

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT
CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY 1. ELECTRONICALLY FILED COST REPORT DATE: 11-19-2013 TIME: 15:24
2. MANUALLY SUBMITTED COST REPORT
3. IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
4. MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

CONTRACTOR USE ONLY 5. COST REPORT STATUS 6. DATE RECEIVED: _____ 10. NPR DATE: _____
1 - AS SUBMITTED 7. CONTRACTOR NO: _____ 11. CONTRACTOR'S VENDOR CODE: _____
2 - SETTLED WITHOUT AUDIT 8. INITIAL REPORT FOR THIS PROVIDER CCN 12. IF LINE 5, COLUMN 1 IS 4: ENTER
3 - SETTLED WITH AUDIT 9. FINAL REPORT FOR THIS PROVIDER CCN NUMBER OF TIMES REOPENED - 0-9.
4 - REOPENED
5 - AMENDED

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 WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY SSH -BEECH GROVE, INC. (15-2013) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 09/01/2012 AND ENDING 08/31/2013, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, 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

PART III - SETTLEMENT SUMMARY

	TITLE V	TITLE XVIII		HIT	TITLE XIX	
	1	PART A	PART B	4	5	
1	HOSPITAL					1
2	SUBPROVIDER - IPF		975,433			2
3	SUBPROVIDER - IRF					3
4	SUBPROVIDER (OTHER)					4
5	SWING BED - SNF					5
6	SWING BED - NF					6
7	SKILLED NURSING FACILITY					7
8	NURSING FACILITY					8
9	HOME HEALTH AGENCY					9
10	HEALTH CLINIC - RHC					10
11	HEALTH CLINIC - FQHC					11
12	OUTPATIENT REHABILITATION PROVIDER					12
200	TOTAL		975,433			200

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 THIS 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 THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 1600 ALBANY GROVE
 2 CITY: BEECH GROVE

STATE: IN

P.O.BOX:
 ZIP CODE: 46107

COUNTY: MARION

1
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)				
						V 6	XVIII 7	XIX 8		
3	HOSPITAL	SSH -BEECH GROVE, INC.	15-2013	26900	2	09/01/1996	N	P	P	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF									7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTG									11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 09/01/2012			TO: 08/31/2013					20
21	TYPE OF CONTROL									21

INPATIENT PPS INFORMATION

		IN-STATE MEDICAID PAID UNPAID DAYS						OUT-OF-STATE MEDICAID PAID UNPAID HMO DAYS		OTHER MEDICAID DAYS 6					
		1	2	3	4	5									
22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILITY SUBJECT TO 42 CFR §412.06(c)(2) (PICKLE AMENDMENT HOSPITAL)? IN COLUMN 2, ENTER 'Y', FOR YES OR 'N' FOR NO.										1 N	2 N	22		
23	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	
24	IF THIS PROVIDER IS AN IPPS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.													24	
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.													25	
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.							1						26	
27	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	
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.													35	
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.							BEGINNING:		ENDING:				36	
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.													37	
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.							BEGINNING:		ENDING:				38	
39	DOES THE FACILITY POTENTIALLY QUALIFY FOR THE INPATIENT HOSPITAL ADJUSTMENT FOR LOW VOLUME HOSPITALS AS DEEMED BY CMS ACCORDING TO THE FEDERAL REGISTER? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. ADDITIONALLY, DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)												1 N	2 N	39

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

		V 1	XVIII 2	XIX 3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	N	N	45
46	IS THIS FACILITY ELIGIBLE FOR ADDITIONAL PAYMENT EXCEPTION FOR EXTRAORDINARY CIRCUMSTANCES PURSUANT TO 42 CFR §412.348(f)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	N	46
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	48

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS		1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N			60
61	DID YOUR FACILITY RECEIVE ADDITIONAL FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 'Y', EFFECTIVE FOR PORTIONS OF COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2011 ENTER THE AVERAGE NUMBER OF PRIMARY CARE FTE RESIDENTS FOR IME IN COLUMN 2 AND DIRECT GME IN COLUMN 3 FROM THE HOSPITAL'S THREE MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)	Y/N N	IME AVERAGE	DIRECT GME AVERAGE	61
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	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)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N			63
SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.					
64	ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	64
ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4)). (SEE INSTRUCTIONS)					
PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))	
1	2	3	4	5	
SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010					
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	66

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

ENTER IN LINES 67-67.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTES THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 ÷ COLUMN 4). (SEE INSTRUCTIONS)

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))
1	2	3	4	5
INPATIENT PSYCHIATRIC FACILITY PPS				
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER?			N 70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			71
INPATIENT REHABILITATION FACILITY PPS				
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER?			N 75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			76
LONG TERM CARE HOSPITAL PPS				
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			Y 80
TEFRA PROVIDERS				
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			N 86
TITLE V AND XIX INPATIENT SERVICES				
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			V 1 2 N N 90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N 92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97
RURAL PROVIDERS				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			N 1 2 105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.			N 108
109	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 EACH THERAPY.		PHY- OCCUP- RESPI- SICAL ATIONAL SPEECH RATORY	N N N N 109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-1§ 2208.1.	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE, ENTER 2 IF THE POLICY IS OCCURRENCE.	1		118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 30,000,000 PAID LOSSES: 30,000,000 SELF INSURANCE:			118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N		118.02
120	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
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		121

TRANSPLANT CENTER INFORMATION

125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S) (MM/DD/YYYY) BELOW.	N		125
126	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
127	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
128	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
129	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
130	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
131	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
132	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
133	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
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			134

ALL PROVIDERS

140	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.	1 Y	2 HB0312	140
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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	NAME: NAME: SELECT MEDICAL CONTRACTOR'S NAME: NOVITAS SOLUTIONS INC. CONTRACTOR'S NUMBER: 12001			141
142	STREET: STREET: 4714 GETTYSBURG RO P.O. BOX:			142
143	CITY: CITY: MECHANICSBURG STATE: PA ZIP CODE: 17055			143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y		144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	Y		145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.	N		146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		149

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)

	TITLE XVIII	TITLE	TITLE	
	PART A	PART B	V	
	1	2	3	
			XIX	
	4			
155	HOSPITAL	N	N	155
156	SUBPROVIDER - IPF	N	N	156
157	SUBPROVIDER - IRF	N	N	157
158	SUBPROVIDER - (OTHER)	N	N	158
159	SNF	N	N	159
160	HHA	N	N	160
161	CMHC		N	161

PROVIDER CCN: 15-2013 SSH -BEECH GROVE, INC.
PERIOD FROM 09/01/2012 TO 08/31/2013

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
11/19/2013 15:24

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I (CONT)

MULTICAMPUS

165 IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs? N 165
ENTER 'Y' FOR YES OR 'N' FOR NO.

166 IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN
COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5.

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
0	1	2	3	4	5

HEALTH INFORMATION TECHNOLOGY (HIT) INCENTIVE IN THE AMERICAN RECOVERY AND REINVESTMENT ACT

167 IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO. N 167

168 IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'),
ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS. 168

169 IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH
(LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR. 169

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

		Y/N	DATE	
PROVIDER ORGANIZATION AND OPERATION				
1	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)	1 N	2	1
		Y/N	DATE	V/I
2	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.	1 N	2	3 2
3	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)	Y		3
FINANCIAL DATA AND REPORTS				
		Y/N	TYPE	DATE
4	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.	1 Y	2 C	3 4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5
APPROVED EDUCATIONAL ACTIVITIES				
		Y/N	Y/N	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	1 N	2	6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11
			Y/N	Y/N
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.		1	2
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.		Y	12 Y 13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.		N	14
BED COMPLEMENT				
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N 15
PART A				
		Y/N	DATE	
PS&R REPORT DATA				
16	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)	1 N	2	3 N 16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N 17
18	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 THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N 18
19	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
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N 20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	Y		N 21

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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 COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

CAPITAL RELATED COST

22	HAVE ASSETS BEEN RELIEFED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS.	22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	27

INTEREST EXPENSE

28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	28
29	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
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.	30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.	31

PURCHASED SERVICES

32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.	32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.	33

PROVIDER-BASED PHYSICIANS

34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.	34
35	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

HOME OFFICE COSTS

	Y/N	DATE	
	1	2	
36			WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT? 36
37			IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS. 37
38	N		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
39			IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS. 39
40			IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS. 40

COST REPORT PREPARER CONTACT INFORMATION

41	FIRST NAME: HEIDI	LAST NAME: JONES	TITLE: REIMBURSEMENT ANALYS	41
42	EMPLOYER: SELECT MEDICAL			42
43	PHONE NUMBER: 717-920-4012	E-MAIL ADDRESS: HELJONES@SELECTMEDICAL.COM		43

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I

LINE	COMPONENT	WKST A LINE NO.	NO OF BEDS	BED DAYS AVAILABLE	CAH HOURS	INPATIENT DAYS / OUTPATIENT VISITS / TRIPS			TOTAL ALL PATIENTS	TRIPS
						TITLE V 5	TITLE XVIII 6	TITLE XIX 7		
1			2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30	45	16,425			5,828		8,454	1
2	HMO						449			2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF									5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)		45	16,425			5,828		8,454	7
8	INTENSIVE CARE UNIT	31								8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43								13
14	TOTAL (SEE INSTRUCTIONS)		45	16,425			5,828		8,454	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (SUM OF LINES 14-26)		45							27
28	OBSERVATION BED DAYS									28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)									32
33	LTCH NON-COVERED DAYS						134			33

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
	1	2	3	4	5	6	
SALARIES							
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	5,948,345		213,983.00		1
2	NON-PHYSICIAN ANESTHETIST PART A						2
3	NON-PHYSICIAN ANESTHETIST PART B						3
4	PHYSICIAN-PART A ADMINISTRATIVE						4
4.01	PHYSICIAN-PART A - TEACHING						4.01
5	PHYSICIAN-PART B						5
6	NON-PHYSICIAN-PART B						6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21					7
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)						7.01
8	HOME OFFICE PERSONNEL						8
9	SNF	44					9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		28,324		1,059.10		10
	OTHER WAGES & RELATED COSTS						
11	CONTRACT LABOR (SEE INSTRUCTIONS)		795,925		15,518.00		11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES						12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE		56,345		383.00		13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		419,910		7,475.00		14
15	HOME OFFICE: PHYSICIAN-PART A - ADMINISTRATIVE						15
16	HOME OFFICE & CONTRACT PHYSICIANS-PART A - TEACHING						16
	WAGE-RELATED COSTS						
17	WAGE-RELATED COSTS (CORE)						17
18	WAGE-RELATED COSTS (OTHER)						18
19	EXCLUDED AREAS						19
20	NON-PHYSICIAN ANESTHETIST PART A						20
21	NON-PHYSICIAN ANESTHETIST PART B						21
22	PHYSICIAN PART A - ADMINISTRATIVE						22
22.01	PHYSICIAN PART A - TEACHING						22.01
23	PHYSICIAN PART B						23
24	WAGE-RELATED COSTS (RHC/FQHC)						24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)						25
	OVERHEAD COSTS - DIRECT SALARIES						
26	EMPLOYEE BENEFITS		40,373		2,876.80		26
27	ADMINISTRATIVE & GENERAL		839,306	-28,324	22,429.67		27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)						28
29	MAINTENANCE & REPAIRS						29
30	OPERATION OF PLANT		144,071		4,786.07		30
31	LAUNDRY & LINEN SERVICE						31
32	HOUSEKEEPING		82,260		6,737.42		32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)						33
34	DIETARY		184,779		11,121.98		34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)						35
36	CAFETERIA						36
37	MAINTENANCE OF PERSONNEL						37
38	NURSING ADMINISTRATION		436,963		9,252.00		38
39	CENTRAL SERVICES AND SUPPLY						39
40	PHARMACY						40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		120,491		5,205.87		41
42	SOCIAL SERVICE						42
43	OTHER GENERAL SERVICE						43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	5,948,345		5,948,345	213,983.00	27.80	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		28,324	28,324	1,059.10	26.74	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	5,948,345	-28,324	5,920,021	212,923.90	27.80	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	1,272,180		1,272,180	23,376.00	54.42	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)						5
6	TOTAL (SUM OF LINES 3 THRU 5)	7,220,525	-28,324	7,192,201	236,299.90	30.44	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	1,848,243	-28,324	1,819,919	62,409.81	29.16	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART A - CORE LIST

	AMOUNT REPORTED
RETIREMENT COST	
1 401K EMPLOYER CONTRIBUTIONS	1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION	2
3 NONQUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	3
4 QUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)	
5 401K/TSA PLAN ADMINISTRATION FEES	5
6 LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN	6
7 EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES	7
HEALTH AND INSURANCE COST	
8 HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	8
9 PRESCRIPTION DRUG PLAN	9
10 DENTAL, HEARING AND VISION PLAN	10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	14
15 WORKERS' COMPENSATION INSURANCE	15
16 RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)	16
TAXES	
17 FICA-EMPLOYERS PORTION ONLY	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY	18
19 UNEMPLOYMENT INSURANCE	19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES	20
OTHER	
21 EXECUTIVE DEFERRED COMPENSATION (OTHER THAN RETIREMENT COST REPORTED ON LINES 1 THROUGH 4 ABOVE) (SEE INSTRUCTIONS)	21
22 DAY CARE COSTS AND ALLOWANCES	22
23 TUITION REIMBURSEMENT	23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	24
PART B - OTHER THAN CORE RELATED COST	
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)	25

PROVIDER CCN: 15-2013 SSH -BEECH GROVE, INC.
PERIOD FROM 09/01/2012 TO 08/31/2013

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
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HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

COMPONENT		CONTRACT	BENEFIT
0		LABOR	COST
		1	2
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST		1
2	HOSPITAL		2
3	SUBPROVIDER - IPF		3
4	SUBPROVIDER - IRF		4
5	SUBPROVIDER - (OTHER)		5
6	SWING BEDS - SNF		6
7	SWING BEDS - NF		7
8	HOSPITAL-BASED SNF		8
9	HOSPITAL-BASED NF		9
10	HOSPITAL-BASED OLTC		10
11	HOSPITAL-BASED HHA		11
12	SEPARATELY CERTIFIED ASC		12
13	HOSPITAL-BASED HOSPICE		13
14	HOSPITAL-BASED HEALTH CLINIC - RHC		14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC		15
16	HOSPITAL-BASED (CMHC)		16
17	RENAL DIALYSIS		17
18	OTHER		18

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL (COL. 1 + COL. 2)	RECLASSIFI- CATIONS	
		1	2	3	4	
GENERAL SERVICE COST CENTERS						
1	00100				1,153,751	1
2	00200		1,644,254	1,644,254	-1,303,087	2
3	00300					3
4	00400	40,373	4,813	45,186	18,073	4
5	00500	839,306	1,532,017	2,371,323	82,294	5
6	00600					6
7	00700	144,071	184,567	328,638		7
8	00800		130,649	130,649		8
9	00900	82,260	73,739	155,999		9
10	01000	184,779	200,921	385,700	-114,612	10
11	01100				114,612	11
12	01200					12
13	01300	436,963	98,286	535,249		13
14	01400					14
15	01500					15
16	01600	120,491	33,235	153,726		16
17	01700					17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	2,520,623	3,028,281	5,548,904	70,142	30
ADULTS & PEDIATRICS						
ANCILLARY SERVICE COST CENTERS						
50	05000	59,036	248,522	307,558	-70,142	50
54	05400	65,267	195,807	261,074		54
60	06000		387,558	387,558		60
62.30	06250					62.30
65	06500	633,286	219,451	852,737		65
66	06600	178,707	54,844	233,551		66
67	06700	132,349	33,140	165,489		67
68	06800	16,972	47,669	64,641		68
69	06900		794	794		69
71	07100	61,859	1,182,430	1,244,289		71
73	07300	319,911	735,032	1,054,943		73
74	07400	112,092	69,693	181,785		74
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
99.10	09910					99.10
99.20	09920					99.20
99.30	09930					99.30
99.40	09940					99.40
SPECIAL PURPOSE COST CENTERS						
118		5,948,345	10,105,702	16,054,047	-48,969	118
SUBTOTALS (SUM OF LINES 1-117)						
NONREIMBURSABLE COST CENTERS						
194	07950				48,969	194
194.01	07951					194.01
200		5,948,345	10,105,702	16,054,047		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7	
1	00100 GENERAL SERVICE COST CENTERS				
2	00200 CAP REL COSTS-BLDG & FIXT	1,153,751	-101,323	1,052,428	1
3	00300 CAP REL COSTS-MVBLE EQUIP	341,167	43,905	385,072	2
4	00400 OTHER CAPITAL RELATED COSTS				3
5	00500 EMPLOYEE BENEFITS	63,259		63,259	4
6	00600 ADMINISTRATIVE & GENERAL	2,453,617	311,245	2,764,862	5
7	00700 MAINTENANCE & REPAIRS				6
8	00800 OPERATION OF PLANT	328,638		328,638	7
9	00900 LAUNDRY & LINEN SERVICE	130,649		130,649	8
10	01000 HOUSEKEEPING	155,999		155,999	9
11	01100 DIETARY	271,088		271,088	10
12	01200 CAFETERIA	114,612	-17,585	97,027	11
13	01300 MAINTENANCE OF PERSONNEL				12
14	01400 NURSING ADMINISTRATION	535,249		535,249	13
15	01500 CENTRAL SERVICES & SUPPLY				14
16	01600 PHARMACY				15
17	01700 MEDICAL RECORDS & LIBRARY	153,726	-1,569	152,157	16
18	01800 SOCIAL SERVICE				17
19	01900 NONPHYSICIAN ANESTHETISTS				19
20	02000 NURSING SCHOOL				20
21	02100 I&R SRVCES-SALARY & FRINGES APPRVD				21
22	02200 I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23	02300 PARAMED ED PRGM-(SPECIFY)				23
30	03000 INPATIENT ROUTINE SERV COST CENTERS				
	ADULTS & PEDIATRICS	5,619,046	-312,892	5,306,154	30
	ANCILLARY SERVICE COST CENTERS				
50	05000 OPERATING ROOM	237,416		237,416	50
54	05400 RADIOLOGY-DIAGNOSTIC	261,074		261,074	54
60	06000 LABORATORY	387,558		387,558	60
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	06500 RESPIRATORY THERAPY	852,737		852,737	65
66	06600 PHYSICAL THERAPY	233,551		233,551	66
67	06700 OCCUPATIONAL THERAPY	165,489		165,489	67
68	06800 SPEECH PATHOLOGY	64,641		64,641	68
69	06900 ELECTROCARDIOLOGY	794		794	69
71	07100 MEDICAL SUPPLIES CHRGED TO PATIENTS	1,244,289		1,244,289	71
73	07300 DRUGS CHARGED TO PATIENTS	1,054,943		1,054,943	73
74	07400 RENAL DIALYSIS	181,785		181,785	74
76.97	07697 CARDIAC REHABILITATION				76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699 LITHOTRIPSY				76.99
92	09200 OUTPATIENT SERVICE COST CENTERS				
	OBSERVATION BEDS				92
	OTHER REIMBURSABLE COST CENTERS				
99.10	09910 CORF				99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY				99.40
	SPECIAL PURPOSE COST CENTERS				
118	SUBTOTALS (SUM OF LINES 1-117)	16,005,078	-78,219	15,926,859	118
	NONREIMBURSABLE COST CENTERS				
194	07950 PROVIDER RELATIONS NRCC	48,969		48,969	194
194.01	07951 NRCC SUBLEASED SPACE				194.01
200	TOTAL (SUM OF LINES 118-199)	16,054,047	-78,219	15,975,828	200

PROVIDER CCN: 15-2013 SSH -BEECH GROVE, INC.
 PERIOD FROM 09/01/2012 TO 08/31/2013

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
 11/19/2013 15:24

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER 2	INCREASE		
			LINE # 3	SALARY 4	OTHER 5
1 FACILITY RENT 500 TOTAL RECLASSIFICATIONS CODE LETTER - A	A	CAP REL COSTS-BLDG & FIXT	1		1,153,751 1 1,153,751 500
1 EMPLOYEE BENEFITS 500 TOTAL RECLASSIFICATIONS CODE LETTER - B	B	EMPLOYEE BENEFITS	4		18,073 1 18,073 500
1 CAPITAL RECONCILIATION 500 TOTAL RECLASSIFICATIONS CODE LETTER - C	C	ADMINISTRATIVE & GENERAL	5		149,336 1 149,336 500
1 PROVIDER RELATION 500 TOTAL RECLASSIFICATIONS CODE LETTER - D	D	PROVIDER RELATIONS NRCC	194	28,324	20,645 1 28,324 20,645 500
1 DIETARY RECLASS TO CAFETERIA 500 TOTAL RECLASSIFICATIONS CODE LETTER - E	E	CAFETERIA	11		114,612 1 114,612 500
1 OPERATING ROOM NURSE RECLASS 500 TOTAL RECLASSIFICATIONS CODE LETTER - F GRAND TOTAL (INCREASES)	F	ADULTS & PEDIATRICS	30	59,036	11,106 1 59,036 11,106 500 87,360 1,467,523

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 FACILITY RENT	A	CAP REL COSTS-MVBLE EQUIP	2		1,153,751	10 1
500 TOTAL RECLASSIFICATIONS CODE LETTER - A					1,153,751	500
1 EMPLOYEE BENEFITS	B	ADMINISTRATIVE & GENERAL	5		18,073	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - B					18,073	500
1 CAPITAL RECONCILIATION	C	CAP REL COSTS-MVBLE EQUIP	2		149,336	12 1
500 TOTAL RECLASSIFICATIONS CODE LETTER - C					149,336	500
1 PROVIDER RELATION	D	ADMINISTRATIVE & GENERAL	5	28,324	20,645	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - D				28,324	20,645	500
1 DIETARY RECLASS TO CAFETERIA	E	DIETARY	10		114,612	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - E					114,612	500
1 OPERATING ROOM NURSE RECLASS	F	OPERATING ROOM	50	59,036	11,106	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - F				59,036	11,106	500
GRAND TOTAL (DECREASES)				87,360	1,467,523	

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
		PURCHASE 2	DONATION 3	TOTAL 4			
1 LAND							1
2 LAND IMPROVEMENTS							2
3 BUILDINGS AND FIXTURES							3
4 BUILDING IMPROVEMENTS	486,530				486,530		4
5 FIXED EQUIPMENT							5
6 MOVABLE EQUIPMENT	1,637,030	1,074,054		1,074,054		2,711,084	6
7 HIT DESIGNATED ASSETS							7
8 SUBTOTAL (SUM OF LINES 1-7)	2,123,560	1,074,054		1,074,054	486,530	2,711,084	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	2,123,560	1,074,054		1,074,054	486,530	2,711,084	10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(1)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT							1
2 CAP REL COSTS-MVBLE EQUIP	283,116	1,178,625		124,463	55,656	2,394	1,644,254
3 TOTAL (SUM OF LINES 1-2)	283,116	1,178,625		124,463	55,656	2,394	1,644,254

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS

DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	OF RATIOS		ALLOCATION OF OTHER CAPITAL			
			FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4	INSURANCE 5	TAXES 6	OTHER CAPITAL- RELATED COSTS 7	TOTAL (SUM OF COLS. 5-7) 8
1 CAP REL COSTS-BLDG & FIXT								1
2 CAP REL COSTS-MVBLE EQUIP	2,711,084		2,711,084	1.000000				2
3 TOTAL (SUM OF LINES 1-2)	2,711,084		2,711,084	1.000000				3

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT		1,052,428					1,052,428
2 CAP REL COSTS-MVBLE EQUIP	327,021	24,874		-24,873	55,656	2,394	385,072
3 TOTAL	327,021	1,077,302		-24,873	55,656	2,394	1,437,500

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)					3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)					4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)					7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)					8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST				
	A-8-2	-312,892			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST				
	A-8-1	335,488			12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS					14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17 SALE OF DRUGS TO OTHER THAN PATIENTS					17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS					18
19 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20 VENDING MACHINES					20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST		RESPIRATORY THERAPY	65	23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST		PHYSICAL THERAPY	66	24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	25
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29 PHYSICIANS' ASSISTANT					29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST		OCCUPATIONAL THERAPY	67	30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST		SPEECH PATHOLOGY	68	31
32 CAH HIT ADJ FOR DEPRECIATION AND					32
33 BAD DEBT REMOVAL	A	-70,967	ADMINISTRATIVE & GENERAL	5	33
34 MEDICAL RECORDS INCOME	B	-1,569	MEDICAL RECORDS & LIBRARY	16	34
35 OTHER PERSONNEL EXPENSE	A	-9,810	ADMINISTRATIVE & GENERAL	5	35
36 AHA DUES	A	-884	ADMINISTRATIVE & GENERAL	5	36
37 DIETARY CAFETERIA INCOME	B	-17,585	CAFETERIA	11	37
38					38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47					47
48					48
49					49
50 TOTAL (SUM OF LINES 1 THRU 49)		-78,219			50
TRANSFER TO WKST A, COL. 6, LINE 200)					

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR THE CLAIMING OF HOME OFFICE COSTS:

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ- USTMENTS (COL. 4-5)	WKST A-7 REF
1	2	3	4	5	6	7
1	2	CAP REL COSTS-MVBLE EQUIP	43,905		43,905	9 1
2	5	ADMINISTRATIVE & GENERAL	593,383	200,477	392,906	2
3	1	CAP REL COSTS-BLDG & FIXT	899,527	1,000,850	-101,323	10 3
4						4
5		TOTALS (SUM OF LINES 1-4) TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.	1,536,815	1,201,327	335,488	5

B. INTERRELATIONSHIP OF RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(b)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

THE INFORMATION IS USED BY THE HEALTH CARE FINANCING ADMINISTRATION AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO YOU BY COMMON OWNERSHIP OR CONTROL REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT. IF YOU DO NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

SYMBOL (1)	NAME	----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----				
		PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS	
1	2	3	4	5	6	
6 B			SELECT MEDICAL	100.00	HEALTHCARE	6
7						7
8						8
9						9
10						10

- (1) USE THE FOLLOWING SYMBOLS TO INDICATE THE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:
- A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.
 - B. CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.
 - C. PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION.
 - D. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN RELATED ORGANIZATION.
 - E. INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
 - F. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
 - G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY:

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT	
1	2	3	4	5	6	7	8	9	
1	30 ADULTS & PEDIATRICS A	3,885		3,885	177,200	35	2,982	149	1
2	30 ADULTS & PEDIATRICS B	2,231		2,231	177,200	13	1,108	55	2
3	30 ADULTS & PEDIATRICS C	4,320		4,320	177,200	48	4,089	204	3
4	30 ADULTS & PEDIATRICS D	59,175		59,175	177,200	658	56,057	2,803	4
5	30 ADULTS & PEDIATRICS E	11,925		11,925	177,200	133	11,331	567	5
6	30 ADULTS & PEDIATRICS F	40,140		40,140	177,200	446	37,996	1,900	6
7	30 ADULTS & PEDIATRICS G	44,775		44,775	177,200	498	42,426	2,121	7
8	30 ADULTS & PEDIATRICS H	42,120		42,120	177,200	468	39,870	1,994	8
9	30 ADULTS & PEDIATRICS I	45,045		45,045	177,200	501	42,681	2,134	9
10	30 ADULTS & PEDIATRICS J	8,640		8,640	177,200	96	8,178	409	10
11	30 ADULTS & PEDIATRICS K	62,805		62,805	177,200	698	59,464	2,973	11
12	30 ADULTS & PEDIATRICS L	21,600		21,600	177,200	240	20,446	1,022	12
13	30 ADULTS & PEDIATRICS M	622,250	112,499	509,751	177,200	7,176	611,340	30,567	13
14	30 ADULTS & PEDIATRICS N	615,603	104,663	510,940	177,200	7,271	619,433	30,972	14
15	30 ADULTS & PEDIATRICS O	78,358	40,806	37,552	177,200	163	13,886	694	15
16	30 ADULTS & PEDIATRICS P	16,763	7,085	9,678	177,200	65	5,538	277	16
200	TOTAL	1,679,635	265,053	1,414,582		18,509	1,576,825	78,841	200

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
10	11	12	13	14	15	16	17	18	
1	30 ADULTS & PEDIATRICS	A				2,982	903	903	1
2	30 ADULTS & PEDIATRICS	B				1,108	1,123	1,123	2
3	30 ADULTS & PEDIATRICS	C				4,089	231	231	3
4	30 ADULTS & PEDIATRICS	D				56,057	3,118	3,118	4
5	30 ADULTS & PEDIATRICS	E				11,331	594	594	5
6	30 ADULTS & PEDIATRICS	F				37,996	2,144	2,144	6
7	30 ADULTS & PEDIATRICS	G				42,426	2,349	2,349	7
8	30 ADULTS & PEDIATRICS	H				39,870	2,250	2,250	8
9	30 ADULTS & PEDIATRICS	I				42,681	2,364	2,364	9
10	30 ADULTS & PEDIATRICS	J				8,178	462	462	10
11	30 ADULTS & PEDIATRICS	K				59,464	3,341	3,341	11
12	30 ADULTS & PEDIATRICS	L				20,446	1,154	1,154	12
13	30 ADULTS & PEDIATRICS	M				611,340		112,499	13
14	30 ADULTS & PEDIATRICS	N				619,433		104,663	14
15	30 ADULTS & PEDIATRICS	O				13,886	23,666	64,472	15
16	30 ADULTS & PEDIATRICS	P				5,538	4,140	11,225	16
200	TOTAL					1,576,825	47,839	312,892	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	1,052,428	1,052,428				1
2 CAP REL COSTS-MVBLE EQUIP	385,072		385,072			2
4 EMPLOYEE BENEFITS	63,259			63,259		4
5 ADMINISTRATIVE & GENERAL	2,764,862	307,804	112,622	8,683	3,193,971	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	328,638			1,543	330,181	7
8 LAUNDRY & LINEN SERVICE	130,649	24,157	8,839		163,645	8
9 HOUSEKEEPING	155,999	7,461	2,730	881	167,071	9
10 DIETARY	271,088	83,305	30,480	1,978	386,851	10
11 CAFETERIA	97,027				97,027	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	535,249	54,374	19,895	4,679	614,197	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	152,157			1,290	153,447	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	5,306,154	495,282	181,217	27,623	6,010,276	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	237,416	12,807	4,686		254,909	50
54 RADIOLOGY-DIAGNOSTIC	261,074	12,807	4,686	699	279,266	54
60 LABORATORY	387,558				387,558	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	852,737			6,781	859,518	65
66 PHYSICAL THERAPY	233,551	5,517	2,019	1,913	243,000	66
67 OCCUPATIONAL THERAPY	165,489	3,917	1,433	1,417	172,256	67
68 SPEECH PATHOLOGY	64,641	1,544	565	182	66,932	68
69 ELECTROCARDIOLOGY	794				794	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	1,244,289	16,152	5,910	662	1,267,013	71
73 DRUGS CHARGED TO PATIENTS	1,054,943	13,293	4,864	3,425	1,076,525	73
74 RENAL DIALYSIS	181,785	11,549	4,226	1,200	198,760	74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	15,926,859	1,049,969	384,172	62,956	15,923,197	118
NONREIMBURSABLE COST CENTERS						
194 PROVIDER RELATIONS NRCC	48,969	2,459	900	303	52,631	194
194.01 NRCC SUBLEASED SPACE						194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	15,975,828	1,052,428	385,072	63,259	15,975,828	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY + LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	3,193,971					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	82,507	412,688				7
8 LAUNDRY & LINEN SERVICE	40,892	13,388	217,925			8
9 HOUSEKEEPING	41,748	4,135		212,954		9
10 DIETARY	96,667	46,169		24,881	554,568	10
11 CAFETERIA	24,245					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	153,477	30,135		16,240		13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	38,344					16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,501,869	274,497	217,925	147,927	554,568	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	63,697	7,098		3,825		50
54 RADIOLOGY-DIAGNOSTIC	69,784	7,098		3,825		54
60 LABORATORY	96,844					60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	214,779					65
66 PHYSICAL THERAPY	60,722	3,058		1,648		66
67 OCCUPATIONAL THERAPY	43,044	2,171		1,170		67
68 SPEECH PATHOLOGY	16,725	856		461		68
69 ELECTROCARDIOLOGY	198					69
71 MEDICAL SUPPLIES CHRGED TO PATIENTS	316,605	8,952		4,824		71
73 DRUGS CHARGED TO PATIENTS	269,005	7,367		3,970		73
74 RENAL DIALYSIS	49,667	6,401		3,449		74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	3,180,819	411,325	217,925	212,220	554,568	118
NONREIMBURSABLE COST CENTERS						
194 PROVIDER RELATIONS NRCC	13,152	1,363		734		194
194.01 NRCC SUBLEASED SPACE						194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	3,193,971	412,688	217,925	212,954	554,568	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	MEDICAL RECORDS + LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA	121,272				11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION	6,678	820,727			13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY	3,751		195,542		16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	77,278	820,727	54,342	9,659,409	30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	607		993	331,129	50
54 RADIOLOGY-DIAGNOSTIC	1,518		3,515	365,006	54
60 LABORATORY			12,136	496,538	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	14,527		39,011	1,127,835	65
66 PHYSICAL THERAPY	3,621		4,192	316,241	66
67 OCCUPATIONAL THERAPY	2,710		3,349	224,700	67
68 SPEECH PATHOLOGY	369		1,365	86,708	68
69 ELECTROCARDIOLOGY			9,777	10,769	69
71 MEDICAL SUPPLIES CHRGED TO PATIENTS	1,496		24,143	1,623,033	71
73 DRUGS CHARGED TO PATIENTS	5,356		39,380	1,401,603	73
74 RENAL DIALYSIS	1,865		3,339	263,481	74
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	119,776	820,727	195,542	15,906,452	118
NONREIMBURSABLE COST CENTERS					
194 PROVIDER RELATIONS NRCC	1,496			69,376	194
194.01 NRCC SUBLEASED SPACE					194.01
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	121,272	820,727	195,542	15,975,828	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION		TOTAL	
		26	
GENERAL SERVICE COST CENTERS			
1	CAP REL COSTS-BLDG & FIXT		1
2	CAP REL COSTS-MVBLE EQUIP		2
4	EMPLOYEE BENEFITS		4
5	ADMINISTRATIVE & GENERAL		5
6	MAINTENANCE & REPAIRS		6
7	OPERATION OF PLANT		7
8	LAUNDRY & LINEN SERVICE		8
9	HOUSEKEEPING		9
10	DIETARY		10
11	CAFETERIA		11
12	MAINTENANCE OF PERSONNEL		12
13	NURSING ADMINISTRATION		13
14	CENTRAL SERVICES & SUPPLY		14
15	PHARMACY		15
16	MEDICAL RECORDS & LIBRARY		16
17	SOCIAL SERVICE		17
19	NONPHYSICIAN ANESTHETISTS		19
20	NURSING SCHOOL		20
21	I&R SRVCES-SALARY & FRINGES APPRVD		21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD		22
23	PARAMED ED PRGM-(SPECIFY)		23
30	INPATIENT ROUTINE SERV COST CENTERS		
	ADULTS & PEDIATRICS	9,659,409	30
	ANCILLARY SERVICE COST CENTERS		
50	OPERATING ROOM	331,129	50
54	RADIOLOGY-DIAGNOSTIC	365,006	54
60	LABORATORY	496,538	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		62.30
65	RESPIRATORY THERAPY	1,127,835	65
66	PHYSICAL THERAPY	316,241	66
67	OCCUPATIONAL THERAPY	224,700	67
68	SPEECH PATHOLOGY	86,708	68
69	ELECTROCARDIOLOGY	10,769	69
71	MEDICAL SUPPLIES CHRGD TO PATIENTS	1,623,033	71
73	DRUGS CHARGED TO PATIENTS	1,401,603	73
74	RENAL DIALYSIS	263,481	74
76.97	CARDIAC REHABILITATION		76.97
76.98	HYPERBARIC OXYGEN THERAPY		76.98
76.99	LITHOTRIPSY		76.99
	OUTPATIENT SERVICE COST CENTERS		
92	OBSERVATION BEDS		92
	OTHER REIMBURSABLE COST CENTERS		
99.10	CORF		99.10
99.20	OUTPATIENT PHYSICAL THERAPY		99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY		99.30
99.40	OUTPATIENT SPEECH PATHOLOGY		99.40
	SPECIAL PURPOSE COST CENTERS		
118	SUBTOTALS (SUM OF LINES 1-117)	15,906,452	118
	NONREIMBURSABLE COST CENTERS		
194	PROVIDER RELATIONS NRCC	69,376	194
194.01	NRCC SUBLEASED SPACE		194.01
200	CROSS FOOT ADJUSTMENTS		200
201	NEGATIVE COST CENTER		201
202	TOTAL (SUM OF LINES 118-201)	15,975,828	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	ADMINIS- TRATIVE & GENERAL 5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	70,771	307,804	112,622	491,197	491,197	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	8,988			8,988	12,689	7
8 LAUNDRY & LINEN SERVICE		24,157	8,839	32,996	6,289	8
9 HOUSEKEEPING		7,461	2,730	10,191	6,420	9
10 DIETARY	499	83,305	30,480	114,284	14,866	10
11 CAFETERIA					3,729	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		54,374	19,895	74,269	23,603	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY					5,897	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		495,282	181,217	676,499	230,971	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		12,807	4,686	17,493	9,796	50
54 RADIOLOGY-DIAGNOSTIC		12,807	4,686	17,493	10,732	54
60 LABORATORY					14,893	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	19,068			19,068	33,030	65
66 PHYSICAL THERAPY		5,517	2,019	7,536	9,338	66
67 OCCUPATIONAL THERAPY		3,917	1,433	5,350	6,620	67
68 SPEECH PATHOLOGY		1,544	565	2,109	2,572	68
69 ELECTROCARDIOLOGY					31	69
71 MEDICAL SUPPLIES CHRGED TO PATIENTS	421,709	16,152	5,910	443,771	48,690	71
73 DRUGS CHARGED TO PATIENTS	9,465	13,293	4,864	27,622	41,370	73
74 RENAL DIALYSIS		11,549	4,226	15,775	7,638	74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	530,500	1,049,969	384,172	1,964,641	489,174	118
NONREIMBURSABLE COST CENTERS						
194 PROVIDER RELATIONS NRCC		2,459	900	3,359	2,023	194
194.01 NRCC SUBLEASED SPACE						194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	530,500	1,052,428	385,072	1,968,000	491,197	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	
	OF PLANT	+ LINEN	KEEPING			
	7	8	9	10	11	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	21,677					7
8 LAUNDRY & LINEN SERVICE	703	39,988				8
9 HOUSEKEEPING	217		16,828			9
10 DIETARY	2,425		1,966	133,541		10
11 CAFETERIA					3,729	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,583		1,283		205	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY					115	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	14,418	39,988	11,691	133,541	2,377	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	373		302		19	50
54 RADIOLOGY-DIAGNOSTIC	373		302		47	54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY					447	65
66 PHYSICAL THERAPY	161		130		111	66
67 OCCUPATIONAL THERAPY	114		92		83	67
68 SPEECH PATHOLOGY	45		36		11	68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	470		381		46	71
73 DRUGS CHARGED TO PATIENTS	387		314		165	73
74 RENAL DIALYSIS	336		273		57	74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	21,605	39,988	16,770	133,541	3,683	118
NONREIMBURSABLE COST CENTERS						
194 PROVIDER RELATIONS NRCC	72		58		46	194
194.01 NRCC SUBLEASED SPACE						194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	21,677	39,988	16,828	133,541	3,729	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION 13	MEDICAL RECORDS + LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION	100,943				13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY		6,012			16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	100,943	1,679	1,212,107		1,212,107 30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM		30	28,013		28,013 50
54 RADIOLOGY-DIAGNOSTIC		108	29,055		29,055 54
60 LABORATORY		372	15,265		15,265 60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY		1,197	53,742		53,742 65
66 PHYSICAL THERAPY		129	17,405		17,405 66
67 OCCUPATIONAL THERAPY		103	12,362		12,362 67
68 SPEECH PATHOLOGY		42	4,815		4,815 68
69 ELECTROCARDIOLOGY		300	331		331 69
71 MEDICAL SUPPLIES CHRGED TO PATIENTS		741	494,099		494,099 71
73 DRUGS CHARGED TO PATIENTS		1,209	71,067		71,067 73
74 RENAL DIALYSIS		102	24,181		24,181 74
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	100,943	6,012	1,962,442		1,962,442 118
NONREIMBURSABLE COST CENTERS					
194 PROVIDER RELATIONS NRCC			5,558		5,558 194
194.01 NRCC SUBLEASED SPACE					194.01
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	100,943	6,012	1,968,000		1,968,000 202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	
	1	2	4	5A	5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	36,814					1
2 CAP REL COSTS-MVBLE EQUIP		36,814				2
4 EMPLOYEE BENEFITS			5,907,972			4
5 ADMINISTRATIVE & GENERAL	10,767	10,767	810,982	-3,193,971	12,781,857	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT			144,071		330,181	7
8 LAUNDRY & LINEN SERVICE	845	845			163,645	8
9 HOUSEKEEPING	261	261	82,260		167,071	9
10 DIETARY	2,914	2,914	184,779		386,851	10
11 CAFETERIA					97,027	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,902	1,902	436,963		614,197	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY			120,491		153,447	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	17,325	17,325	2,579,659		6,010,276	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	448	448			254,909	50
54 RADIOLOGY-DIAGNOSTIC	448	448	65,267		279,266	54
60 LABORATORY					387,558	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY			633,286		859,518	65
66 PHYSICAL THERAPY	193	193	178,707		243,000	66
67 OCCUPATIONAL THERAPY	137	137	132,349		172,256	67
68 SPEECH PATHOLOGY	54	54	16,972		66,932	68
69 ELECTROCARDIOLOGY					794	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	565	565	61,859		1,267,013	71
73 DRUGS CHARGED TO PATIENTS	465	465	319,911		1,076,525	73
74 RENAL DIALYSIS	404	404	112,092		198,760	74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	36,728	36,728	5,879,648	-3,193,971	12,729,226	118
NONREIMBURSABLE COST CENTERS						
194 PROVIDER RELATIONS NRCC	86	86	28,324		52,631	194
194.01 NRCC SUBLEASED SPACE						194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	1,052,428	385,072	63,259		3,193,971	202
203 UNIT COST MULT-WS B PT I	28.587711	10.459934	0.010707		0.249883	203
204 COST TO BE ALLOC PER B PT II					491,197	204
205 UNIT COST MULT-WS B PT II					0.038429	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
	SQUARE FEET 7	PATIENT DAYS 8	SQUARE FEET 9	PATIENT DAYS 10	MEALS 11	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	26,047					7
8 LAUNDRY & LINEN SERVICE	845	8,454				8
9 HOUSEKEEPING	261		24,941			9
10 DIETARY	2,914		2,914	8,454		10
11 CAFETERIA					5,593	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,902		1,902		308	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY					173	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	17,325	8,454	17,325	8,454	3,564	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	448		448		28	50
54 RADIOLOGY-DIAGNOSTIC	448		448		70	54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY					670	65
66 PHYSICAL THERAPY	193		193		167	66
67 OCCUPATIONAL THERAPY	137		137		125	67
68 SPEECH PATHOLOGY	54		54		17	68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	565		565		69	71
73 DRUGS CHARGED TO PATIENTS	465		465		247	73
74 RENAL DIALYSIS	404		404		86	74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	25,961	8,454	24,855	8,454	5,524	118
NONREIMBURSABLE COST CENTERS						
194 PROVIDER RELATIONS NRCC	86		86		69	194
194.01 NRCC SUBLEASED SPACE						194.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	412,688	217,925	212,954	554,568	121,272	202
203 UNIT COST MULT-WS B PT I	15.843974	25.777738	8.538310	65.598297	21.682818	203
204 COST TO BE ALLOC PER B PT II	21,677	39,988	16,828	133,541	3,729	204
205 UNIT COST MULT-WS B PT II	0.832226	4.730069	0.674712	15.796191	0.666726	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION NURSING FTE'S	MEDICAL RECORDS + LIBRARY GROSS REVENUE	
	13	16	
GENERAL SERVICE COST CENTERS			
1 CAP REL COSTS-BLDG & FIXT			1
2 CAP REL COSTS-MVBLE EQUIP			2
4 EMPLOYEE BENEFITS			4
5 ADMINISTRATIVE & GENERAL			5
6 MAINTENANCE & REPAIRS			6
7 OPERATION OF PLANT			7
8 LAUNDRY & LINEN SERVICE			8
9 HOUSEKEEPING			9
10 DIETARY			10
11 CAFETERIA			11
12 MAINTENANCE OF PERSONNEL			12
13 NURSING ADMINISTRATION	52,000		13
14 CENTRAL SERVICES & SUPPLY			14
15 PHARMACY			15
16 MEDICAL RECORDS & LIBRARY		29,563,501	16
17 SOCIAL SERVICE			17
19 NONPHYSICIAN ANESTHETISTS			19
20 NURSING SCHOOL			20
21 I&R SRVCES-SALARY & FRINGES APPRVD			21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD			22
23 PARAMED ED PRGM-(SPECIFY)			23
INPATIENT ROUTINE SERV COST CENTERS			
30 ADULTS & PEDIATRICS	52,000	8,215,000	30
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM		150,129	50
54 RADIOLOGY-DIAGNOSTIC		531,446	54
60 LABORATORY		1,834,875	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			62.30
65 RESPIRATORY THERAPY		5,898,248	65
66 PHYSICAL THERAPY		633,773	66
67 OCCUPATIONAL THERAPY		506,371	67
68 SPEECH PATHOLOGY		206,308	68
69 ELECTROCARDIOLOGY		1,478,179	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		3,650,301	71
73 DRUGS CHARGED TO PATIENTS		5,953,971	73
74 RENAL DIALYSIS		504,900	74
76.97 CARDIAC REHABILITATION			76.97
76.98 HYPERBARIC OXYGEN THERAPY			76.98
76.99 LITHOTRIPSY			76.99
OUTPATIENT SERVICE COST CENTERS			
92 OBSERVATION BEDS			92
OTHER REIMBURSABLE COST CENTERS			
99.10 CORF			99.10
99.20 OUTPATIENT PHYSICAL THERAPY			99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40 OUTPATIENT SPEECH PATHOLOGY			99.40
SPECIAL PURPOSE COST CENTERS			
118 SUBTOTALS (SUM OF LINES 1-117)	52,000	29,563,501	118
NONREIMBURSABLE COST CENTERS			
194 PROVIDER RELATIONS NRCC			194
194.01 NRCC SUBLEASED SPACE			194.01
200 CROSS FOOT ADJUSTMENTS			200
201 NEGATIVE COST CENTER			201
202 COST TO BE ALLOC PER B PT I	820,727	195,542	202
203 UNIT COST MULT-WS B PT I	15.783212	0.006614	203
204 COST TO BE ALLOC PER B PT II	100,943	6,012	204
205 UNIT COST MULT-WS B PT II	1.941212	0.000203	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
30 INPATIENT ROUTINE SERV COST CENTERS						30
ADULTS & PEDIATRICS	9,659,409		9,659,409	47,839	9,707,248	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	331,129		331,129		331,129	50
54 RADIOLOGY-DIAGNOSTIC	365,006		365,006		365,006	54
60 LABORATORY	496,538		496,538		496,538	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	1,127,835		1,127,835		1,127,835	65
66 PHYSICAL THERAPY	316,241		316,241		316,241	66
67 OCCUPATIONAL THERAPY	224,700		224,700		224,700	67
68 SPEECH PATHOLOGY	86,708		86,708		86,708	68
69 ELECTROCARDIOLOGY	10,769		10,769		10,769	69
71 MEDICAL SUPPLIES CHRGED TO	1,623,033		1,623,033		1,623,033	71
73 DRUGS CHARGED TO PATIENTS	1,401,603		1,401,603		1,401,603	73
74 RENAL DIALYSIS	263,481		263,481		263,481	74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
200 SUBTOTAL (SEE INSTRUCTIONS)	15,906,452		15,906,452	47,839	15,954,291	200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	15,906,452		15,906,452		15,954,291	202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8			
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	8,215,000		8,215,000			30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	150,129		150,129	2.205630	2.205630	2.205630 50
54 RADIOLOGY-DIAGNOSTIC	531,446		531,446	0.686817	0.686817	0.686817 54
60 LABORATORY	1,834,875		1,834,875	0.270611	0.270611	0.270611 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	5,898,248		5,898,248	0.191215	0.191215	0.191215 65
66 PHYSICAL THERAPY	633,773		633,773	0.498981	0.498981	0.498981 66
67 OCCUPATIONAL THERAPY	506,371		506,371	0.443746	0.443746	0.443746 67
68 SPEECH PATHOLOGY	206,308		206,308	0.420284	0.420284	0.420284 68
69 ELECTROCARDIOLOGY	1,478,179		1,478,179	0.007285	0.007285	0.007285 69
71 MEDICAL SUPPLIES CHRGED TO	3,650,301		3,650,301	0.444630	0.444630	0.444630 71
73 DRUGS CHARGED TO PATIENTS	5,953,971		5,953,971	0.235406	0.235406	0.235406 73
74 RENAL DIALYSIS	504,900		504,900	0.521848	0.521848	0.521848 74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
200 SUBTOTAL (SEE INSTRUCTIONS)	29,563,501		29,563,501			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	29,563,501		29,563,501			202

PROVIDER CCN: 15-2013 SSH -BEECH GROVE, INC.
 PERIOD FROM 09/01/2012 TO 08/31/2013

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
 11/19/2013 15:24

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

CHECK [] TITLE V
 APPLICABLE [XX] TITLE XVIII-PT A
 BOXES [] TITLE XIX

COST CENTER DESCRIPTION	CAP-REL COST	REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT (COL.1 MINUS COL.2)	(COL.1 MINUS COL.2)	(COL.3 ÷ COL.4)	PGM DAYS	(COL.5 x COL.6)	
	1	2	3	4	5	6	7
INPAT ROUTINE SERV COST CTRS							
30 ADULTS & PEDIATRICS	1,212,107		1,212,107	8,454	143.38	5,828	835,619 30
31 INTENSIVE CARE UNIT							31
32 CORONARY CARE UNIT							32
33 BURN INTENSIVE CARE UNIT							33
34 SURGICAL INTENSIVE CARE UNIT							34
35 OTHER SPECIAL CARE (SPECIFY)							35
40 SUBPROVIDER - IPF							40
41 SUBPROVIDER - IRF							41
42 SUBPROVIDER I							42
43 NURSERY							43
44 SKILLED NURSING FACILITY							44
45 NURSING FACILITY							45
200 TOTAL (LINES 30-199)	1,212,107		1,212,107	8,454		5,828	835,619 200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (15-2013) [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX [] IRF

COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	28,013	150,129	0.186593	102,910	19,202	50
54 RADIOLOGY-DIAGNOSTIC	29,055	531,446	0.054672	339,157	18,542	54
60 LABORATORY	15,265	1,834,875	0.008319	1,230,988	10,241	60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY	53,742	5,898,248	0.009112	3,598,084	32,786	65
66 PHYSICAL THERAPY	17,405	633,773	0.027463	391,425	10,750	66
67 OCCUPATIONAL THERAPY	12,362	506,371	0.024413	315,342	7,698	67
68 SPEECH PATHOLOGY	4,815	206,308	0.023339	123,911	2,892	68
69 ELECTROCARDIOLOGY	331	1,478,179	0.000224	909,720	204	69
71 MEDICAL SUPPLIES CHRGED TO PA	494,099	3,650,301	0.135358	2,374,058	321,348	71
73 DRUGS CHARGED TO PATIENTS	71,067	5,953,971	0.011936	4,028,971	48,090	73
74 RENAL DIALYSIS	24,181	504,900	0.047893	381,021	18,248	74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)	750,335	21,348,501		13,795,587	490,001	200

PROVIDER CCN: 15-2013 SSH -BEECH GROVE, INC.
PERIOD FROM 09/01/2012 TO 08/31/2013

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK [] TITLE V
APPLICABLE [XX] TITLE XVIII-PT A
BOXES [] TITLE XIX

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					30
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)					200

PROVIDER CCN: 15-2013 SSH -BEECH GROVE, INC.
 PERIOD FROM 09/01/2012 TO 08/31/2013

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [XX] TITLE XVIII-PT A
 BOXES [] TITLE XIX

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	8,454		5,828		30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	8,454		5,828		200

PROVIDER CCN: 15-2013 SSH -BEECH GROVE, INC.
 PERIOD FROM 09/01/2012 TO 08/31/2013

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (15-2013) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN			MEDICAL	COST	COST
	ANESTHETIST	SCHOOL	HEALTH	EDUCATION	(SUM OF	(SUM OF
	COST			COST	COLS.1-4)	COLS.2-4)
	1	2	3	4	5	6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGED TO PA						71
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

PROVIDER CCN: 15-2013 SSH -BEECH GROVE, INC.
 PERIOD FROM 09/01/2012 TO 08/31/2013

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (15-2013) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	150,129			102,910			50
54 RADIOLOGY-DIAGNOSTIC	531,446			339,157			54
60 LABORATORY	1,834,875			1,230,988			60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	5,898,248			3,598,084			65
66 PHYSICAL THERAPY	633,773			391,425			66
67 OCCUPATIONAL THERAPY	506,371			315,342			67
68 SPEECH PATHOLOGY	206,308			123,911			68
69 ELECTROCARDIOLOGY	1,478,179			909,720			69
71 MEDICAL SUPPLIES CHRGED TO P	3,650,301			2,374,058			71
73 DRUGS CHARGED TO PATIENTS	5,953,971			4,028,971			73
74 RENAL DIALYSIS	504,900			381,021			74
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
92 OBSERVATION BEDS							92
OTHER REIMBURSABLE COST CENTERS							
200 TOTAL (SUM OF LINES 50-199)	21,348,501			13,795,587			200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (15-2013) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	----- PROGRAM CHARGES -----				----- PROGRAM COSTS -----		
	COST TO		COST REIMB.	COST REIMB.	COST	COST	
	CHARGE RATIO	PPS	SERVICES	SVCES NOT	SERVICES	SVCES NOT	
	FROM WKST C,	REIMBURSED	SUBJECT TO	SUBJECT TO	PPS	SUBJECT TO	SUBJECT TO
	PT I, COL. 9	SERVICES	DED & COINS	DED & COINS	SERVICES	DED & COINS	DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	2.205630					50
54	RADIOLOGY-DIAGNOSTIC	0.686817					54
60	LABORATORY	0.270611					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	0.191215					65
66	PHYSICAL THERAPY	0.498981					66
67	OCCUPATIONAL THERAPY	0.443746					67
68	SPEECH PATHOLOGY	0.420284					68
69	ELECTROCARDIOLOGY	0.007285					69
71	MEDICAL SUPPLIES CHRGED TO PATI	0.444630					71
73	DRUGS CHARGED TO PATIENTS	0.235406					73
74	RENAL DIALYSIS	0.521848					74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS							
200	SUBTOTAL (SEE INSTRUCTIONS)						200
201	LESS PBP CLINIC LAB SERVICES						201
202	NET CHARGES (LINE 200 - LINE 201)						202

PROVIDER CCN: 15-2013 SSH -BEECH GROVE, INC.
 PERIOD FROM 09/01/2012 TO 08/31/2013

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
 11/19/2013 15:24

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII-PT A
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	CAP-REL COST	REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT (COL.1 MINUS COL.2)	(COL.1 MINUS COL.2)	(COL.3 ÷ COL.4)	PGM DAYS	(COL.5 x COL.6)
	1	2	3	4	5	6
INPAT ROUTINE SERV COST CTRS						
30 ADULTS & PEDIATRICS	1,212,107		1,212,107	8,454	143.38	30
31 INTENSIVE CARE UNIT						31
32 CORONARY CARE UNIT						32
33 BURN INTENSIVE CARE UNIT						33
34 SURGICAL INTENSIVE CARE UNIT						34
35 OTHER SPECIAL CARE (SPECIFY)						35
40 SUBPROVIDER - IPF						40
41 SUBPROVIDER - IRF						41
42 SUBPROVIDER I						42
43 NURSERY						43
44 SKILLED NURSING FACILITY						44
45 NURSING FACILITY						45
200 TOTAL (LINES 30-199)	1,212,107		1,212,107	8,454		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (15-2013) [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] OTHER

COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	28,013	150,129	0.186593		50
54 RADIOLOGY-DIAGNOSTIC	29,055	531,446	0.054672		54
60 LABORATORY	15,265	1,834,875	0.008319		60
62.30 BLOOD CLOTTING FOR HEMOPHILIA					62.30
65 RESPIRATORY THERAPY	53,742	5,898,248	0.009112		65
66 PHYSICAL THERAPY	17,405	633,773	0.027463		66
67 OCCUPATIONAL THERAPY	12,362	506,371	0.024413		67
68 SPEECH PATHOLOGY	4,815	206,308	0.023339		68
69 ELECTROCARDIOLOGY	331	1,478,179	0.000224		69
71 MEDICAL SUPPLIES CHRGED TO PA	494,099	3,650,301	0.135358		71
73 DRUGS CHARGED TO PATIENTS	71,067	5,953,971	0.011936		73
74 RENAL DIALYSIS	24,181	504,900	0.047893		74
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-199)	750,335	21,348,501			200

PROVIDER CCN: 15-2013 SSH -BEECH GROVE, INC.
 PERIOD FROM 09/01/2012 TO 08/31/2013

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
 11/19/2013 15:24

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII-PT A
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					30
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)					200

PROVIDER CCN: 15-2013 SSH -BEECH GROVE, INC.
 PERIOD FROM 09/01/2012 TO 08/31/2013

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII-PT A
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	8,454				30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	8,454				200

PROVIDER CCN: 15-2013 SSH -BEECH GROVE, INC.
 PERIOD FROM 09/01/2012 TO 08/31/2013

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
 11/19/2013 15:24

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (15-2013) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] OTHER

COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGED TO PA						71
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

PROVIDER CCN: 15-2013 SSH -BEECH GROVE, INC.
 PERIOD FROM 09/01/2012 TO 08/31/2013

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
 11/19/2013 15:24

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (15-2013) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] OTHER

COST CENTER DESCRIPTION	TOTAL	RATIO OF	O/P RATIO	INPAT	INPAT PGM	O/P PGM	O/P PGM
	CHARGES	COST TO	OF COST TO		PASS-THRU		PASS-THRU
	(FROM WKST	CHARGES	CHARGES	PGM	COSTS	CHARGES	COSTS
	C, PT. I,	(COL. 5 ÷	(COL. 6 ÷	CHARGES	(COL. 8 x		(COL. 9 x
	COL. 8)	COL. 7)	COL. 7)	10	COL. 10)	12	COL. 12)
	7	8	9		11		13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	150,129						50
54 RADIOLOGY-DIAGNOSTIC	531,446						54
60 LABORATORY	1,834,875						60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	5,898,248						65
66 PHYSICAL THERAPY	633,773						66
67 OCCUPATIONAL THERAPY	506,371						67
68 SPEECH PATHOLOGY	206,308						68
69 ELECTROCARDIOLOGY	1,478,179						69
71 MEDICAL SUPPLIES CHRGED TO P	3,650,301						71
73 DRUGS CHARGED TO PATIENTS	5,953,971						73
74 RENAL DIALYSIS	504,900						74
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
92 OBSERVATION BEDS							92
OTHER REIMBURSABLE COST CENTERS							
200 TOTAL (SUM OF LINES 50-199)	21,348,501						200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (15-2013) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PPS REIMBURSED SERVICES	COST REIMB. SERVICES DED & COINS	COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PPS SERVICES	COST SERVICES DED & COINS	COST SVCES NOT SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	2.205630						50
54 RADIOLOGY-DIAGNOSTIC	0.686817						54
60 LABORATORY	0.270611						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.191215						65
66 PHYSICAL THERAPY	0.498981						66
67 OCCUPATIONAL THERAPY	0.443746						67
68 SPEECH PATHOLOGY	0.420284						68
69 ELECTROCARDIOLOGY	0.007285						69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.444630						71
73 DRUGS CHARGED TO PATIENTS	0.235406						73
74 RENAL DIALYSIS	0.521848						74
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
92 OBSERVATION BEDS							92
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-2013) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	8,454	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	8,454	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	8,454	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	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)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	5,828	9
10	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)		10
11	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)		11
12	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		12
13	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)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	9,707,248	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	9,707,248	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	8,215,000	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	8,215,000	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.181649	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	971.73	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	9,707,248	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-2013) [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,148.24 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 6,691,943 39
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 6,691,943 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42 NURSERY (TITLES V AND XIX ONLY)						42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43 INTENSIVE CARE UNIT						43
44 CORONARY CARE UNIT						44
45 BURN INTENSIVE CARE UNIT						45
46 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					4,077,854	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					10,769,797	49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 835,619 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 490,001 51
 52 TOTAL PROGRAM EXCLUDABLE COST 1,325,620 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 9,444,177 53

TARGET AMOUNT AND LIMIT COMPUTATION
 54 PROGRAM DISCHARGES 54
 55 TARGET AMOUNT PER DISCHARGE 55
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET 59
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60
 61 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) 61
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63
 PROGRAM INPATIENT ROUTINE SWING BED COST
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 66
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 1,148.24 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 89

	TOTAL OBS. BED OBS. COST (FROM LINE 89)	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.)			
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) (SEE INSTR.)
90 CAPITAL-RELATED COST					90
91 NURSING SCHOOL COST					91
92 ALLIED HEALTH COST					92
93 ALL OTHER MEDICAL EDUCATION					93

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-2013) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	8,454	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	8,454	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	8,454	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	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)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)		9
10	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)		10
11	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)		11
12	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		12
13	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)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	9,707,248	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	9,707,248	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	8,215,000	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	8,215,000	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.181649	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	971.73	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	9,707,248	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-2013) [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,148.24 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 39
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5
42 NURSERY (TITLES V AND XIX ONLY)					42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT					43
44 CORONARY CARE UNIT					44
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT					46
47 OTHER SPECIAL CARE (SPECIFY)					47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 51
 52 TOTAL PROGRAM EXCLUDABLE COST 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 53

TARGET AMOUNT AND LIMIT COMPUTATION
 54 PROGRAM DISCHARGES 54
 55 TARGET AMOUNT PER DISCHARGE 55
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET 59
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60
 61 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) 61
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

PROGRAM INPATIENT ROUTINE SWING BED COST
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 66
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 89

	ROUTINE COST (FROM LINE 27)	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89)	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.)
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST	COST 1			
90 CAPITAL-RELATED COST				90
91 NURSING SCHOOL COST				91
92 ALLIED HEALTH COST				92
93 ALL OTHER MEDICAL EDUCATION				93

PROVIDER CCN: 15-2013 SSH -BEECH GROVE, INC.
 PERIOD FROM 09/01/2012 TO 08/31/2013

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
 11/19/2013 15:24

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (15-2013) [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2)		
			3	3	
30 INPATIENT ROUTINE SERVICE COST CENTERS					
ADULTS & PEDIATRICS		6,328,708			30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	2.205630	102,910	226,981		50
54 RADIOLOGY-DIAGNOSTIC	0.686817	339,157	232,939		54
60 LABORATORY	0.270611	1,230,988	333,119		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.191215	3,598,084	688,008		65
66 PHYSICAL THERAPY	0.498981	391,425	195,314		66
67 OCCUPATIONAL THERAPY	0.443746	315,342	139,932		67
68 SPEECH PATHOLOGY	0.420284	123,911	52,078		68
69 ELECTROCARDIOLOGY	0.007285	909,720	6,627		69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.444630	2,374,058	1,055,577		71
73 DRUGS CHARGED TO PATIENTS	0.235406	4,028,971	948,444		73
74 RENAL DIALYSIS	0.521848	381,021	198,835		74
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
92 OUTPATIENT SERVICE COST CENTERS					
OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		13,795,587	4,077,854		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		13,795,587			202

PROVIDER CCN: 15-2013 SSH -BEECH GROVE, INC.
 PERIOD FROM 09/01/2012 TO 08/31/2013

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
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INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (15-2013) [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	2.205630			50
54 RADIOLOGY-DIAGNOSTIC	0.686817			54
60 LABORATORY	0.270611			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.191215			65
66 PHYSICAL THERAPY	0.498981			66
67 OCCUPATIONAL THERAPY	0.443746			67
68 SPEECH PATHOLOGY	0.420284			68
69 ELECTROCARDIOLOGY	0.007285			69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.444630			71
73 DRUGS CHARGED TO PATIENTS	0.235406			73
74 RENAL DIALYSIS	0.521848			74
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
92 OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)				202

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [XX] HOSPITAL (15-2013) [] SUB (OTHER)
 APPLICABLE [] IPF [] SNF
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A PART B

DESCRIPTION	MM/DD/YYYY		AMOUNT	
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		9,461,778		1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		2
3 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.	.01 08/22/2013	172,453		NONE 3.01
	.02			3.02
	PROGRAM .03			3.03
	TO .04			3.04
	PROVIDER .05			3.05
	.06			3.06
	.07			3.07
	.08			3.08
	.09			3.09
	.50			3.50
	.51 01/28/2013	2,144,509		NONE 3.51
	PROVIDER .52			3.52
	TO .53			3.53
	PROGRAM .54			3.54
	.55			3.55
	.56			3.56
	.57			3.57
	.58			3.58
	.59			3.59
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)	.99	-1,972,056		3.99
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		7,489,722		4

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01			5.01
	TO .02			5.02
	PROVIDER .03			5.03
	.04			5.04
	.05			5.05
	.06			5.06
	.07			5.07
	.08			5.08
	.09			5.09
	PROVIDER .50			5.50
	TO .51			5.51
	PROGRAM .52			5.52
	.53			5.53
	.54			5.54
	.55			5.55
	.56			5.56
	.57			5.57
	.58			5.58
	.59			5.59
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)	.99			5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM .01			6.01
	TO .02			6.02
	PROVIDER .01			6.01
	PROVIDER .02			6.02
	TO .02			6.02
	PROGRAM			
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				7

8 NAME OF CONTRACTOR: _____ CONTRACTOR NUMBER: _____ NPR DATE: _____ 8

PROVIDER CCN: 15-2013 SSH -BEECH GROVE, INC.
PERIOD FROM 09/01/2012 TO 08/31/2013

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
11/19/2013 15:24

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (15-2013) [] CAH
APPLICABLE BOX

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	8,454 4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168	7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	8

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	30
31	OTHER ADJUSTMENTS (SPECIFY)	31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)	32

PROVIDER CCN: 15-2013 SSH -BEECH GROVE, INC.
PERIOD FROM 09/01/2012 TO 08/31/2013

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
11/19/2013 15:24

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART IV

CHECK [XX] HOSPITAL (15-2013)
APPLICABLE BOX:

PART IV - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER LTCH PPS

1	NET FEDERAL PPS PAYMENT (SEE INSTRUCTIONS)	7,683,901	1
2	OUTLIER PAYMENTS	1,114,617	2
3	TOTAL PPS PAYMENTS (SUM OF LINES 1 AND 2)	8,798,518	3
4	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENTS (SEE INSTRUCTIONS)		4
5	ORGAN ACQUISITION		5
6	COST OF TEACHING PHYSICIANS		6
7	SUBTOTAL (SEE INSTRUCTIONS)	8,798,518	7
8	PRIMARY PAYER PAYMENTS		8
9	SUBTOTAL (LINE 7 LESS LINE 8)	8,798,518	9
10	DEDUCTIBLES	23,714	10
11	SUBTOTAL (LINE 9 MINUS LINE 10)	8,774,804	11
12	COINSURANCE	476,039	12
13	SUBTOTAL (LINE 11 MINUS LINE 12)	8,298,765	13
14	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	237,700	14
15	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	166,390	15
16	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	167,281	16
17	SUBTOTAL (SUM OF LINES 13 AND 15)	8,465,155	17
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49) (FOR FREESTANDING LTCH ONLY)		18
19	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)		19
20	OUTLIER PAYMENTS RECONCILIATION		20
21	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		21
22	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	8,465,155	22
23	INTERIM PAYMENTS	7,489,722	23
24	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		24
25	BALANCE DUE PROVIDER/PROGRAM (LINE 22 MINUS THE SUM OF LINES 23 AND 24)	975,433	25
26	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		26

TO BE COMPLETED BY CONTRACTOR

50	ORIGINAL PPS PAYMENT AND OUTLIER AMOUNT FROM WORKSHEET E-3, PART IV, LINE 3 (SEE INSTRUCTIONS)		50
51	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		52
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		53

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK [] TITLE V [XX] HOSPITAL (15-2013) [] SNF [XX] PPS
 APPLICABLE [XX] TITLE XIX [] IPF [] NF [] TEFRA
 BOXES: [] IRF [] ICF/MR [] OTHER
 [] SUB (OTHER)

PART VII - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

	INPATIENT	OUTPATIENT	
	TITLE V OR	TITLE V OR	
	TITLE XIX	TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES			
1 INPATIENT HOSPITAL SNF/NF SERVICES			1
2 MEDICAL AND OTHER SERVICES			2
3 ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)			3
4 SUBTOTAL (SUM OF LINES 1, 2 AND 3)			4
5 INPATIENT PRIMARY PAYER PAYMENTS			5
6 OUTPATIENT PRIMARY PAYER PAYMENTS			6
7 SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)			7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8 ROUTINE SERVICE CHARGES			8
9 ANCILLARY SERVICE CHARGES			9
10 ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11 INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12 TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)			12
CUSTOMARY CHARGES			
13 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14 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)			14
15 RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000	1.000000	15
16 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)			16
17 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))			17
18 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))			18
19 INTERNS AND RESIDENTS (SEE INSTRUCTIONS)			19
20 COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)			20
21 COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)			21
PROSPECTIVE PAYMENT AMOUNT			
22 OTHER THAN OUTLIER PAYMENTS			22
23 OUTLIER PAYMENTS			23
24 PROGRAM CAPITAL PAYMENTS			24
25 CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)			25
26 ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			26
27 SUBTOTAL (SUM OF LINES 22 THROUGH 26)			27
28 CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)			28
29 SUM OF LINES 27 AND 21			29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30 EXCESS OF REASONABLE COST (FROM LINE 18)			30
31 SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)			31
32 DEDUCTIBLES			32
33 COINSURANCE			33
34 ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)			34
35 UTILIZATION REVIEW			35
36 SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)			36
37 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			37
38 SUBTOTAL (LINE 36 ± LINE 37)			38
39 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)			39
40 TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)			40
41 INTERIM PAYMENTS			41
42 BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)			42
43 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

BALANCE SHEET

WORKSHEET G

ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
CURRENT ASSETS				
1 CASH ON HAND AND IN BANKS				1
2 TEMPORARY INVESTMENTS				2
3 NOTES RECEIVABLE				3
4 ACCOUNTS RECEIVABLE	1,789,694			4
5 OTHER RECEIVABLES				5
6 ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-132,581			6
7 INVENTORY				7
8 PREPAID EXPENSES	39,396			8
9 OTHER CURRENT ASSETS	115,200			9
10 DUE FROM OTHER FUNDS				10
11 TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	1,811,709			11
FIXED ASSETS				
12 LAND				12
13 LAND IMPROVEMENTS				13
14 ACCUMULATED DEPRECIATION				14
15 BUILDINGS				15
16 ACCUMULATED DEPRECIATION				16
17 LEASEHOLD IMPROVEMENTS				17
18 ACCUMULATED AMORTIZATION				18
19 FIXED EQUIPMENT				19
20 ACCUMULATED DEPRECIATION				20
21 AUTOMOBILES AND TRUCKS				21
22 ACCUMULATED DEPRECIATION				22
23 MAJOR MOVABLE EQUIPMENT	2,711,084			23
24 ACCUMULATED DEPRECIATION	-1,146,859			24
25 MINOR EQUIPMENT DEPRECIABLE				25
26 ACCUMULATED DEPRECIATION				26
27 HIT DESIGNATED ASSETS				27
28 ACCUMULATED DEPRECIATION				28
29 MINOR EQUIPMENT-NONDEPRECIABLE				29
30 TOTAL FIXED ASSETS (SUM OF LINES 12-29)	1,564,225			30
OTHER ASSETS				
31 INVESTMENTS				31
32 DEPOSITS ON LEASES	5,345			32
33 DUE FROM OWNERS/OFFICERS	11,986,541			33
34 OTHER ASSETS	-50,885			34
35 TOTAL OTHER ASSETS (SUM OF LINES 31-34)	11,941,001			35
36 TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	15,316,935			36
LIABILITIES AND FUND BALANCES				
	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
CURRENT LIABILITIES				
37 ACCOUNTS PAYABLE	1,065,958			37
38 SALARIES, WAGES & FEES PAYABLE	356,614			38
39 PAYROLL TAXES PAYABLE				39
40 NOTES & LOANS PAYABLE (SHORT TERM)				40
41 DEFERRED INCOME				41
42 ACCELERATED PAYMENTS				42
43 DUE TO OTHER FUNDS	-1,594,436			43
44 OTHER CURRENT LIABILITIES				44
45 TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	-171,864			45
LONG-TERM LIABILITIES				
46 MORTGAGE PAYABLE				46
47 NOTES PAYABLE				47
48 UNSECURED LOANS				48
49 OTHER LONG TERM LIABILITIES				49
50 TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)				50
51 TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	-171,864			51
CAPITAL ACCOUNTS				
52 GENERAL FUND BALANCE	15,488,799			52
53 SPECIFIC PURPOSE FUND BALANCE				53
54 DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				54
55 DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				55
56 GOVERNING BODY CREATED - ENDOWMENT FUND BAL				56
57 PLANT FUND BALANCE - INVESTED IN PLANT				57
58 PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				58
59 TOTAL FUND BALANCES (SUM OF LINES 52-58)	15,488,799			59
60 TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	15,316,935			60

PROVIDER CCN: 15-2013 SSH -BEECH GROVE, INC.
 PERIOD FROM 09/01/2012 TO 08/31/2013

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
 11/19/2013 15:24

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4	ENDOWMENT FUND 5	6	PLANT FUND 7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		16,859,488							1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		-1,370,690							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		15,488,798							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5 FUND BALANCE RECON								1	5
6									6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)								1	10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		15,488,799							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13									13
14									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)									18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		15,488,799							19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	8,215,000		8,215,000	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF				6
7 SKILLED NURSING FACILITY				7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	8,215,000		8,215,000	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				17
18 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	8,215,000		8,215,000	18
19 ANCILLARY SERVICES	21,348,501		21,348,501	19
20 OUTPATIENT SERVICES				20
21 RHC				21
22 FQHC				22
23 HOME HEALTH AGENCY				23
25 AMBULANCE				25
26 ASC				26
27 HOSPICE				27
28 OTHER (SPECIFY)				28
TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	29,563,501		29,563,501	

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		16,054,047	29
30 ADD (SPECIFY)			30
31			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37 **DEDUCT BAD DEBT EXPENSE**	-70,967		37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)		-70,967	42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		15,983,080	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	29,563,501	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	16,495,385	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	13,068,116	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	15,983,080	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-2,914,964	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS		7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	17,585	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	1,569	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (OTHER REVENUE)	184	24
24.01	OTHER (PHYSICIAN REVENUE)	1,453,120	24.01
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	1,472,458	25
26	TOTAL (LINE 5 PLUS LINE 25)	-1,442,506	26
27	OTHER EXPENSES (MANAGEMENT FEE)	682,346	27
27.01	OTHER EXPENSES (INTERCOMPANY INTEREST)	-17,706	27.01
27.02	OTHER EXPENSES (TAXES)	-736,454	27.02
27.03	OTHER EXPENSES (MISC)	-2	27.03
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	-71,816	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	-1,370,690	29