	54.00
60.00	06000	LABORATORY	197,204	35,821,666	0.005505	3,101,328	17,073	60.00
65.00	06500	RESPIRATORY THERAPY	77,205	7,955,853	0.009704	1,631,468	15,832	65.00
66.00	06600	PHYSICAL THERAPY	110,612	4,349,171	0.025433	431,207	10,967	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,832	1,097,520	0.004403	241,842	1,065	67.00
68.00	06800	SPEECH PATHOLOGY	2,838	483,343	0.005872	69,844	410	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	194,801	14,044,775	0.013870	1,486,368	20,616	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	183,001	5,484,400	0.033368	897,592	29,951	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	17,343	7,044,389	0.002462	2,763,994	6,805	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	115,879	44,113,395	0.002627	4,291,185	11,273	73.00
76.00	03020	CARDIAC	0	0	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	54,618	317,016	0.172288	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,334	354,794	0.006578	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	79,123	4,817,101	0.016425	3,335	55	90.01
90.02	09002	DIABETES CLINIC	861	76,281	0.011287	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	61,967	49,336	1.256020	0	0	90.04
90.05	09005	PRIME TIME	774	352,507	0.002196	47	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	3,005	1,784,052	0.001684	0	0	90.06
90.07	04951	ONCOLOGY	337,325	3,380,132	0.099796	1,314	131	90.07
90.08	04950	ANDERSON WOMENS CENTER	4,873	3,162,063	0.001541	5,507	8	90.08
91.00	09100	EMERGENCY	582,536	25,953,777	0.022445	2,205,964	49,513	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	248,139	2,662,747	0.093189	231	22	92.00
200.00		Total (lines 50-199)	3,687,121	231,560,183		22,307,438	311,055	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part III Date/Time Prepared: 5/26/2016 2:22 pm

Title XVIII | Hospital | PPS

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

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,446	0.00	1,237	0		30.00
31.00	03100	INTENSIVE CARE UNIT	5,230	0.00	2,466	0		31.00
40.00	04000	SUBPROVIDER - IPF	2,610	0.00	2,562	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0		41.00
200.00		Total (lines 30-199)	13,286		6,265	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/26/2016 2:22 pm

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	209,222	0	209,222	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	209,222	0	209,222	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/26/2016 2:22 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	15,628,810	0.000000	0.000000	2,427,583	50.00
51.00	05100	RECOVERY ROOM	0	2,206,489	0.000000	0.000000	356,568	51.00
53.00	05300	ANESTHESIOLOGY	0	16,911	0.000000	0.000000	1,398	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	209,222	50,403,655	0.004151	0.004151	2,390,663	54.00
60.00	06000	LABORATORY	0	35,821,666	0.000000	0.000000	3,101,328	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,955,853	0.000000	0.000000	1,631,468	65.00
66.00	06600	PHYSICAL THERAPY	0	4,349,171	0.000000	0.000000	431,207	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,097,520	0.000000	0.000000	241,842	67.00
68.00	06800	SPEECH PATHOLOGY	0	483,343	0.000000	0.000000	69,844	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0.000000	0.000000	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	14,044,775	0.000000	0.000000	1,486,368	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,484,400	0.000000	0.000000	897,592	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	7,044,389	0.000000	0.000000	2,763,994	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	44,113,395	0.000000	0.000000	4,291,185	73.00
76.00	03020	CARDIAC	0	0	0.000000	0.000000	0	76.00
76.01	03160	CARDIOPULMONARY	0	317,016	0.000000	0.000000	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	354,794	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	WOUND CLINIC	0	4,817,101	0.000000	0.000000	3,335	90.01
90.02	09002	DIABETES CLINIC	0	76,281	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	49,336	0.000000	0.000000	0	90.04
90.05	09005	PRIME TIME	0	352,507	0.000000	0.000000	47	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	1,784,052	0.000000	0.000000	0	90.06
90.07	04951	ONCOLOGY	0	3,380,132	0.000000	0.000000	1,314	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	3,162,063	0.000000	0.000000	5,507	90.08
91.00	09100	EMERGENCY	0	25,953,777	0.000000	0.000000	2,205,964	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,662,747	0.000000	0.000000	231	92.00
200.00		Total (lines 50-199)	209,222	231,560,183			22,307,438	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV Date/Time Prepared: 5/26/2016 2:22 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,099,687	0		50.00
51.00	05100	RECOVERY ROOM	0	322,564	0		51.00
53.00	05300	ANESTHESIOLOGY	0	753	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,924	13,377,487	55,530		54.00
60.00	06000	LABORATORY	0	4,243,245	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,518,324	0		65.00
66.00	06600	PHYSICAL THERAPY	0	5,821	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,548	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	67,361	0		68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	4,045,448	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	833,765	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	399,998	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,996,732	0		73.00
76.00	03020	CARDIAC	0	0	0		76.00
76.01	03160	CARDIOPULMONARY	0	92,204	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	2,619,971	0		90.01
90.02	09002	DIABETES CLINIC	0	53	0		90.02
90.03	09003	ASTHMA CLINIC	0	0	0		90.03
90.04	09004	ANDIS CLINIC	0	3,354	0		90.04
90.05	09005	PRIME TIME	0	20,028	0		90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	327,352	0		90.06
90.07	04951	ONCOLOGY	0	471,755	0		90.07
90.08	04950	ANDERSON WOMENS CENTER	0	687	0		90.08
91.00	09100	EMERGENCY	0	4,960,858	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,522,375	0		92.00
200.00		Total (lines 50-199)	9,924	49,933,370	55,530		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/26/2016 2:22 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.524219	2,099,687	0	0	1,100,696	50.00
51.00	05100	RECOVERY ROOM	0.243142	322,564	0	0	78,429	51.00
53.00	05300	ANESTHESIOLOGY	9.716338	753	0	0	7,316	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.125375	13,377,487	0	0	1,677,202	54.00
60.00	06000	LABORATORY	0.152040	4,243,245	0	0	645,143	60.00
65.00	06500	RESPIRATORY THERAPY	0.235134	1,518,324	0	0	357,010	65.00
66.00	06600	PHYSICAL THERAPY	0.422243	5,821	0	0	2,458	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.371180	3,548	0	0	1,317	67.00
68.00	06800	SPEECH PATHOLOGY	0.515563	67,361	0	0	34,729	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.107457	4,045,448	0	0	434,712	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.760024	833,765	0	0	633,681	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.384891	399,998	0	0	153,956	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.212023	12,996,732	258	29,629	2,755,606	73.00
76.00	03020	CARDIAC	0.000000	0	0	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.706311	92,204	0	0	65,125	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	0.270414	2,619,971	0	0	708,477	90.01
90.02	09002	DIABETES CLINIC	0.893237	53	0	0	47	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ANDIS CLINIC	4.789545	3,354	0	0	16,064	90.04
90.05	09005	PRIME TIME	0.343466	20,028	0	0	6,879	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.246734	327,352	0	0	80,769	90.06
90.07	04951	ONCOLOGY	0.596401	471,755	0	0	281,355	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.127481	687	0	0	88	90.08
91.00	09100	EMERGENCY	0.208717	4,960,858	0	0	1,035,415	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.926186	1,522,375	0	0	1,410,002	92.00
200.00		Subtotal (see instructions)		49,933,370	258	29,629	11,486,476	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		49,933,370	258	29,629	11,486,476	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/26/2016 2:22 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55	6,282		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)	55	6,282		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	55	6,282		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150037 | Component CCN: 15S037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/26/2016 2:22 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	686,679	15,628,810	0.043937	22,548	991	50.00
51.00	05100	RECOVERY ROOM	56,332	2,206,489	0.025530	2,295	59	51.00
53.00	05300	ANESTHESIOLOGY	1,051	16,911	0.062149	37	2	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	663,789	50,403,655	0.013169	114,148	1,503	54.00
60.00	06000	LABORATORY	197,204	35,821,666	0.005505	414,913	2,284	60.00
65.00	06500	RESPIRATORY THERAPY	77,205	7,955,853	0.009704	166,989	1,620	65.00
66.00	06600	PHYSICAL THERAPY	110,612	4,349,171	0.025433	44,047	1,120	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,832	1,097,520	0.004403	79,048	348	67.00
68.00	06800	SPEECH PATHOLOGY	2,838	483,343	0.005872	10,485	62	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	194,801	14,044,775	0.013870	19,565	271	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	183,001	5,484,400	0.033368	54,175	1,808	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	17,343	7,044,389	0.002462	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	115,879	44,113,395	0.002627	411,557	1,081	73.00
76.00	03020	CARDIAC	0	0	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	54,618	317,016	0.172288	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,334	354,794	0.006578	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	79,123	4,817,101	0.016425	788	13	90.01
90.02	09002	DIABETES CLINIC	861	76,281	0.011287	0	0	90.02
90.03	09003	ASTHMA CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	61,967	49,336	1.256020	0	0	90.04
90.05	09005	PRIME TIME	774	352,507	0.002196	7	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	3,005	1,784,052	0.001684	0	0	90.06
90.07	04951	ONCOLOGY	337,325	3,380,132	0.099796	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	4,873	3,162,063	0.001541	1,457	2	90.08
91.00	09100	EMERGENCY	582,536	25,953,777	0.022445	58,745	1,319	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,662,747	0.000000	0	0	92.00
200.00		Total (lines 50-199)	3,438,982	231,560,183		1,400,804	12,483	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150037 | Component CCN: 15S037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/26/2016 2:22 pm

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	209,222	0	209,222	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	209,222	0	209,222	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150037 | Component CCN: 15S037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/26/2016 2:22 pm

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	15,628,810	0.000000	0.000000	22,548	50.00
51.00	05100	RECOVERY ROOM	0	2,206,489	0.000000	0.000000	2,295	51.00
53.00	05300	ANESTHESIOLOGY	0	16,911	0.000000	0.000000	37	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	209,222	50,403,655	0.004151	0.004151	114,148	54.00
60.00	06000	LABORATORY	0	35,821,666	0.000000	0.000000	414,913	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,955,853	0.000000	0.000000	166,989	65.00
66.00	06600	PHYSICAL THERAPY	0	4,349,171	0.000000	0.000000	44,047	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,097,520	0.000000	0.000000	79,048	67.00
68.00	06800	SPEECH PATHOLOGY	0	483,343	0.000000	0.000000	10,485	68.00
68.01	06801	OCCUPATIONAL HEALTH	0	0	0.000000	0.000000	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	14,044,775	0.000000	0.000000	19,565	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,484,400	0.000000	0.000000	54,175	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	7,044,389	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	44,113,395	0.000000	0.000000	411,557	73.00
76.00	03020	CARDIAC	0	0	0.000000	0.000000	0	76.00
76.01	03160	CARDIOPULMONARY	0	317,016	0.000000	0.000000	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	354,794	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	WOUND CLINIC	0	4,817,101	0.000000	0.000000	788	90.01
90.02	09002	DIABETES CLINIC	0	76,281	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	49,336	0.000000	0.000000	0	90.04
90.05	09005	PRIME TIME	0	352,507	0.000000	0.000000	7	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0	1,784,052	0.000000	0.000000	0	90.06
90.07	04951	ONCOLOGY	0	3,380,132	0.000000	0.000000	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0	3,162,063	0.000000	0.000000	1,457	90.08
91.00	09100	EMERGENCY	0	25,953,777	0.000000	0.000000	58,745	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,662,747	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	209,222	231,560,183			1,400,804	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150037 | Component CCN: 15S037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/26/2016 2:22 pm

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	474	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)	474	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 2:22 pm

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)	5,446	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,446	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)	3,348	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)	1,237	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)	6,401,779	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)	6,401,779	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)	6,401,779	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)	1,175.50	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,454,094	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)	1,454,094	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 2:22 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	7,428,086	5,230	1,420.28	2,466	3,502,410	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	6,114,202	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	11,070,706	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)	466,288	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	320,979	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	787,267	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	10,283,439	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/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID 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)	2,098	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,175.50	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,466,199	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 2:22 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	644,122	6,401,779	0.100616	2,466,199	248,139	90.00
91.00	Nursing School cost	0	6,401,779	0.000000	2,466,199	0	91.00
92.00	Allied health cost	0	6,401,779	0.000000	2,466,199	0	92.00
93.00	All other Medical Education	0	6,401,779	0.000000	2,466,199	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150037 Component CCN: 15S037	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/26/2016 2:22 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,610	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,610	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)	2,610	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)	2,562	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)	2,356,681	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)	2,356,681	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)	2,356,681	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)	902.94	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,313,332	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)	2,313,332	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150037 | Component CCN: 15S037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 2:22 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	325,941	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,639,273	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)	192,919	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	12,957	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	205,876	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,433,397	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/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID 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 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 2:22 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	196,528	2,356,681	0.083392	0	0	90.00
91.00	Nursing School cost	0	2,356,681	0.000000	0	0	91.00
92.00	Allied health cost	0	2,356,681	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,356,681	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 2:22 pm

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)	5,446	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,446	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)	3,348	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)	177	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)	6,401,779	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)	6,401,779	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)	6,401,779	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)	1,175.50	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	208,064	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)	208,064	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 2:22 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	7,428,086	5,230	1,420.28	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)	183,357	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	391,421	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/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID 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)	2,098	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,175.50	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,466,199	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/26/2016 2:22 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	644,122	6,401,779	0.100616	2,466,199	248,139	90.00
91.00	Nursing School cost	0	6,401,779	0.000000	2,466,199	0	91.00
92.00	Allied health cost	0	6,401,779	0.000000	2,466,199	0	92.00
93.00	All other Medical Education	0	6,401,779	0.000000	2,466,199	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/26/2016 2:22 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		927,404		30.00
31.00	03100	INTENSIVE CARE UNIT		4,840,942		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	0.524219	2,427,583	1,272,585	50.00
51.00	05100	RECOVERY ROOM	0.243142	356,568	86,697	51.00
53.00	05300	ANESTHESIOLOGY	9.716338	1,398	13,583	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.125375	2,390,663	299,729	54.00
60.00	06000	LABORATORY	0.152040	3,101,328	471,526	60.00
65.00	06500	RESPIRATORY THERAPY	0.235134	1,631,468	383,614	65.00
66.00	06600	PHYSICAL THERAPY	0.422243	431,207	182,074	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.371180	241,842	89,767	67.00
68.00	06800	SPEECH PATHOLOGY	0.515563	69,844	36,009	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.107457	1,486,368	159,721	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.760024	897,592	682,191	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.384891	2,763,994	1,063,836	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.212023	4,291,185	909,830	73.00
76.00	03020	CARDIAC	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.706311	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	0.270414	3,335	902	90.01
90.02	09002	DIABETES CLINIC	0.893237	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	4.789545	0	0	90.04
90.05	09005	PRIME TIME	0.343466	47	16	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.246734	0	0	90.06
90.07	04951	ONCOLOGY	0.596401	1,314	784	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.127481	5,507	702	90.08
91.00	09100	EMERGENCY	0.208717	2,205,964	460,422	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.926186	231	214	92.00
200.00		Total (sum of lines 50-94 and 96-98)		22,307,438	6,114,202	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		22,307,438		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150037 | Component CCN: 15S037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/26/2016 2:22 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		3,137,669		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.524219	22,548	11,820	50.00
51.00	05100	RECOVERY ROOM	0.243142	2,295	558	51.00
53.00	05300	ANESTHESIOLOGY	9.716338	37	360	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.125375	114,148	14,311	54.00
60.00	06000	LABORATORY	0.152040	414,913	63,083	60.00
65.00	06500	RESPIRATORY THERAPY	0.235134	166,989	39,265	65.00
66.00	06600	PHYSICAL THERAPY	0.422243	44,047	18,599	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.371180	79,048	29,341	67.00
68.00	06800	SPEECH PATHOLOGY	0.515563	10,485	5,406	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.107457	19,565	2,102	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.760024	54,175	41,174	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.384891	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.212023	411,557	87,260	73.00
76.00	03020	CARDIAC	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.706311	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	0.270414	788	213	90.01
90.02	09002	DIABETES CLINIC	0.893237	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	4.789545	0	0	90.04
90.05	09005	PRIME TIME	0.343466	7	2	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.246734	0	0	90.06
90.07	04951	ONCOLOGY	0.596401	0	0	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.127481	1,457	186	90.08
91.00	09100	EMERGENCY	0.208717	58,745	12,261	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.926186	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,400,804	325,941	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)		1,400,804		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/26/2016 2:22 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		311,107		30.00
31.00	03100	INTENSIVE CARE UNIT		99,558		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	0.524219	99,514	52,167	50.00
51.00	05100	RECOVERY ROOM	0.243142	14,349	3,489	51.00
53.00	05300	ANESTHESIOLOGY	9.716338	628	6,102	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.125375	51,618	6,472	54.00
60.00	06000	LABORATORY	0.152040	104,011	15,814	60.00
65.00	06500	RESPIRATORY THERAPY	0.235134	38,617	9,080	65.00
66.00	06600	PHYSICAL THERAPY	0.422243	3,334	1,408	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.371180	1,592	591	67.00
68.00	06800	SPEECH PATHOLOGY	0.515563	866	446	68.00
68.01	06801	OCCUPATIONAL HEALTH	0.000000	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.107457	32,344	3,476	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.760024	53,774	40,870	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.384891	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.212023	161,184	34,175	73.00
76.00	03020	CARDIAC	0.000000	0	0	76.00
76.01	03160	CARDIOPULMONARY	0.706311	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.953987	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.270414	0	0	90.01
90.02	09002	DIABETES CLINIC	0.893237	0	0	90.02
90.03	09003	ASTHMA CLINIC	0.000000	0	0	90.03
90.04	09004	ANDIS CLINIC	4.789545	0	0	90.04
90.05	09005	PRIME TIME	0.343466	0	0	90.05
90.06	09006	SHELBYVILLE WOUND CLINIC	0.246734	0	0	90.06
90.07	04951	ONCOLOGY	0.596401	245	146	90.07
90.08	04950	ANDERSON WOMENS CENTER	0.127481	0	0	90.08
91.00	09100	EMERGENCY	0.208717	43,698	9,121	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.926186	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		605,774	183,357	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)		605,774		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Date/Time Prepared: 5/26/2016 2:22 pm

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)		6,594,732		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		2,198,244		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)		56,089		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)		55.25		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	Adjustment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
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)		15.47		31.00
32.00	Sum of lines 30 and 31		17.08		32.00
33.00	Allowable disproportionate share percentage (see instructions)		3.85		33.00
34.00	Disproportionate share adjustment (see instructions)		84,632		34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A | Date/Time Prepared: 5/26/2016 2:22 pm

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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)		7,647,644,885	6,406,145,534	35.00
35.01	Factor 3 (see instructions)		0.000039112	0.000038334	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		299,118	245,574	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		223,724	61,729	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		285,453		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)		9,219,150		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)		9,219,150		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		704,862		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		2,216		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)		9,924		58.00
59.00	Total (sum of amounts on lines 49 through 58)		9,936,152		59.00
60.00	Primary payer payments		5,001		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		9,931,151		61.00
62.00	Deductibles billed to program beneficiaries		1,124,696		62.00
63.00	Coinsurance billed to program beneficiaries		2,835		63.00
64.00	Allowable bad debts (see instructions)		58,120		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		37,778		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)		8,841,398		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)		13,781		70.93
70.94	HRR adjustment amount (see instructions)		-463		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Date/Time Prepared: 5/26/2016 2:22 pm

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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)	0	0		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)	2016	79,747		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)		8,934,463		71.00
71.01	Sequestration adjustment (see instructions)		178,689		71.01
72.00	Interim payments		8,720,167		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)		35,607		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,399,047		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)	0.0000000000	0.0000000000	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 01/01/2015 To 12/31/2015 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/26/2016 2:22 pm

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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	6,594,732	0	6,594,732	0	6,594,732	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,198,244	0	0	2,198,244	2,198,244	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	56,089	0	42,067	14,022	56,089	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	0.0385	0.0385	0.0385	0.0385		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	84,632	0	63,474	21,158	84,632	11.00
11.01	Uncompensated care payments	36.00	285,453	0	214,090	71,363	285,453	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	9,219,150	0	6,914,363	2,304,787	9,219,150	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	9,219,150	0	6,914,363	2,304,787	9,219,150	15.00
16.00	Payment for inpatient program capital	50.00	704,862	0	528,647	176,215	704,862	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	Credits 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 01/01/2015 To 12/31/2015 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/26/2016 2:22 pm

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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	7,443,010	2,481,002	9,924,012	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	703,798	0	527,849	175,949	703,798	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	1,064	0	798	266	1,064	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	704,862	0	528,647	176,215	704,862	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				0.000000	0.032143		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				79,747	79,747	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 01/01/2015 To 12/31/2015 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/26/2016 2:22 pm

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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	6,594,732	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,198,244		8,792,976	8,792,976	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	56,089	0	56,089	56,089	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	0.0385	0.0385	0.0385		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	84,632	0	84,632	84,632	11.00
11.01	Uncompensated care payments	36.00	285,453	223,724	61,729	285,453	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	9,219,150	223,724	8,995,426	9,219,150	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	9,219,150	223,724	8,995,426	9,219,150	15.00
16.00	Payment for inpatient program capital	50.00	704,862	796	704,066	704,862	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	Credits 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			224,520	9,699,492	9,924,012	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/26/2016 2:22 pm

Title XVIII | Hospital | PPS

		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	703,798	0	703,798	703,798	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	1,064	796	268	1,064	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	704,862	796	704,066	704,862	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	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	79,747		79,747	79,747	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	13,781	0	13,781	13,781	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	-463	0	-463	-463	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 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/26/2016 2:22 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,337	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	11,430,946	2.00
3.00	PPS payments	8,686,527	3.00
4.00	Outlier payment (see instructions)	66,203	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	55,530	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,337	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	29,887	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	29,887	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)	29,887	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	23,550	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)	6,337	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)	8,808,260	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)	1,891,777	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] (see instructions)	6,922,820	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)	6,922,820	30.00
31.00	Primary payer payments	383	31.00
32.00	Subtotal (line 30 minus line 31)	6,922,437	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)	150,346	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	97,725	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	7,020,162	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	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)	7,020,162	40.00
40.01	Sequestration adjustment (see instructions)	140,403	40.01
41.00	Interim payments	6,887,806	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-8,047	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 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I Date/Time Prepared: 5/26/2016 2:22 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		8,675,947		6,724,632	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	12/31/2015	44,220	12/31/2015	163,174	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)		44,220		163,174	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)		8,720,167		6,887,806	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		35,607		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		8,047	6.02
7.00	Total Medicare program liability (see instructions)		8,755,774		6,879,759	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 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2016 2:22 pm

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,225,983		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)		2,225,983		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		469		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,226,452		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 01/01/2015 To 12/31/2015	Worksheet E-1 Part II Date/Time Prepared: 5/26/2016 2:22 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD 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	2,556	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	3,703	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	351	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	8,578	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	252,930,422	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	4,253,653	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)	274,167	8.00
9.00	Sequestration adjustment amount (see instructions)	5,483	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	268,684	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	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)	268,684	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150037 Component CCN: 15S037	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part II Date/Time Prepared: 5/26/2016 2:22 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	2,431,272	1.00
2.00	Net IPF PPS Outlier Payments	15,064	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)	7.150685	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)	2,446,336	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)	2,446,336	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	2,446,336	18.00
19.00	Deductibles	174,920	19.00
20.00	Subtotal (line 18 minus line 19)	2,271,416	20.00
21.00	Coinsurance	0	21.00
22.00	Subtotal (line 20 minus line 21)	2,271,416	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)	2,271,416	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)	474	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)	2,271,890	31.00
31.01	Sequestration adjustment (see instructions)	45,438	31.01
32.00	Interim payments	2,225,983	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)	469	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	15,064	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 01/01/2015 To 12/31/2015	Worksheet E-3 Part VII Date/Time Prepared: 5/26/2016 2:22 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	391,421		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)	391,421	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)	391,421	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	605,774	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)	605,774	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)	605,774	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	214,353	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)	391,421	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)	391,421	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)	391,421	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)	391,421	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	391,421	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)	391,421	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	391,421	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 01/01/2015 To 12/31/2015 | Worksheet G | Date/Time Prepared: 5/26/2016 2:22 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	6,511,826	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	11,264,261	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	21,304,760	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	37,024,241	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)	76,105,088	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	7,819,448	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	104,511,857	0	0	0	15.00
16.00	Accumulated depreciation	-120,470,188	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	77,558,187	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)	69,419,304	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	7,829,435	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	7,829,435	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	153,353,827	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,501,499	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,378,121	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	5,190,094	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	13,069,714	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)	13,069,714	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	140,284,113				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)	140,284,113	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	153,353,827	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-1 | Date/Time Prepared: 5/26/2016 2:22 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		119,245,763		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		21,038,350				2.00
3.00	Total (sum of line 1 and line 2)		140,284,113		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)		140,284,113		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)		140,284,113		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 01/01/2015 To 12/31/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/26/2016 2:22 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	7,122,935		7,122,935	1.00
2.00	SUBPROVIDER - IPF	3,214,429		3,214,429	2.00
3.00	SUBPROVIDER - IRF	0		0	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)	10,337,364		10,337,364	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	11,483,203		11,483,203	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)	11,483,203		11,483,203	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	21,820,567		21,820,567	17.00
18.00	Ancillary services	45,427,561	145,287,412	190,714,973	18.00
19.00	Outpatient services	3,869,072	36,020,305	39,889,377	19.00
20.00	RURAL HEALTH CLINIC	0	357,009	357,009	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		-387	-387	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	907,140	1,441,531	2,348,671	26.00
27.00	PRIVATE DUTY/ DIETARY	97	332,963	333,060	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	72,024,437	183,438,833	255,463,270	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		97,820,027		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		97,820,027		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 150037 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-3 | Date/Time Prepared: 5/26/2016 2:22 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	255,463,270	1.00
2.00	Less contractual allowances and discounts on patients' accounts	160,544,108	2.00
3.00	Net patient revenues (line 1 minus line 2)	94,919,162	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	97,820,027	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,900,865	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/NON OP INCOME	7,503,643	24.00
24.01	LTC	16,390,123	24.01
25.00	Total other income (sum of lines 6-24)	23,893,766	25.00
26.00	Total (line 5 plus line 25)	20,992,901	26.00
27.00	GAIN/ LOSS INVENTORY AND ASSETS	-45,449	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-45,449	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	21,038,350	29.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150037 Hospice CCN: 151547 | Period: From 01/01/2015 To 12/31/2015 | Worksheet K | Date/Time Prepared: 5/26/2016 2:22 pm

Hospice I

		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	203,694	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	143,561	0	0	0	0	9.00
10.00	Nursing Care	563,565	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	91,322	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	95,895	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	1,639,714	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)	1,098,037	0	0	0	1,639,714	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150037 Hospice CCN: 151547 | Period: From 01/01/2015 To 12/31/2015 | Worksheet K | Date/Time Prepared: 5/26/2016 2:22 pm

Hospice I

		Total (cols. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	203,694	0	203,694	0	203,694	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	143,561	0	143,561	0	143,561	9.00
10.00	Nursing Care	563,565	0	563,565	0	563,565	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	91,322	0	91,322	0	91,322	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	95,895	0	95,895	0	95,895	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	1,639,714	0	1,639,714	-1,167	1,638,547	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)	2,737,751	0	2,737,751	-1,167	2,736,584	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150037 Hospice CCN: 151547 | Period: From 01/01/2015 To 12/31/2015 | Worksheet K-1 | Date/Time Prepared: 5/26/2016 2:22 pm

Hospice I

		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	203,694	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	143,561	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	563,565	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	91,322	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)	347,255	0	91,322	0	563,565	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150037 Hospice CCN: 151547

Period: From 01/01/2015 To 12/31/2015

Worksheet K-1

Date/Time Prepared: 5/26/2016 2:22 pm

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	0	203,694		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	143,561		9.00
10.00	Nursing Care		0	0	563,565		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	91,322		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		95,895	0	95,895		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	95,895	0	1,098,037		39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 150037 Hospice CCN: 151547

Period: From 01/01/2015 To 12/31/2015

Worksheet K-4 Part I Date/Time Prepared: 5/26/2016 2:22 pm

Hospice I

			CAPITAL RELATED COST				
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
		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	203,694	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	143,561	0	0	0	0	9.00
10.00	Nursing Care	563,565	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	91,322	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	95,895	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	1,638,547	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)	2,736,584	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 150037 Hospice CCN: 151547

Period: From 01/01/2015 To 12/31/2015

Worksheet K-4 Part I Date/Time Prepared: 5/26/2016 2:22 pm

Hospice I

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (cols. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A ± col. 6)		
		5.00	5A	6.00	7.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance						3.00
4.00	Transportation - Staff						4.00
5.00	Volunteer Service Coordination	0					5.00
6.00	Administrative and General	0	203,694	203,694			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	143,561	11,545	155,106		9.00
10.00	Nursing Care	0	563,565	45,322	608,887		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	91,322	7,344	98,666		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	95,895	7,712	103,607		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	1,638,547	131,771	1,770,318		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	2,736,584		2,736,584		39.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150037 Hospice CCN: 151547 | Period: From 01/01/2015 To 12/31/2015 | Worksheet K-4 Part II Date/Time Prepared: 5/26/2016 2:22 pm

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 01/01/2015 To 12/31/2015 | Worksheet K-4 Part II Date/Time Prepared: 5/26/2016 2:22 pm

Hospice I

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)		
		6A	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0			1.00
2.00	Capital Related Costs-Movable Equip.	0			2.00
3.00	Plant Operation and Maintenance	0			3.00
4.00	Transportation - Staff	0			4.00
5.00	Volunteer Service Coordination				5.00
6.00	Administrative and General	-203,694	2,532,890		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	143,561		9.00
10.00	Nursing Care	0	563,565		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	91,322		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	95,895		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	1,638,547		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)		203,694		39.00
40.00	Unit Cost Multiplier		0.080420		40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150037 Hospice CCN: 151547

Period: From 01/01/2015 To 12/31/2015

Worksheet K-5 Part I Date/Time Prepared: 5/26/2016 2:22 pm

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		173,026	149,617	322,643	59,201	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	155,106	0	0	155,106	28,460	4.00
5.00	Nursing Care	608,887	0	0	608,887	111,723	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	98,666	0	0	98,666	18,104	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	103,607	0	0	103,607	19,011	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	1,770,318	0	0	1,770,318	324,832	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)	2,736,584	173,026	149,617	3,059,227	561,331	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 01/01/2015
To 12/31/2015

Worksheet K-5
Part I
Date/Time Prepared:
5/26/2016 2:22 pm

Hospice I

	Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	192,897	0	50,631	98,813	262,771	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)	192,897	0	50,631	98,813	262,771	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 01/01/2015
To 12/31/2015

Worksheet K-5
Part I
Date/Time Prepared:
5/26/2016 2:22 pm

Hospice I

	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal (cols. 4A-23)	
		14.00	15.00	16.00	23.00	24.00	
1.00	Administrative and General	1,995	0	0	0	988,951	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	183,566	4.00
5.00	Nursing Care	0	0	0	0	720,610	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	116,770	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	122,618	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	2,095,150	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	1,995	0	0	0	4,227,665	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 01/01/2015 To 12/31/2015

Worksheet K-5 Part I Date/Time Prepared: 5/26/2016 2:22 pm

Hospice I

	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (cols. 26 ± 27)		
		25.00	26.00	27.00	28.00		
1.00	Administrative and General						1.00
2.00	Inpatient - General Care	0	0	0	0		2.00
3.00	Inpatient - Respite Care	0	0	0	0		3.00
4.00	Physician Services	0	183,566	56,052	239,618		4.00
5.00	Nursing Care	0	720,610	220,040	940,650		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	116,770	35,656	152,426		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	122,618	37,442	160,060		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	2,095,150	639,761	2,734,911		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	4,227,665		4,227,665		34.00
35.00	Unit Cost Multiplier (see instructions)			0.305353			35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150037
Hospice CCN: 151547

Period:
From 01/01/2015
To 12/31/2015

Worksheet K-5
Part II
Date/Time Prepared:
5/26/2016 2:22 pm

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	1,098,036	0	322,643	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	155,106	0	4.00
5.00	Nursing Care	0	0	0	608,887	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	98,666	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	103,607	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	1,770,318	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	9,240	1,098,036		3,059,227	9,240	34.00
35.00	Total cost to be allocated	173,026	149,617		561,331	192,897	35.00
36.00	Unit Cost Multiplier (see instructions)	18.725758	0.136259		0.183488	20.876299	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150037
Hospice CCN: 151547

Period:
From 01/01/2015
To 12/31/2015

Worksheet K-5
Part II
Date/Time Prepared:
5/26/2016 2:22 pm

Hospice I

	Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	1,009	35,622	35,622	54,205	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	1,009	35,622	35,622	54,205	34.00
35.00	Total cost to be allocated	0	50,631	98,813	262,771	1,995	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	50.179386	2.773932	7.376649	0.036805	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150037
Hospice CCN: 151547

Period:
From 01/01/2015
To 12/31/2015

Worksheet K-5
Part II
Date/Time Prepared:
5/26/2016 2:22 pm

Hospice I

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

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 150037 Hospice CCN: 151547

Period: From 01/01/2015 To 12/31/2015

Worksheet K-5 Part III Date/Time Prepared: 5/26/2016 2:22 pm

Hospice I

	Cost Center Description	Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1.00	2.00	3.00	
	ANCILLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.422243	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.371180	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.515563	0	0	3.00
3.01	OCCUPATIONAL HEALTH	68.01	0.000000	0	0	3.01
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.212023	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00
6.00	LABORATORY	60.00	0.152040	0	0	6.00
6.01	BLOOD LABORATORY	60.01				6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.760024	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	0.706311	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 01/01/2015 To 12/31/2015

Worksheet K-6

Date/Time Prepared: 5/26/2016 2:22 pm

Hospice I

		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				4,227,665	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				5,710	2.00
3.00	Average cost per diem (line 1 divided by line 2)				740.40	3.00
4.00	Updduplicated Medicare Days (Worksheet S-9, column 1, line 5)	5,540				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	4,101,816				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		0			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		0			7.00
8.00	Updduplicated SNF Days (Worksheet S-9, column 3, line 5)	275				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	203,610				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)			170		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			125,868		13.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 150037	Period: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Prepared: 5/26/2016 2:22 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	703,798	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	1,064	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	23.82	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, columns 1 and 1.01)(see instructions)	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 (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	704,862	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 HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Provider CCN: 150037 Component CCN: 153987 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-1 | Date/Time Prepared: 5/26/2016 2:22 pm

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	14,280	14,280	0	14,280	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	120,576	0	120,576	0	120,576	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	24,653	0	24,653	0	24,653	9.00
10.00	Subtotal (sum of lines 1 through 9)	145,229	14,280	159,509	0	159,509	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)	145,229	14,280	159,509	0	159,509	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	0	0	0	0	29.00
30.00	Administrative Costs	30,213	79,062	109,275	0	109,275	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	30,213	79,062	109,275	0	109,275	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	175,442	93,342	268,784	0	268,784	32.00

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

Provider CCN: 150037 | Component CCN: 153987 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-1 | Date/Time Prepared: 5/26/2016 2:22 pm

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	14,280		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	120,576		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	24,653		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	159,509		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	159,509		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	0		29.00
30.00	Administrative Costs	-6,757	102,518		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-6,757	102,518		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-6,757	262,027		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 150037 | Component CCN: 153987 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-2 | Date/Time Prepared: 5/26/2016 2:22 pm

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.13	1,674	2,100	2,373		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.13	1,674		2,373	2,373	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)	1.13	1,674			2,373	8.00
9.00	Physician Services Under Agreements		24			24	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					159,509	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)					159,509	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)					102,518	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					76,442	15.00
16.00	Total overhead (sum of lines 14 and 15)					178,960	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					178,960	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					178,960	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					338,469	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 150037 Component CCN: 153987	Period: From 01/01/2015 To 12/31/2015	Worksheet M-3 Date/Time Prepared: 5/26/2016 2:22 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		338,469	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		8,307	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		330,162	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		2,373	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		24	5.00
6.00	Total adjusted visits (line 4 plus line 5)		2,397	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		137.74	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	80.44	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	80.44	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	289	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	23,247	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) *		23,247	16.00
16.01	Total program charges (see instructions)(from contractor's records)		65,083	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.)		14,478	16.04
16.05	Total program cost (see instructions)		14,478	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		5,150	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		11,987	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		14,478	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		3,347	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		17,825	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)		17,825	26.00
26.01	Sequestration adjustment (see instructions)		357	26.01
27.00	Interim payments		13,748	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)		3,720	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 01/01/2015 To 12/31/2015	Worksheet M-4 Date/Time Prepared: 5/26/2016 2:22 pm
	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)	159,509	159,509	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000821	0.007011	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	131	1,118	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	903	1,763	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,034	2,881	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	159,509	159,509	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	178,960	178,960	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.006482	0.018062	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,160	3,232	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	2,194	6,113	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	13	111	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	168.77	55.07	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	12	24	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	2,025	1,322	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)		8,307	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)		3,347	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 01/01/2015 To 12/31/2015	Worksheet M-5 Date/Time Prepared: 5/26/2016 2:22 pm
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		13,748	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)		13,748	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		3,720	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		17,468	7.00

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