Sarah D Culbertson Memorial Hospital

Medicare Cost Report

Fiscal Year Ended 2.28.2013

McGladrey

Assurance ▪ Tax ▪ Consulting

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Falure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141333	Period: From 03/01/2012 To 02/28/2013	Worksheet S Parts I-III Date/Time Prepared: 7/23/2013 12:22 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 7/23/2013 Time: 12:22 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SARAH D CULBERTSON (141333) for the cost reporting period beginning 03/01/2012 and ending 02/28/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 7/23/2013 Time: 12:22 pm
Fh8IIlPefnGiXPO6SxD8j0lOcEfPU0
BZ5uj09rAg0dV:bdyzB3:Dn2t6QVjL
UXZ.05vqmR0ustt6

PI: Date: 7/23/2013 Time: 12:22 pm
WO3CFnd9C74PD5C0Mj1YxpK1UVz2.0
bc::T0EtFtq5SVc8u1SBm6yEuDQQ48
QnH.0dDJpw0O2y71

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

_____
Title

_____
Date

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	229,482	765,741	-12,510	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	320,022	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		-64,021		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	549,504	701,720	-12,510	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet S-2 Part I | Date/Time Prepared: 7/23/2013 12:21 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 238 SOUTH CONGRESS	PO Box:			1.00
2.00	City: RUSHVILLE	State: IL	Zip Code: 62681	County: SCHUYLER	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	SARAH D CULBERTSON	141333	99914	1	05/01/2004	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	SDCMH SWING BED- SNF	14Z333	99914		05/01/2004	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	ELMER HUGH TAYLOR CLINIC	143483	99914		10/01/2006	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	03/01/2012	02/28/2013	20.00
21.00	Type of Control (see instructions)	11		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N		22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet S-2 Part I Date/Time Prepared: 7/23/2013 12:21 pm

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME Average	Direct GME Average	
		1.00	2.00	3.00	
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)				
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings				
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N			63.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet S-2 Part I Date/Time Prepared: 7/23/2013 12:21 pm

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

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet S-2 Part I | Date/Time Prepared: 7/23/2013 12:21 pm

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N		0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	Y	N	109.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet S-2 Part I Date/Time Prepared: 7/23/2013 12:21 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	258,424	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N	145.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141333	Period: From 03/01/2012 To 02/28/2013	Worksheet S-2 Part I Date/Time Prepared: 7/23/2013 12:21 pm

							1.00	
	Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						605,497	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet S-2 Part II | Date/Time Prepared: 7/23/2013 12:21 pm

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

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

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

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	05/21/2013	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet S-2 Part II | Date/Time Prepared: 7/23/2013 12:21 pm

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KARRIE	PENCE	41.00
42.00	Enter the employer/company name of the cost report preparer.	MCGLADREY LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	816-751-1831	KARRIE.PENCE@MCGLADREY.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet S-2 Part II | Date/Time Prepared: 7/23/2013 12:21 pm

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)				16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	05/21/2013			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		SUPERVISOR		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet S-3 Part I Date/Time Prepared: 7/23/2013 12:21 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	25	9,125	15,472.00	0	1.00
2.00	HMO						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	15,472.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	15,472.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00	NURSING FACILITY	45.00	0	0		0	20.00
21.00	OTHER LONG TERM CARE	46.00	0	0			21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC	99.00				0	25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet S-3 Part I | Date/Time Prepared: 7/23/2013 12:21 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	479	41	631			1.00
2.00	HMO	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	628	0	691			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	60			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,107	41	1,382			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,107	41	1,382	0.00	132.82	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY		0	0	0.00	0.00	20.00
21.00	OTHER LONG TERM CARE			0	0.00	0.00	21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC	0	0	0	0.00	0.00	25.00
26.00	RURAL HEALTH CLINIC	4,091	0	13,264	0.00	23.22	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	156.04	27.00
28.00	Observation Bed Days		0	178			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			2			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet S-3 Part I | Date/Time Prepared: 7/23/2013 12:21 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)		0	130	13	183	1.00
2.00	HMO			0			2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	130	13	183	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY	0.00					20.00
21.00	OTHER LONG TERM CARE	0.00				0	21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC	0.00					25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

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

Provider CCN: 141333 Component CCN: 143483 | Period: From 03/01/2012 To 02/28/2013 | Worksheet S-8 | Date/Time Prepared: 7/23/2013 12:21 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	238 S. CONGRESS	1.00

		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	RUSHVILLE	IL	62681	2.00

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

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

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

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	17:00	08:00	11.00

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

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number	COMMUNITY MEDICAL CLINIC	143484	14.00
14.01		ELMER HUGH TAYLOR CLINIC	143483	14.01

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

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

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141333 Component CCN: 143483	Period: From 03/01/2012 To 02/28/2013	Worksheet S-8 Date/Time Prepared: 7/23/2013 12:21 pm
		Rural Health Clinic (RHC) I	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141333	Period: From 03/01/2012 To 02/28/2013	Worksheet S-10 Date/Time Prepared: 7/23/2013 12:21 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.556958	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,808,847	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	3,475,076	6.00
7.00	Medicaid cost (line 1 times line 6)	1,935,471	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	126,624	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	534,791	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	126,624	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	120,922	4,959	125,881	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	67,348	2,762	70,110	21.00
22.00	Partial payment by patients approved for charity care	9,893	1,719	11,612	22.00
23.00	Cost of charity care (line 21 minus line 22)	57,455	1,043	58,498	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	832,627	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	326,922	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	505,705	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	281,656	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	340,154	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	466,778	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet A | Date/Time Prepared: 7/23/2013 12:21 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		227,969	227,969	7,449	235,418	1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME		107,991	107,991	2,195	110,186	1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME		29,488	29,488	912	30,400	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		776,076	776,076	7,780	783,856	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	0	2,771,200	2,771,200	0	2,771,200	4.00
5.02	00511	BUSINESS OFFICE - HOSPITAL	178,300	59,509	237,809	0	237,809	5.02
5.04	00513	HOSPITAL ONLY ADMIN & GENERAL	313,863	185,536	499,399	0	499,399	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	589,383	1,210,835	1,800,218	-21,420	1,778,798	5.05
6.00	00600	MAINTENANCE & REPAIRS	174,595	139,027	313,622	0	313,622	6.00
7.00	00700	OPERATION OF PLANT	58,652	144,641	203,293	0	203,293	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	19,432	19,432	0	19,432	7.01
9.00	00900	HOUSEKEEPING	247,704	27,980	275,684	60,536	336,220	9.00
10.00	01000	DIETARY	280,248	267,910	548,158	0	548,158	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	93,514	8,265	101,779	15,271	117,050	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	286,443	47,884	334,327	0	334,327	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	735,596	278,748	1,014,344	55	1,014,399	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	181,126	118,322	299,448	-41,014	258,434	50.00
53.00	05300	ANESTHESIOLOGY	224,512	23,263	247,775	0	247,775	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	335,906	581,063	916,969	40,794	957,763	54.00
60.00	06000	LABORATORY	368,704	489,994	858,698	31,588	890,286	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	64,167	64,167	0	64,167	62.00
65.00	06500	RESPIRATORY THERAPY	24,811	45,167	69,978	0	69,978	65.00
66.00	06600	PHYSICAL THERAPY	335,030	49,340	384,370	-98,558	285,812	66.00
67.00	06700	OCCUPATIONAL THERAPY	192,821	0	192,821	74,225	267,046	67.00
68.00	06800	SPEECH PATHOLOGY	56,384	765	57,149	24,333	81,482	68.00
69.00	06900	ELECTROCARDIOLOGY	85,789	175,537	261,326	0	261,326	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	55,142	55,142	0	55,142	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,169	8,169	0	8,169	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	870,730	870,730	0	870,730	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,077,687	570,882	1,648,569	-109,918	1,538,651	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	141,309	890,903	1,032,212	20,011	1,052,223	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	544,956	52,466	597,422	-23,000	574,422	90.01
90.02	09002	GEROPSYCH	106,088	79,061	185,149	0	185,149	90.02
91.00	09100	EMERGENCY	452,310	1,751,026	2,203,336	5,677	2,209,013	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,085,731	12,128,488	19,214,219	-3,084	19,211,135	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	172,164	207,159	379,323	3,084	382,407	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	16,221	61,382	77,603	0	77,603	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118-199)	7,274,116	12,397,029	19,671,145	0	19,671,145	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet A | Date/Time Prepared: 7/23/2013 12:21 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	235,418		1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME	0	110,186		1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	30,400		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-219,758	564,098		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS	-558,401	2,212,799		4.00
5.02	00511	BUSINESS OFFICE - HOSPITAL	-10,422	227,387		5.02
5.04	00513	HOSPITAL ONLY ADMIN & GENERAL	-146,492	352,907		5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	-107,850	1,670,948		5.05
6.00	00600	MAINTENANCE & REPAIRS	-18,376	295,246		6.00
7.00	00700	OPERATION OF PLANT	-476	202,817		7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	19,432		7.01
9.00	00900	HOUSEKEEPING	0	336,220		9.00
10.00	01000	DIETARY	-119,270	428,888		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	117,050		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-16,177	318,150		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,014,399		30.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
45.00	04500	NURSING FACILITY	0	0		45.00
46.00	04600	OTHER LONG TERM CARE	0	0		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-28,119	230,315		50.00
53.00	05300	ANESTHESIOLOGY	0	247,775		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	957,763		54.00
60.00	06000	LABORATORY	0	890,286		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	64,167		62.00
65.00	06500	RESPIRATORY THERAPY	0	69,978		65.00
66.00	06600	PHYSICAL THERAPY	0	285,812		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	267,046		67.00
68.00	06800	SPEECH PATHOLOGY	0	81,482		68.00
69.00	06900	ELECTROCARDIOLOGY	-37,282	224,044		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	55,142		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,169		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	870,730		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-36,867	1,501,784		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	-481,852	570,371		90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	-395,553	178,869		90.01
90.02	09002	GEROPSYCH	0	185,149		90.02
91.00	09100	EMERGENCY	-273,601	1,935,412		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
99.00	09900	CMHC	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,450,496	16,760,639		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	CULBERTSON GARDENS	-30,052	352,355		194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0		194.01
194.02	07952	FOUNDATION	0	77,603		194.02
194.03	07953	OUTPATIENT MEALS	0	0		194.03
194.04	07954	VACANT SPACE	0	0		194.04
200.00		TOTAL (SUM OF LINES 118-199)	-2,480,548	17,190,597		200.00

RECLASSIFICATIONS | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet A-6 | Date/Time Prepared: 7/23/2013 12:21 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	18,336	1.00
2.00	CULBERTSON GARDENS	194.00	0	3,084	2.00
	TOTALS		0	21,420	
	B - CLIENT/ER/INF CNTR/MED SURG SALARIES				
1.00	NURSING ADMINISTRATION	13.00	15,271	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	55	0	2.00
3.00	CLINIC	90.00	20,011	0	3.00
4.00	EMERGENCY	91.00	5,677	0	4.00
	TOTALS		41,014	0	
	C - RHC PHYSICIAN EXPENSE				
1.00	RURAL HEALTH CLINIC	88.00	23,000	0	1.00
	TOTALS		23,000	0	
	D - RHC EXPENSES				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	40,794	0	1.00
2.00	LABORATORY	60.00	31,588	0	2.00
3.00	HOUSEKEEPING	9.00	51,776	8,760	3.00
	TOTALS		124,158	8,760	
	E - THERAPY RECLASS				
1.00	OCCUPATIONAL THERAPY	67.00	57,302	16,923	1.00
2.00	SPEECH PATHOLOGY	68.00	18,785	5,548	2.00
	TOTALS		76,087	22,471	
500.00	Grand Total: Increases		264,259	52,651	500.00

RECLASSIFICATIONS | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet A-6 | Date/Time Prepared: 7/23/2013 12:21 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - PROPERTY INSURANCE					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	21,420	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	21,420		
	B - CLIENT/ER/INF CNTR/MED SURG SALARIES					
1.00	OPERATING ROOM	50.00	41,014	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
	TOTALS		41,014	0		
	C - RHC PHYSICIAN EXPENSE					
1.00	RUSHVILLE FAMILY CLINIC	90.01	23,000	0	0	1.00
	TOTALS		23,000	0		
	D - RHC EXPENSES					
1.00	RURAL HEALTH CLINIC	88.00	124,158	8,760	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		124,158	8,760		
	E - THERAPY RECLASS					
1.00	PHYSICAL THERAPY	66.00	76,087	22,471	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		76,087	22,471		
500.00	Grand Total: Decreases		264,259	52,651		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet A-7 Part I | Date/Time Prepared: 7/23/2013 12:21 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	332,648	93,443	0	93,443	14,939	1.00
2.00	Land Improvements	719,040	218,936	0	218,936	0	2.00
3.00	Buildings and Fixtures	8,989,246	246,894	0	246,894	107,812	3.00
4.00	Building Improvements	165,650	531,892	0	531,892	636,075	4.00
5.00	Fixed Equipment	129,018	26,121	0	26,121	0	5.00
6.00	Movable Equipment	5,778,071	445,832	0	445,832	106,355	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	16,113,673	1,563,118	0	1,563,118	865,181	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	16,113,673	1,563,118	0	1,563,118	865,181	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	411,152	0	1.00
2.00	Land Improvements	937,976	0	2.00
3.00	Buildings and Fixtures	9,128,328	0	3.00
4.00	Building Improvements	61,467	0	4.00
5.00	Fixed Equipment	155,139	0	5.00
6.00	Movable Equipment	6,117,548	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	16,811,610	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	16,811,610	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet A-7 Part II | Date/Time Prepared: 7/23/2013 12:21 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	216,923	11,046	0	0	0	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	98,391	9,600	0	0	0	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	29,488	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	697,255	78,821	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,042,057	99,467	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	227,969	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	0	107,991	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	29,488	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	776,076	2.00
3.00	Total (sum of lines 1-2)	0	1,141,524	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet A-7 Part III Date/Time Prepared: 7/23/2013 12:21 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	5,479,835	0	5,479,835	0.406277	7,449	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	1,614,446	0	1,614,446	0.119696	2,195	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	670,510	0	670,510	0.049712	912	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	5,723,134	0	5,723,134	0.424315	7,780	2.00
3.00	Total (sum of lines 1-2)	13,487,925	0	13,487,925	1.000000	18,336	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	7,449	216,923	11,046	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	0	0	2,195	98,391	9,600	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	0	912	29,488	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	7,780	477,497	78,821	2.00
3.00	Total (sum of lines 1-2)	0	0	18,336	822,299	99,467	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	7,449	0	0	235,418	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	0	2,195	0	0	110,186	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	912	0	0	30,400	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	7,780	0	0	564,098	2.00
3.00	Total (sum of lines 1-2)	0	18,336	0	0	940,102	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet A-8 | Date/Time Prepared: 7/23/2013 12:21 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP REL COSTS-RHCS BLDG/MME (chapter 2)		0	NEW CAP REL COSTS-RHCS BLDG/MME	1.01	0	1.01
1.02	Investment income - NEW CAP REL COSTS-MED ARTS BLDG/MME (chapter 2)		0	NEW CAP REL COSTS-MED ARTS BLDG/MME	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-36,943	HOSPITAL ONLY ADMIN & GENERAL	5.04	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-3,070	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-5,676	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	7.00
8.00	Television and radio service (chapter 21)	A	-476	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,216,650			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-118,953	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-10,383	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-317	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-RHCS BLDG/MME		0	NEW CAP REL COSTS-RHCS BLDG/MME	1.01	0	26.01
26.02	Depreciation - NEW CAP REL COSTS-MED ARTS BLDG/MME		0	NEW CAP REL COSTS-MED ARTS BLDG/MME	1.02	0	26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet A-8 | Date/Time Prepared: 7/23/2013 12:21 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-218,314	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	INTEREST INCOME	B	-26,254	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.00
33.01	INTEREST INCOME	B	-30,052	CULBERTSON GARDENS	194.00	0	33.01
33.02	OPC RENT	B	-55,106	HOSPITAL ONLY ADMIN & GENERAL	5.04	0	33.02
33.03	MISCELLANEOUS INCOME	B	-35,496	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.03
33.04	MARKETING SALARY EXPENSE	A	-14,513	HOSPITAL ONLY ADMIN & GENERAL	5.04	0	33.04
33.05	MARKETING BENEFITS EXPENSE	A	-5,529	EMPLOYEE BENEFITS	4.00	0	33.05
33.06	MARKETING OTHER EXPENSE	A	-80,347	HOSPITAL ONLY ADMIN & GENERAL	5.04	0	33.06
33.07	MARKETING OTHER EXPENSE	A	-14,219	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.07
33.08	MARKETING OTHER EXPENSE	A	-16,374	RURAL HEALTH CLINIC	88.00	0	33.08
33.09	MARKETING OTHER EXPENSE	A	-1,444	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.09
33.10	LOBBYING PORTION OF DUES	A	-8,720	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.10
33.11	HEALTHLINK ADMINISTRATIVE FEES	A	40,417	HOSPITAL ONLY ADMIN & GENERAL	5.04	0	33.11
33.12	SELF INSURANCE OFFSET	A	-548,901	EMPLOYEE BENEFITS	4.00	0	33.12
33.13	PART B PHYSICIAN BILLING SALARIES	A	-10,422	BUSINESS OFFICE - HOSPITAL	5.02	0	33.13
33.14	PART B PHYSICIAN BILLING EMP BENEFIT	A	-3,971	EMPLOYEE BENEFITS	4.00	0	33.14
33.15	NONALLOWABLE COSTS-FISCAL SERVICES	A	-6,002	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.15
33.16	NON-RHC PHYSICIAN ASSISTANT SALARIES	A	-5,732	RURAL HEALTH CLINIC	88.00	0	33.16
33.17	MARKETING OTHER EXPENSE	A	-9,873	RUSHVILLE FAMILY CLINIC	90.01	0	33.17
33.18	NON-RHC NURSE PRACTITIONER SALARIES	A	-4,645	RURAL HEALTH CLINIC	88.00	0	33.18
33.19	PATIENT COLLECTION FEES	B	-7,002	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.19
33.20	SPECIAL ASSESSMENTS ASBESTOS COSTS A	A	4,594	MAINTENANCE & REPAIRS	6.00	0	33.20
33.21	SPECIAL ASSESSMENTS ASBESTOS COSTS	A	-22,970	MAINTENANCE & REPAIRS	6.00	0	33.21
33.22	CHARITABLE CONTRIBUTIONS	A	-1,411	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.22
33.23	EHR EXPENSED ASSETS	A	-5,794	MEDICAL RECORDS & LIBRARY	16.00	0	33.23
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,480,548				50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet A-8-2 | Date/Time Prepared: 7/23/2013 12:21 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	28,119	28,119	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	12,000	0	12,000	0	0	2.00
3.00	60.00	LABORATORY	15,600	0	15,600	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	6,000	0	6,000	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	37,282	37,282	0	0	0	5.00
6.00	90.00	CLINIC	225,000	225,000	0	0	0	6.00
7.00	90.00	CLINIC	200,000	200,000	0	0	0	7.00
8.00	90.00	CLINIC	6,708	0	6,708	0	0	8.00
9.00	90.00	CLINIC	56,852	56,852	0	0	0	9.00
10.00	91.00	EMERGENCY	1,694,561	273,601	1,420,960	0	0	10.00
11.00	88.00	RURAL HEALTH CLINIC	10,116	10,116	0	0	0	11.00
12.00	90.01	RUSHVILLE FAMILY CLINIC	385,680	385,680	0	0	0	12.00
200.00			2,677,918	1,216,650	1,461,268		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	90.00	CLINIC	0	0	0	0	0	7.00
8.00	90.00	CLINIC	0	0	0	0	0	8.00
9.00	90.00	CLINIC	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
11.00	88.00	RURAL HEALTH CLINIC	0	0	0	0	0	11.00
12.00	90.01	RUSHVILLE FAMILY CLINIC	0	0	0	0	0	12.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	50.00	OPERATING ROOM	0	0	0	28,119		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	37,282		5.00
6.00	90.00	CLINIC	0	0	0	225,000		6.00
7.00	90.00	CLINIC	0	0	0	200,000		7.00
8.00	90.00	CLINIC	0	0	0	0		8.00
9.00	90.00	CLINIC	0	0	0	56,852		9.00
10.00	91.00	EMERGENCY	0	0	0	273,601		10.00
11.00	88.00	RURAL HEALTH CLINIC	0	0	0	10,116		11.00
12.00	90.01	RUSHVILLE FAMILY CLINIC	0	0	0	385,680		12.00
200.00			0	0	0	1,216,650		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 7/23/2013 12:21 pm

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					3	1.00
2.00	Line 1 multiplied by 15 hours per week					45	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					2	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.65	7.00
8.00	Optional travel expense rate per mile					0.57	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	17.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	83.88	67.11	50.33	33.55	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	33.56	33.56	25.17			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					1,141	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					1,141	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					1,141	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					67.12	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					3,020	22.00
23.00	Total salary equivalency (see instructions)					3,020	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					67	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					67	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					11	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					78	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					78	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					11	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 7/23/2013 12:21 pm

Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	67.11	50.33	33.55	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	3,020		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	78		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	3,098		63.00
64.00	Total cost of outside supplier services (from your records)	765		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	67		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	11		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	78		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	11		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	11		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet B Part I Date/Time Prepared: 7/23/2013 12:21 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	NEW RHCS BLDG/MME	NEW MED ARTS BLDG/MME	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	235,418	235,418				1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME	110,186	0	110,186			1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME	30,400	0	0	30,400		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	564,098				564,098	2.00
4.00	00400	EMPLOYEE BENEFITS	2,212,799	0	0	0	0	4.00
5.02	00511	BUSINESS OFFICE - HOSPITAL	227,387	0	0	0	0	5.02
5.04	00513	HOSPITAL ONLY ADMIN & GENERAL	352,907	13,992	0	0	33,526	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	1,670,948	20,744	0	0	49,707	5.05
6.00	00600	MAINTENANCE & REPAIRS	295,246	23,186	0	0	55,557	6.00
7.00	00700	OPERATION OF PLANT	202,817	0	0	0	0	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	19,432	0	0	0	0	7.01
9.00	00900	HOUSEKEEPING	336,220	9,425	0	0	22,583	9.00
10.00	01000	DIETARY	428,888	11,806	0	0	28,290	10.00
11.00	01100	CAFETERIA	0	4,034	0	0	9,665	11.00
13.00	01300	NURSING ADMINISTRATION	117,050	512	0	0	1,227	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	318,150	10,342	0	0	24,782	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,014,399	25,546	0	0	61,213	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	230,315	15,848	0	0	37,975	50.00
53.00	05300	ANESTHESIOLOGY	247,775	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	957,763	13,458	0	0	32,248	54.00
60.00	06000	LABORATORY	890,286	6,172	0	0	14,789	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	64,167	427	0	0	1,023	62.00
65.00	06500	RESPIRATORY THERAPY	69,978	3,227	0	0	7,732	65.00
66.00	06600	PHYSICAL THERAPY	285,812	7,401	0	0	17,735	66.00
67.00	06700	OCCUPATIONAL THERAPY	267,046	3,304	0	0	7,916	67.00
68.00	06800	SPEECH PATHOLOGY	81,482	1,993	0	0	4,776	68.00
69.00	06900	ELECTROCARDIOLOGY	224,044	1,076	0	0	2,577	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	55,142	7,094	0	0	16,998	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,169	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	870,730	2,949	0	0	7,067	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,501,784	0	110,186	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	570,371	33,243	0	0	79,654	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	178,869	0	0	23,609	0	90.01
90.02	09002	GEROPSYCH	185,149	9,711	0	0	23,268	90.02
91.00	09100	EMERGENCY	1,935,412	9,928	0	0	23,790	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,760,639	235,418	110,186	23,609	564,098	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	352,355	0	0	0	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	6,791	0	194.01
194.02	07952	FOUNDATION	77,603	0	0	0	0	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	17,190,597	235,418	110,186	30,400	564,098	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet B Part I Date/Time Prepared: 7/23/2013 12:21 pm

		Cost Center Description	EMPLOYEE BENEFITS	BUSINESS OFFICE - HOSPITAL	Subtotal	HOSPITAL ONLY ADMIN & GENERAL	Subtotal	
			4.00	5.02	5A.02	5.04	5A.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	2,212,799					4.00
5.02	00511	BUSINESS OFFICE - HOSPITAL	53,861	281,248				5.02
5.04	00513	HOSPITAL ONLY ADMIN & GENERAL	96,042	0	496,467	496,467		5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	189,096	0	1,930,495	59,174	1,989,669	5.05
6.00	00600	MAINTENANCE & REPAIRS	56,017	0	430,006	13,181	443,187	6.00
7.00	00700	OPERATION OF PLANT	18,818	0	221,635	6,794	228,429	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	19,432	596	20,028	7.01
9.00	00900	HOUSEKEEPING	96,084	0	464,312	14,232	478,544	9.00
10.00	01000	DIETARY	89,914	0	558,898	17,131	576,029	10.00
11.00	01100	CAFETERIA	0	0	13,699	420	14,119	11.00
13.00	01300	NURSING ADMINISTRATION	34,902	0	153,691	4,711	158,402	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	91,902	0	445,176	13,646	458,822	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	236,024	13,857	1,351,039	41,412	1,392,451	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	44,953	15,281	344,372	10,556	354,928	50.00
53.00	05300	ANESTHESIOLOGY	72,032	4,744	324,551	9,948	334,499	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	117,906	67,866	1,189,241	36,453	1,225,694	54.00
60.00	06000	LABORATORY	131,382	53,398	1,096,027	33,595	1,129,622	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,159	66,776	2,047	68,823	62.00
65.00	06500	RESPIRATORY THERAPY	7,960	1,836	90,733	2,781	93,514	65.00
66.00	06600	PHYSICAL THERAPY	83,078	13,344	407,370	12,487	419,857	66.00
67.00	06700	OCCUPATIONAL THERAPY	80,249	8,270	366,785	11,243	378,028	67.00
68.00	06800	SPEECH PATHOLOGY	24,117	2,247	114,615	3,513	118,128	68.00
69.00	06900	ELECTROCARDIOLOGY	27,524	17,126	272,347	8,348	280,695	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,758	81,992	2,513	84,505	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	222	8,391	257	8,648	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,606	906,352	27,782	934,134	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	309,975	14,963	1,936,908	59,370	1,996,278	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	51,757	14,885	749,910	22,986	772,896	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	57,789	2,279	262,546	8,048	270,594	90.01
90.02	09002	GEROPSYCH	34,037	2,186	254,351	7,796	262,147	90.02
91.00	09100	EMERGENCY	146,939	19,221	2,135,290	65,447	2,200,737	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,152,358	281,248	16,693,407	496,467	16,693,407	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	55,237	0	407,592	0	407,592	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	6,791	0	6,791	194.01
194.02	07952	FOUNDATION	5,204	0	82,807	0	82,807	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments			0		0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,212,799	281,248	17,190,597	496,467	17,190,597	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet B Part I Date/Time Prepared: 7/23/2013 12:21 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	PLANT & HOUSEKEEPING-RHC	HOUSEKEEPING	
			5.05	6.00	7.00	7.01	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.02	00511	BUSINESS OFFICE - HOSPITAL						5.02
5.04	00513	HOSPITAL ONLY ADMIN & GENERAL						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	1,989,669					5.05
6.00	00600	MAINTENANCE & REPAIRS	58,009	501,196				6.00
7.00	00700	OPERATION OF PLANT	29,899	0	258,328			7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	2,621	0	0	22,649		7.01
9.00	00900	HOUSEKEEPING	62,637	26,612	13,717	0	581,510	9.00
10.00	01000	DIETARY	75,397	33,338	17,183	0	40,849	10.00
11.00	01100	CAFETERIA	1,848	11,390	5,871	0	13,956	11.00
13.00	01300	NURSING ADMINISTRATION	20,733	1,446	745	0	1,772	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	60,056	29,203	15,052	0	35,783	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	182,259	72,135	37,180	0	88,387	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	46,457	44,751	23,066	0	54,834	50.00
53.00	05300	ANESTHESIOLOGY	43,783	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	160,432	38,002	19,587	0	46,564	54.00
60.00	06000	LABORATORY	147,857	17,428	8,983	0	21,355	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	9,008	1,205	621	0	1,477	62.00
65.00	06500	RESPIRATORY THERAPY	12,240	9,112	4,696	0	11,165	65.00
66.00	06600	PHYSICAL THERAPY	54,956	20,899	10,772	0	25,608	66.00
67.00	06700	OCCUPATIONAL THERAPY	49,480	9,329	4,808	0	11,431	67.00
68.00	06800	SPEECH PATHOLOGY	15,462	5,629	2,901	0	6,897	68.00
69.00	06900	ELECTROCARDIOLOGY	36,740	3,037	1,565	0	3,722	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,061	20,031	10,325	0	24,545	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,132	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	122,270	8,328	4,293	0	10,205	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	261,295	0	0	22,649	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	101,165	93,867	48,380	0	115,011	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	35,418	0	0	0	0	90.01
90.02	09002	GEROPSYCH	34,313	27,420	14,133	0	33,598	90.02
91.00	09100	EMERGENCY	288,063	28,034	14,450	0	34,351	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,924,591	501,196	258,328	22,649	581,510	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	53,350	0	0	0	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	889	0	0	0	0	194.01
194.02	07952	FOUNDATION	10,839	0	0	0	0	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,989,669	501,196	258,328	22,649	581,510	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet B Part I Date/Time Prepared: 7/23/2013 12:21 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	
			10.00	11.00	13.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.02	00511	BUSINESS OFFICE - HOSPITAL						5.02
5.04	00513	HOSPITAL ONLY ADMIN & GENERAL						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC						7.01
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	742,796					10.00
11.00	01100	CAFETERIA	384,805	431,989				11.00
13.00	01300	NURSING ADMINISTRATION	0	7,690	190,788			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	48,098	0	647,014		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	104,136	102,197	93,169	150,939	2,222,853	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	15,025	13,681	0	552,742	50.00
53.00	05300	ANESTHESIOLOGY	0	9,957	0	0	388,239	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	46,319	0	44,654	1,581,252	54.00
60.00	06000	LABORATORY	0	53,565	0	42,328	1,421,138	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	81,134	62.00
65.00	06500	RESPIRATORY THERAPY	0	2,978	2,711	16,280	152,696	65.00
66.00	06600	PHYSICAL THERAPY	0	33,784	0	23,490	589,366	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	16,670	0	0	469,746	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,290	0	0	154,307	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,002	9,103	12,094	356,958	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	150,467	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	9,780	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,079,230	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	182,568	2,462,790	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	22,537	20,549	58,608	1,233,013	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	0	0	0	306,012	90.01
90.02	09002	GEROPSYCH	0	1,289	0	0	372,900	90.02
91.00	09100	EMERGENCY	0	56,588	51,575	116,053	2,789,851	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	488,941	431,989	190,788	647,014	16,374,474	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	224,320	0	0	0	685,262	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	7,680	194.01
194.02	07952	FOUNDATION	0	0	0	0	93,646	194.02
194.03	07953	OUTPATIENT MEALS	29,535	0	0	0	29,535	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	742,796	431,989	190,788	647,014	17,190,597	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet B Part I | Date/Time Prepared: 7/23/2013 12:21 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME				1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME				1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS				4.00
5.02	00511	BUSINESS OFFICE - HOSPITAL				5.02
5.04	00513	HOSPITAL ONLY ADMIN & GENERAL				5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL				5.05
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC				7.01
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,222,853		30.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
45.00	04500	NURSING FACILITY	0	0		45.00
46.00	04600	OTHER LONG TERM CARE	0	0		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	552,742		50.00
53.00	05300	ANESTHESIOLOGY	0	388,239		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,581,252		54.00
60.00	06000	LABORATORY	0	1,421,138		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	81,134		62.00
65.00	06500	RESPIRATORY THERAPY	0	152,696		65.00
66.00	06600	PHYSICAL THERAPY	0	589,366		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	469,746		67.00
68.00	06800	SPEECH PATHOLOGY	0	154,307		68.00
69.00	06900	ELECTROCARDIOLOGY	0	356,958		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	150,467		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,780		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,079,230		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	2,462,790		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	1,233,013		90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	306,012		90.01
90.02	09002	GEROPSYCH	0	372,900		90.02
91.00	09100	EMERGENCY	0	2,789,851		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
99.00	09900	CMHC	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	16,374,474		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	CULBERTSON GARDENS	0	685,262		194.00
194.01	07951	MEDICAL ARTS BUILDING	0	7,680		194.01
194.02	07952	FOUNDATION	0	93,646		194.02
194.03	07953	OUTPATIENT MEALS	0	29,535		194.03
194.04	07954	VACANT SPACE	0	0		194.04
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	17,190,597		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet B Part II Date/Time Prepared: 7/23/2013 12:21 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	NEW RHCS BLDG/MME	NEW MED ARTS BLDG/MME	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0	0	0	0	0	4.00
5.02	00511	BUSINESS OFFICE - HOSPITAL	0	0	0	0	0	5.02
5.04	00513	HOSPITAL ONLY ADMIN & GENERAL	0	13,992	0	0	33,526	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	0	20,744	0	0	49,707	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	23,186	0	0	55,557	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	0	0	0	7.01
9.00	00900	HOUSEKEEPING	0	9,425	0	0	22,583	9.00
10.00	01000	DIETARY	0	11,806	0	0	28,290	10.00
11.00	01100	CAFETERIA	0	4,034	0	0	9,665	11.00
13.00	01300	NURSING ADMINISTRATION	0	512	0	0	1,227	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,342	0	0	24,782	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	25,546	0	0	61,213	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	15,848	0	0	37,975	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,458	0	0	32,248	54.00
60.00	06000	LABORATORY	0	6,172	0	0	14,789	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	427	0	0	1,023	62.00
65.00	06500	RESPIRATORY THERAPY	0	3,227	0	0	7,732	65.00
66.00	06600	PHYSICAL THERAPY	0	7,401	0	0	17,735	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,304	0	0	7,916	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,993	0	0	4,776	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,076	0	0	2,577	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,094	0	0	16,998	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,949	0	0	7,067	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	110,186	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	33,243	0	0	79,654	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	0	0	23,609	0	90.01
90.02	09002	GEROPSYCH	0	9,711	0	0	23,268	90.02
91.00	09100	EMERGENCY	0	9,928	0	0	23,790	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	235,418	110,186	23,609	564,098	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0	0	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	6,791	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	235,418	110,186	30,400	564,098	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet B Part II Date/Time Prepared: 7/23/2013 12:21 pm

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS	BUSINESS OFFICE - HOSPITAL	HOSPITAL ONLY ADMIN & GENERAL	OTHER ADMINISTRATIVE AND GENERAL	
			2A	4.00	5.02	5.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0	0				4.00
5.02	00511	BUSINESS OFFICE - HOSPITAL	0	0	0			5.02
5.04	00513	HOSPITAL ONLY ADMIN & GENERAL	47,518	0	0	47,518		5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	70,451	0	0	5,664	76,115	5.05
6.00	00600	MAINTENANCE & REPAIRS	78,743	0	0	1,262	2,219	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	650	1,144	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	0	57	100	7.01
9.00	00900	HOUSEKEEPING	32,008	0	0	1,362	2,396	9.00
10.00	01000	DIETARY	40,096	0	0	1,640	2,884	10.00
11.00	01100	CAFETERIA	13,699	0	0	40	71	11.00
13.00	01300	NURSING ADMINISTRATION	1,739	0	0	451	793	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	35,124	0	0	1,306	2,297	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	86,759	0	0	3,964	6,972	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	53,823	0	0	1,010	1,777	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	952	1,675	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	45,706	0	0	3,489	6,137	54.00
60.00	06000	LABORATORY	20,961	0	0	3,216	5,656	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,450	0	0	196	345	62.00
65.00	06500	RESPIRATORY THERAPY	10,959	0	0	266	468	65.00
66.00	06600	PHYSICAL THERAPY	25,136	0	0	1,195	2,102	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,220	0	0	1,076	1,893	67.00
68.00	06800	SPEECH PATHOLOGY	6,769	0	0	336	591	68.00
69.00	06900	ELECTROCARDIOLOGY	3,653	0	0	799	1,405	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	24,092	0	0	241	423	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	25	43	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,016	0	0	2,659	4,677	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	110,186	0	0	5,683	9,995	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	112,897	0	0	2,200	3,870	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	23,609	0	0	770	1,355	90.01
90.02	09002	GEROPSYCH	32,979	0	0	746	1,313	90.02
91.00	09100	EMERGENCY	33,718	0	0	6,263	11,024	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	933,311	0	0	47,518	73,625	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0	0	2,041	194.00
194.01	07951	MEDICAL ARTS BUILDING	6,791	0	0	0	34	194.01
194.02	07952	FOUNDATION	0	0	0	0	415	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	940,102	0	0	47,518	76,115	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet B Part II | Date/Time Prepared: 7/23/2013 12:21 pm

		Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	PLANT & HOUSEKEEPING-RHC	HOUSEKEEPING	DIETARY	
			6.00	7.00	7.01	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.02	00511	BUSINESS OFFICE - HOSPITAL						5.02
5.04	00513	HOSPITAL ONLY ADMIN & GENERAL						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS	82,224					6.00
7.00	00700	OPERATION OF PLANT	0	1,794				7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	157			7.01
9.00	00900	HOUSEKEEPING	4,366	95	0	40,227		9.00
10.00	01000	DIETARY	5,469	119	0	2,826	53,034	10.00
11.00	01100	CAFETERIA	1,869	41	0	965	27,474	11.00
13.00	01300	NURSING ADMINISTRATION	237	5	0	123	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,791	105	0	2,475	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,834	258	0	6,114	7,435	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,342	160	0	3,793	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,234	136	0	3,221	0	54.00
60.00	06000	LABORATORY	2,859	62	0	1,477	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	198	4	0	102	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,495	33	0	772	0	65.00
66.00	06600	PHYSICAL THERAPY	3,429	75	0	1,771	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,530	33	0	791	0	67.00
68.00	06800	SPEECH PATHOLOGY	923	20	0	477	0	68.00
69.00	06900	ELECTROCARDIOLOGY	498	11	0	257	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,286	72	0	1,698	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,366	30	0	706	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	157	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	15,401	337	0	7,959	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	0	0	0	0	90.01
90.02	09002	GEROPSYCH	4,498	98	0	2,324	0	90.02
91.00	09100	EMERGENCY	4,599	100	0	2,376	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	82,224	1,794	157	40,227	34,909	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0	0	16,016	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	2,109	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	82,224	1,794	157	40,227	53,034	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet B Part II Date/Time Prepared: 7/23/2013 12:21 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.02	00511	BUSINESS OFFICE - HOSPITAL						5.02
5.04	00513	HOSPITAL ONLY ADMIN & GENERAL						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC						7.01
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	44,159					11.00
13.00	01300	NURSING ADMINISTRATION	786	4,134				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,917	0	51,015			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,446	2,019	11,901	147,702	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,536	296	0	69,737	0	50.00
53.00	05300	ANESTHESIOLOGY	1,018	0	0	3,645	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,735	0	3,521	73,179	0	54.00
60.00	06000	LABORATORY	5,476	0	3,337	43,044	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	2,295	0	62.00
65.00	06500	RESPIRATORY THERAPY	304	59	1,284	15,640	0	65.00
66.00	06600	PHYSICAL THERAPY	3,453	0	1,852	39,013	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,704	0	0	18,247	0	67.00
68.00	06800	SPEECH PATHOLOGY	541	0	0	9,657	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,022	197	954	8,796	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	29,812	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	68	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	19,454	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	14,395	140,416	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	2,304	445	4,621	150,034	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	0	0	25,734	0	90.01
90.02	09002	GEROPSYCH	132	0	0	42,090	0	90.02
91.00	09100	EMERGENCY	5,785	1,118	9,150	74,133	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	44,159	4,134	51,015	912,696	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0	18,057	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	6,825	0	194.01
194.02	07952	FOUNDATION	0	0	0	415	0	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	2,109	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	44,159	4,134	51,015	940,102	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet B Part II | Date/Time Prepared: 7/23/2013 12:21 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME			1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS			4.00
5.02	00511	BUSINESS OFFICE - HOSPITAL			5.02
5.04	00513	HOSPITAL ONLY ADMIN & GENERAL			5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL			5.05
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC			7.01
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	147,702		30.00
44.00	04400	SKILLED NURSING FACILITY	0		44.00
45.00	04500	NURSING FACILITY	0		45.00
46.00	04600	OTHER LONG TERM CARE	0		46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	69,737		50.00
53.00	05300	ANESTHESIOLOGY	3,645		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	73,179		54.00
60.00	06000	LABORATORY	43,044		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,295		62.00
65.00	06500	RESPIRATORY THERAPY	15,640		65.00
66.00	06600	PHYSICAL THERAPY	39,013		66.00
67.00	06700	OCCUPATIONAL THERAPY	18,247		67.00
68.00	06800	SPEECH PATHOLOGY	9,657		68.00
69.00	06900	ELECTROCARDIOLOGY	8,796		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	29,812		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	68		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,454		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	140,416		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		89.00
90.00	09000	CLINIC	150,034		90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	25,734		90.01
90.02	09002	GEROPSYCH	42,090		90.02
91.00	09100	EMERGENCY	74,133		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
99.00	09900	CMHC	0		99.00
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	912,696		118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
194.00	07950	CULBERTSON GARDENS	18,057		194.00
194.01	07951	MEDICAL ARTS BUILDING	6,825		194.01
194.02	07952	FOUNDATION	415		194.02
194.03	07953	OUTPATIENT MEALS	2,109		194.03
194.04	07954	VACANT SPACE	0		194.04
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	940,102		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet B-1 | Date/Time Prepared: 7/23/2013 12:21 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW RHCS BLDG/MME (SQUARE FEET)	NEW MED ARTS BLDG/MME (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIE)	
			1.00	1.01	1.02	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	55,154					1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME	0	11,800				1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	0	9,400			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				55,154		2.00
4.00	00400	EMPLOYEE BENEFITS	0	0	0	0	6,896,964	4.00
5.02	00511	BUSINESS OFFICE - HOSPITAL	0	0	0	0	167,877	5.02
5.04	00513	HOSPITAL ONLY ADMIN & GENERAL	3,278	0	0	3,278	299,349	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	4,860	0	0	4,860	589,383	5.05
6.00	00600	MAINTENANCE & REPAIRS	5,432	0	0	5,432	174,595	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	58,652	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	0	0	0	7.01
9.00	00900	HOUSEKEEPING	2,208	0	0	2,208	299,480	9.00
10.00	01000	DIETARY	2,766	0	0	2,766	280,248	10.00
11.00	01100	CAFETERIA	945	0	0	945	0	11.00
13.00	01300	NURSING ADMINISTRATION	120	0	0	120	108,785	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,423	0	0	2,423	286,443	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,985	0	0	5,985	735,651	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,713	0	0	3,713	140,111	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	224,512	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,153	0	0	3,153	367,494	54.00
60.00	06000	LABORATORY	1,446	0	0	1,446	409,498	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	100	0	0	100	0	62.00
65.00	06500	RESPIRATORY THERAPY	756	0	0	756	24,811	65.00
66.00	06600	PHYSICAL THERAPY	1,734	0	0	1,734	258,943	66.00
67.00	06700	OCCUPATIONAL THERAPY	774	0	0	774	250,123	67.00
68.00	06800	SPEECH PATHOLOGY	467	0	0	467	75,169	68.00
69.00	06900	ELECTROCARDIOLOGY	252	0	0	252	85,789	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,662	0	0	1,662	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	691	0	0	691	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	11,800	0	0	966,152	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	7,788	0	0	7,788	161,320	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	0	7,300	0	180,119	90.01
90.02	09002	GEROPSYCH	2,275	0	0	2,275	106,088	90.02
91.00	09100	EMERGENCY	2,326	0	0	2,326	457,987	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	55,154	11,800	7,300	55,154	6,708,579	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0	0	172,164	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	2,100	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	16,221	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	235,418	110,186	30,400	564,098	2,212,799	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.268376	9.337797	3.234043	10.227690	0.320837	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet B-1 | Date/Time Prepared: 7/23/2013 12:21 pm

		Cost Center Description	BUSINESS OFFICE - HOSPITAL (GROSS CHARGES)	Reconciliation	HOSPITAL ONLY ADMIN & GENERAL (ACCUM. COST)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			5.02	5A.04	5.04	5A.05	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.02	00511	BUSINESS OFFICE - HOSPITAL	29,399,837					5.02
5.04	00513	HOSPITAL ONLY ADMIN & GENERAL	0	-496,467	16,196,940			5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	0	0	1,930,495	-1,989,669	15,200,928	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	430,006	0	443,187	6.00
7.00	00700	OPERATION OF PLANT	0	0	221,635	0	228,429	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	19,432	0	20,028	7.01
9.00	00900	HOUSEKEEPING	0	0	464,312	0	478,544	9.00
10.00	01000	DIETARY	0	0	558,898	0	576,029	10.00
11.00	01100	CAFETERIA	0	0	13,699	0	14,119	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	153,691	0	158,402	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	445,176	0	458,822	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,448,562	0	1,351,039	0	1,392,451	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,597,417	0	344,372	0	354,928	50.00
53.00	05300	ANESTHESIOLOGY	495,900	0	324,551	0	334,499	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,093,697	0	1,189,241	0	1,225,694	54.00
60.00	06000	LABORATORY	5,582,025	0	1,096,027	0	1,129,622	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	121,134	0	66,776	0	68,823	62.00
65.00	06500	RESPIRATORY THERAPY	191,969	0	90,733	0	93,514	65.00
66.00	06600	PHYSICAL THERAPY	1,394,953	0	407,370	0	419,857	66.00
67.00	06700	OCCUPATIONAL THERAPY	864,471	0	366,785	0	378,028	67.00
68.00	06800	SPEECH PATHOLOGY	234,897	0	114,615	0	118,128	68.00
69.00	06900	ELECTROCARDIOLOGY	1,790,329	0	272,347	0	280,695	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	288,320	0	81,992	0	84,505	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,207	0	8,391	0	8,648	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,676,822	0	906,352	0	934,134	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,564,137	0	1,936,908	0	1,996,278	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,556,007	0	749,910	0	772,896	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	238,188	0	262,546	0	270,594	90.01
90.02	09002	GEROPSYCH	228,510	0	254,351	0	262,147	90.02
91.00	09100	EMERGENCY	2,009,292	0	2,135,290	0	2,200,737	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,399,837	-496,467	16,196,940	-1,989,669	14,703,738	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	-407,592	0	0	407,592	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	-6,791	0	0	6,791	194.01
194.02	07952	FOUNDATION	0	-82,807	0	0	82,807	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	281,248		496,467		1,989,669	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.009566		0.030652		0.130891	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		47,518		76,115	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		0.002934		0.005007	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet B-1 | Date/Time Prepared: 7/23/2013 12:21 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	PLANT & HOUSEKEEPING-RHC (SQUARE FEET)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	7.01	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.02	00511	BUSINESS OFFICE - HOSPITAL						5.02
5.04	00513	HOSPITAL ONLY ADMIN & GENERAL						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS	41,584					6.00
7.00	00700	OPERATION OF PLANT	0	41,584				7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	11,800			7.01
9.00	00900	HOUSEKEEPING	2,208	2,208	0	39,376		9.00
10.00	01000	DIETARY	2,766	2,766	0	2,766	33,047	10.00
11.00	01100	CAFETERIA	945	945	0	945	17,120	11.00
13.00	01300	NURSING ADMINISTRATION	120	120	0	120	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,423	2,423	0	2,423	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,985	5,985	0	5,985	4,633	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,713	3,713	0	3,713	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,153	3,153	0	3,153	0	54.00
60.00	06000	LABORATORY	1,446	1,446	0	1,446	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	100	100	0	100	0	62.00
65.00	06500	RESPIRATORY THERAPY	756	756	0	756	0	65.00
66.00	06600	PHYSICAL THERAPY	1,734	1,734	0	1,734	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	774	774	0	774	0	67.00
68.00	06800	SPEECH PATHOLOGY	467	467	0	467	0	68.00
69.00	06900	ELECTROCARDIOLOGY	252	252	0	252	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,662	1,662	0	1,662	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	691	691	0	691	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	11,800	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	7,788	7,788	0	7,788	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	0	0	0	0	90.01
90.02	09002	GEROPSYCH	2,275	2,275	0	2,275	0	90.02
91.00	09100	EMERGENCY	2,326	2,326	0	2,326	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	41,584	41,584	11,800	39,376	21,753	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0	0	9,980	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	1,314	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	501,196	258,328	22,649	581,510	742,796	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.052616	6.212197	1.919407	14.768133	22.476957	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	82,224	1,794	157	40,227	53,034	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.977299	0.043142	0.013305	1.021612	1.604805	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet B-1 | Date/Time Prepared: 7/23/2013 12:21 pm

		Cost Center Description	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			11.00	13.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME					1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME					1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.02	00511	BUSINESS OFFICE - HOSPITAL					5.02
5.04	00513	HOSPITAL ONLY ADMIN & GENERAL					5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL					5.05
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC					7.01
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA	9,718				11.00
13.00	01300	NURSING ADMINISTRATION	173	70,508			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,082	0	2,782		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,299	34,432	649		30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
45.00	04500	NURSING FACILITY	0	0	0		45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0		46.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	338	5,056	0		50.00
53.00	05300	ANESTHESIOLOGY	224	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,042	0	192		54.00
60.00	06000	LABORATORY	1,205	0	182		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	67	1,002	70		65.00
66.00	06600	PHYSICAL THERAPY	760	0	101		66.00
67.00	06700	OCCUPATIONAL THERAPY	375	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	119	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	225	3,364	52		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	785		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	507	7,594	252		90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	0	0		90.01
90.02	09002	GEROPSYCH	29	0	0		90.02
91.00	09100	EMERGENCY	1,273	19,060	499		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		OTHER REIMBURSABLE COST CENTERS					
99.00	09900	CMHC	0	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,718	70,508	2,782		118.00
		NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
194.00	07950	CULBERTSON GARDENS	0	0	0		194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0		194.01
194.02	07952	FOUNDATION	0	0	0		194.02
194.03	07953	OUTPATIENT MEALS	0	0	0		194.03
194.04	07954	VACANT SPACE	0	0	0		194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	431,989	190,788	647,014		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	44.452459	2.705906	232.571531		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	44,159	4,134	51,015		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.544042	0.058632	18.337527		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet C Part I Date/Time Prepared: 7/23/2013 12:21 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,222,853		2,222,853	0	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	552,742		552,742	0	0	50.00
53.00	05300	ANESTHESIOLOGY	388,239		388,239	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,581,252		1,581,252	0	0	54.00
60.00	06000	LABORATORY	1,421,138		1,421,138	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	81,134		81,134	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	152,696	0	152,696	0	0	65.00
66.00	06600	PHYSICAL THERAPY	589,366	0	589,366	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	469,746	0	469,746	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	154,307	0	154,307	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	356,958		356,958	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	150,467		150,467	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,780		9,780	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,079,230		1,079,230	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,462,790		2,462,790	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	1,233,013		1,233,013	0	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	306,012		306,012	0	0	90.01
90.02	09002	GEROPSYCH	372,900		372,900	0	0	90.02
91.00	09100	EMERGENCY	2,789,851		2,789,851	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	262,867		262,867		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0		0		0	99.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	16,637,341	0	16,637,341	0	0	200.00
201.00		Less Observation Beds	262,867		262,867		0	201.00
202.00		Total (see instructions)	16,374,474	0	16,374,474	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet C Part I Date/Time Prepared: 7/23/2013 12:21 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,280,350		1,280,350			30.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	73,188	1,524,229	1,597,417	0.346022	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	24,905	470,995	495,900	0.782898	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	135,968	6,957,729	7,093,697	0.222909	0.000000	54.00
60.00	06000	LABORATORY	212,739	5,369,286	5,582,025	0.254592	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	23,650	97,484	121,134	0.669787	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	191,969	191,969	0.795420	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	101,716	1,293,237	1,394,953	0.422499	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	124,365	740,106	864,471	0.543391	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	25,009	209,888	234,897	0.656913	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	78,867	1,711,462	1,790,329	0.199381	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	177,769	110,551	288,320	0.521875	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	23,207	23,207	0.421425	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	654,101	2,022,721	2,676,822	0.403176	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	9,062	1,555,075	1,564,137			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	7,226	1,548,781	1,556,007	0.792421	0.000000	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	238,188	238,188	1.284750	0.000000	90.01
90.02	09002	GEROPSYCH	0	228,510	228,510	1.631876	0.000000	90.02
91.00	09100	EMERGENCY	11,780	1,997,512	2,009,292	1.388475	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,538	164,674	168,212	1.562713	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0			99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	2,944,233	26,455,604	29,399,837			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,944,233	26,455,604	29,399,837			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet C Part I Date/Time Prepared: 7/23/2013 12:21 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
44.00	04400	SKILLED NURSING FACILITY		44.00
45.00	04500	NURSING FACILITY		45.00
46.00	04600	OTHER LONG TERM CARE		46.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		89.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0.000000	90.01
90.02	09002	GEROPSYCH	0.000000	90.02
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
99.00	09900	CMHC		99.00
101.00	10100	HOME HEALTH AGENCY		101.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet C Part I Date/Time Prepared: 7/23/2013 12:21 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,222,853		2,222,853	0	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	552,742		552,742	0	0	50.00
53.00	05300	ANESTHESIOLOGY	388,239		388,239	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,581,252		1,581,252	0	0	54.00
60.00	06000	LABORATORY	1,421,138		1,421,138	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	81,134		81,134	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	152,696	0	152,696	0	0	65.00
66.00	06600	PHYSICAL THERAPY	589,366	0	589,366	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	469,746	0	469,746	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	154,307	0	154,307	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	356,958		356,958	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	150,467		150,467	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,780		9,780	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,079,230		1,079,230	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,462,790		2,462,790	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	1,233,013		1,233,013	0	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	306,012		306,012	0	0	90.01
90.02	09002	GEROPSYCH	372,900		372,900	0	0	90.02
91.00	09100	EMERGENCY	2,789,851		2,789,851	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	262,867		262,867		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0		0		0	99.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	16,637,341	0	16,637,341	0	0	200.00
201.00		Less Observation Beds	262,867		262,867		0	201.00
202.00		Total (see instructions)	16,374,474	0	16,374,474	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet C Part I Date/Time Prepared: 7/23/2013 12:21 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,280,350		1,280,350			30.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	73,188	1,524,229	1,597,417	0.346022	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	24,905	470,995	495,900	0.782898	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	135,968	6,957,729	7,093,697	0.222909	0.000000	54.00
60.00	06000	LABORATORY	212,739	5,369,286	5,582,025	0.254592	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	23,650	97,484	121,134	0.669787	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	191,969	191,969	0.795420	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	101,716	1,293,237	1,394,953	0.422499	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	124,365	740,106	864,471	0.543391	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	25,009	209,888	234,897	0.656913	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	78,867	1,711,462	1,790,329	0.199381	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	177,769	110,551	288,320	0.521875	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	23,207	23,207	0.421425	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	654,101	2,022,721	2,676,822	0.403176	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	9,062	1,555,075	1,564,137	1.574536	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	7,226	1,548,781	1,556,007	0.792421	0.000000	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	238,188	238,188	1.284750	0.000000	90.01
90.02	09002	GEROPSYCH	0	228,510	228,510	1.631876	0.000000	90.02
91.00	09100	EMERGENCY	11,780	1,997,512	2,009,292	1.388475	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,538	164,674	168,212	1.562713	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0			99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	2,944,233	26,455,604	29,399,837			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,944,233	26,455,604	29,399,837			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet C Part I Date/Time Prepared: 7/23/2013 12:21 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0.000000		90.01
90.02	09002	GEROPSYCH	0.000000		90.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
99.00	09900	CMHC			99.00
101.00	10100	HOME HEALTH AGENCY			101.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet D Part II Date/Time Prepared: 7/23/2013 12:21 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	69,737	1,597,417	0.043656	22,722	992	50.00
53.00	05300	ANESTHESIOLOGY	3,645	495,900	0.007350	4,328	32	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	73,179	7,093,697	0.010316	93,183	961	54.00
60.00	06000	LABORATORY	43,044	5,582,025	0.007711	149,107	1,150	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,295	121,134	0.018946	17,629	334	62.00
65.00	06500	RESPIRATORY THERAPY	15,640	191,969	0.081471	0	0	65.00
66.00	06600	PHYSICAL THERAPY	39,013	1,394,953	0.027967	8,963	251	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,247	864,471	0.021108	9,975	211	67.00
68.00	06800	SPEECH PATHOLOGY	9,657	234,897	0.041112	9,931	408	68.00
69.00	06900	ELECTROCARDIOLOGY	8,796	1,790,329	0.004913	67,435	331	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	29,812	288,320	0.103399	110,092	11,383	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	68	23,207	0.002930	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,454	2,676,822	0.007268	232,087	1,687	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	140,416	1,564,137	0.089772	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	150,034	1,556,007	0.096422	6,367	614	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	25,734	238,188	0.108041	0	0	90.01
90.02	09002	GEROPSYCH	42,090	228,510	0.184193	0	0	90.02
91.00	09100	EMERGENCY	74,133	2,009,292	0.036895	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	168,212	0.000000	0	0	92.00
200.00		Total (lines 50-199)	764,994	28,119,487		731,819	18,354	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet D Part IV Date/Time Prepared: 7/23/2013 12:21 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	0	0	0	0	90.01
90.02	09002	GEROPSYCH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet D Part IV Date/Time Prepared: 7/23/2013 12:21 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,597,417	0.000000	0.000000	22,722	50.00
53.00	05300	ANESTHESIOLOGY	0	495,900	0.000000	0.000000	4,328	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,093,697	0.000000	0.000000	93,183	54.00
60.00	06000	LABORATORY	0	5,582,025	0.000000	0.000000	149,107	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	121,134	0.000000	0.000000	17,629	62.00
65.00	06500	RESPIRATORY THERAPY	0	191,969	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,394,953	0.000000	0.000000	8,963	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	864,471	0.000000	0.000000	9,975	67.00
68.00	06800	SPEECH PATHOLOGY	0	234,897	0.000000	0.000000	9,931	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,790,329	0.000000	0.000000	67,435	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	288,320	0.000000	0.000000	110,092	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	23,207	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,676,822	0.000000	0.000000	232,087	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,564,137	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	1,556,007	0.000000	0.000000	6,367	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	238,188	0.000000	0.000000	0	90.01
90.02	09002	GEROPSYCH	0	228,510	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	2,009,292	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	168,212	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	28,119,487			731,819	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet D Part IV Date/Time Prepared: 7/23/2013 12:21 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	0	0		90.01
90.02	09002	GEROPSYCH	0	0	0		90.02
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet D Part V Date/Time Prepared: 7/23/2013 12:21 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.346022	0	716,200	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.782898	0	205,914	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222909	0	2,829,692	0	0	54.00
60.00	06000	LABORATORY	0.254592	0	2,734,611	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.669787	0	78,082	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.795420	0	80,868	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.422499	0	582,649	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.543391	0	401,043	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.656913	0	26,990	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.199381	0	974,312	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.521875	0	79,237	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.421425	0	19,953	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.403176	0	1,490,305	1,902	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.792421	0	1,175,552	2,123	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	1.284750	0	85,249	31	0	90.01
90.02	09002	GEROPSYCH	1.631876	0	220,197	0	0	90.02
91.00	09100	EMERGENCY	1.388475	0	731,236	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.562713	0	109,132	0	0	92.00
200.00		Subtotal (see instructions)		0	12,541,222	4,056	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	12,541,222	4,056	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet D Part V Date/Time Prepared: 7/23/2013 12:21 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	247,821	0		50.00
53.00	05300	ANESTHESIOLOGY	161,210	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	630,764	0		54.00
60.00	06000	LABORATORY	696,210	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	52,298	0		62.00
65.00	06500	RESPIRATORY THERAPY	64,324	0		65.00
66.00	06600	PHYSICAL THERAPY	246,169	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	217,923	0		67.00
68.00	06800	SPEECH PATHOLOGY	17,730	0		68.00
69.00	06900	ELECTROCARDIOLOGY	194,259	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	41,352	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,409	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	600,855	767		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	931,532	1,682		90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	109,524	40		90.01
90.02	09002	GEROPSYCH	359,334	0		90.02
91.00	09100	EMERGENCY	1,015,303	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	170,542	0		92.00
200.00		Subtotal (see instructions)	5,765,559	2,489		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,765,559	2,489		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141333 | Component CCN: 14Z333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet D Part V | Date/Time Prepared: 7/23/2013 12:21 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.346022	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.782898	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222909	0	0	0	0	54.00
60.00	06000	LABORATORY	0.254592	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.669787	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.795420	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.422499	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.543391	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.656913	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.199381	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.521875	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.421425	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.403176	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.792421	0	0	0	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	1.284750	0	0	0	0	90.01
90.02	09002	GEROPSYCH	1.631876	0	0	0	0	90.02
91.00	09100	EMERGENCY	1.388475	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.562713	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141333 | Component CCN: 14Z333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet D Part V | Date/Time Prepared: 7/23/2013 12:21 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	0		90.01
90.02	09002	GEROPSYCH	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet D-1 | Date/Time Prepared: 7/23/2013 12:21 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,560	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	809	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	631	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	579	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	112	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	49	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	11	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	479	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	579	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	49	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	127.18	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	131.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,222,853	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	6,232	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	1,441	25.00
26.00	Total swing-bed cost (see instructions)	1,028,135	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,194,718	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	1,129,678	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,129,678	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.057574	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,790.30	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,194,718	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,476.79	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	707,382	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	707,382	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet D-1 | Date/Time Prepared: 7/23/2013 12:21 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	267,037	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	974,419	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	855,061	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	72,363	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	927,424	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	178	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,476.78	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	262,867	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141333	Period: From 03/01/2012 To 02/28/2013	Worksheet D-1 Date/Time Prepared: 7/23/2013 12:21 pm
	Title XVIII	Hospital	Cost

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet D-3 | Date/Time Prepared: 7/23/2013 12:21 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		650,769		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.346022	22,722	7,862	50.00
53.00	05300	ANESTHESIOLOGY	0.782898	4,328	3,388	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222909	93,183	20,771	54.00
60.00	06000	LABORATORY	0.254592	149,107	37,961	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.669787	17,629	11,808	62.00
65.00	06500	RESPIRATORY THERAPY	0.795420	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.422499	8,963	3,787	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.543391	9,975	5,420	67.00
68.00	06800	SPEECH PATHOLOGY	0.656913	9,931	6,524	68.00
69.00	06900	ELECTROCARDIOLOGY	0.199381	67,435	13,445	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.521875	110,092	57,454	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.421425	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.403176	232,087	93,572	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.792421	6,367	5,045	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	1.284750	0	0	90.01
90.02	09002	GEROPSYCH	1.631876	0	0	90.02
91.00	09100	EMERGENCY	1.388475	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.562713	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		731,819	267,037	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		731,819		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet D-3

Component CCN: 14Z333 | Date/Time Prepared: 7/23/2013 12:21 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.346022	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.782898	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222909	10,203	2,274	54.00
60.00	06000	LABORATORY	0.254592	40,945	10,424	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.669787	1,008	675	62.00
65.00	06500	RESPIRATORY THERAPY	0.795420	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.422499	78,082	32,990	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.543391	94,876	51,555	67.00
68.00	06800	SPEECH PATHOLOGY	0.656913	10,429	6,851	68.00
69.00	06900	ELECTROCARDIOLOGY	0.199381	8,749	1,744	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.521875	39,535	20,632	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.421425	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.403176	230,670	93,001	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.792421	375	297	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	1.284750	0	0	90.01
90.02	09002	GEROPSYCH	1.631876	0	0	90.02
91.00	09100	EMERGENCY	1.388475	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.562713	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		514,872	220,443	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		514,872		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141333	Period: From 03/01/2012 To 02/28/2013	Worksheet E Part B Date/Time Prepared: 7/23/2013 12:21 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,768,048	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,768,048	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	5,825,728	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	42,494	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,953,007	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	3,830,227	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,830,227	30.00
31.00	Primary payer payments	862	31.00
32.00	Subtotal (line 30 minus line 31)	3,829,365	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	315,129	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	315,129	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	311,196	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	4,144,494	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.98	AB Re-billing demo amount (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	4,144,494	40.00
41.00	Interim payments	3,378,753	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)	765,741	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet E-1 Part I | Date/Time Prepared: 7/23/2013 12:21 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		667,654		3,378,753	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		667,654		3,378,753	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		229,482		765,741	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		897,136		4,144,494	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141333 | Component CCN: 14Z333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet E-1 Part I | Date/Time Prepared: 7/23/2013 12:21 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		819,075		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		819,075		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		320,022		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,139,097		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 141333	Period: From 03/01/2012 To 02/28/2013	Worksheet E-1 Part II Date/Time Prepared: 7/23/2013 12:21 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	183	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	479	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	0	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	631	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	29,399,837	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	125,881	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	605,497	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	582,936	8.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	595,446	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)	-12,510	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141333 | Component CCN: 14Z333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet E-2 | Date/Time Prepared: 7/23/2013 12:21 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	936,698	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	222,647	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	628	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,159,345	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,159,345	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,159,345	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	20,248	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,139,097	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Reimbursable bad debts (see instructions)	0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	1,139,097	0	19.00
20.00	Interim payments	819,075	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	320,022	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141333	Period: From 03/01/2012 To 02/28/2013	Worksheet E-3 Part V Date/Time Prepared: 7/23/2013 12:21 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	974,419	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	974,419	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	984,163	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	984,163	19.00
20.00	Deductibles (exclude professional component)	98,820	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	885,343	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	885,343	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	11,793	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	11,793	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	11,793	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	897,136	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	897,136	30.00
31.00	Interim payments	667,654	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)	229,482	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet G | Date/Time Prepared: 7/23/2013 12:21 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	4,460,290	0	0	0	1.00
2.00	Temporary investments	162,984	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,136,626	0	0	0	4.00
5.00	Other receivable	623,923	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	423,790	0	0	0	7.00
8.00	Prepaid expenses	28,018	0	0	0	8.00
9.00	Other current assets	171,912	0	0	0	9.00
10.00	Due from other funds	926,909	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	9,934,452	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	411,152	0	0	0	12.00
13.00	Land improvements	937,976	0	0	0	13.00
14.00	Accumulated depreciation	-522,922	0	0	0	14.00
15.00	Buildings	6,020,638	0	0	0	15.00
16.00	Accumulated depreciation	-3,017,415	0	0	0	16.00
17.00	Leasehold improvements	61,467	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	9,380,378	0	0	0	23.00
24.00	Accumulated depreciation	-7,165,889	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	6,105,385	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	3,134,793	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	102,517	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,237,310	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	19,277,147	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	221,575	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,156,816	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	383,026	0	0	0	40.00
41.00	Deferred income	261,041	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,022,458	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,171,429	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	119,306	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	1,290,735	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	3,313,193	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	15,963,954				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	15,963,954	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	19,277,147	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet G-1 | Date/Time Prepared: 7/23/2013 12:21 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		14,466,649		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,497,304				2.00
3.00	Total (sum of line 1 and line 2)		15,963,953		0		3.00
4.00	Additions (credit adjustments) (specify)	1		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		1		0		10.00
11.00	Subtotal (line 3 plus line 10)		15,963,954		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		15,963,954		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141333 | Period: From 03/01/2012 To 02/28/2013 | Worksheet G-2 Parts I & II | Date/Time Prepared: 7/23/2013 12:21 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,129,678		1,129,678	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	322,164		322,164	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,451,842		1,451,842	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,451,842		1,451,842	17.00
18.00	Ancillary services	1,580,001	21,570,586	23,150,587	18.00
19.00	Outpatient services	23,038	6,226,585	6,249,623	19.00
20.00	RURAL HEALTH CLINIC	9,466	1,587,087	1,596,553	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC		0	0	24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	CULBERTSON GARDENS	0	324,552	324,552	27.00
27.01	DIETARY	0	1,400	1,400	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	3,064,347	29,710,210	32,774,557	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		19,671,145		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		19,671,145		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141333	Period: From 03/01/2012 To 02/28/2013	Worksheet G-3 Date/Time Prepared: 7/23/2013 12:21 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	32,774,557	1.00
2.00	Less contractual allowances and discounts on patients' accounts	12,129,718	2.00
3.00	Net patient revenues (line 1 minus line 2)	20,644,839	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	19,671,145	4.00
5.00	Net income from service to patients (line 3 minus line 4)	973,694	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	610,155	6.00
7.00	Income from investments	95,304	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	38,884	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC INCOME	889,840	24.00
24.01	TAX REVENUE	537,665	24.01
24.02	MEALS ON WHEELS	80,070	24.02
25.00	Total other income (sum of lines 6-24)	2,251,918	25.00
26.00	Total (line 5 plus line 25)	3,225,612	26.00
27.00	BAD DEBTS	1,451,086	27.00
27.01	CHARITY CARE	277,222	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	1,728,308	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,497,304	29.00

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

Provider CCN: 141333 Component CCN: 143483 | Period: From 03/01/2012 To 02/28/2013 | Worksheet M-1 | Date/Time Prepared: 7/23/2013 12:21 pm

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	168,910	0	168,910	23,000	191,910	1.00
2.00	Physician Assistant	110,147	0	110,147	0	110,147	2.00
3.00	Nurse Practitioner	175,396	0	175,396	0	175,396	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	270,227	0	270,227	0	270,227	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	72,382	0	72,382	-72,382	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	797,062	0	797,062	-49,382	747,680	10.00
11.00	Physician Services Under Agreement	0	420,349	420,349	0	420,349	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	50,758	50,758	0	50,758	13.00
14.00	Subtotal (sum of lines 11-13)	0	471,107	471,107	0	471,107	14.00
15.00	Medical Supplies	0	21,862	21,862	0	21,862	15.00
16.00	Transportation (Health Care Staff)	0	12,464	12,464	0	12,464	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	34,326	34,326	0	34,326	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	797,062	505,433	1,302,495	-49,382	1,253,113	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	280,625	65,449	346,074	-60,536	285,538	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	280,625	65,449	346,074	-60,536	285,538	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,077,687	570,882	1,648,569	-109,918	1,538,651	32.00

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

Provider CCN: 141333 | Component CCN: 143483 | Period: From 03/01/2012 To 02/28/2013 | Worksheet M-1 | Date/Time Prepared: 7/23/2013 12:21 pm

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-10,116	181,794		1.00
2.00	Physician Assistant	-5,732	104,415		2.00
3.00	Nurse Practitioner	-4,645	170,751		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	270,227		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	-20,493	727,187		10.00
11.00	Physician Services Under Agreement	0	420,349		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	50,758		13.00
14.00	Subtotal (sum of lines 11-13)	0	471,107		14.00
15.00	Medical Supplies	0	21,862		15.00
16.00	Transportation (Health Care Staff)	0	12,464		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	34,326		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-20,493	1,232,620		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-16,374	269,164		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-16,374	269,164		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-36,867	1,501,784		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141333 | Component CCN: 143483 | Period: From 03/01/2012 To 02/28/2013 | Worksheet M-2 | Date/Time Prepared: 7/23/2013 12:21 pm

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.94	7,163	4,200	8,148		1.00
2.00	Physician Assistant	0.86	2,167	2,100	1,806		2.00
3.00	Nurse Practitioner	1.66	3,934	2,100	3,486		3.00
4.00	Subtotal (sum of lines 1-3)	4.46	13,264		13,440	13,440	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	4.46	13,264			13,440	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					1,232,620	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,232,620	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					269,164	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					961,006	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,230,170	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					1,230,170	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					1,230,170	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					2,462,790	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 141333 | Component CCN: 143483 | Period: From 03/01/2012 To 02/28/2013 | Worksheet M-3 | Date/Time Prepared: 7/23/2013 12:21 pm

Title XVIII | Rural Health Clinic (RHC) I | Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		2,462,790	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		13,080	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,449,710	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		13,440	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		13,440	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		182.27	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27,Sec. 505 or your contractor)	78.54	79.17	8.00
9.00	Rate for Program covered visits (see instructions)	182.27	182.27	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	4,091	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	745,667	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		745,667	16.00
16.01	Total program charges (see instructions)(from contractor's records)		473,962	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,629	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		2,563	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		546,617	16.04
16.05	Total program cost (see instructions)		549,180	16.05
17.00	Primary payer amounts		164	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		59,833	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		549,016	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		8,692	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		557,708	22.00
23.00	Reimbursable bad debts (see instructions)		0	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		557,708	26.00
27.00	Interim payments		621,729	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 27 and 28)		-64,021	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141333 | Component CCN: 143483 | Period: From 03/01/2012 To 02/28/2013 | Worksheet M-4 | Date/Time Prepared: 7/23/2013 12:21 pm

Title XVIII | Rural Health Clinic (RHC) I | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	727,187	727,187	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000105	0.002202	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	76	1,601	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	835	4,035	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	911	5,636	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	1,232,620	1,232,620	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	1,230,170	1,230,170	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000739	0.004572	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	909	5,624	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,820	11,260	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	14	294	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	130.00	38.30	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	10	193	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	1,300	7,392	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		13,080	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		8,692	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 141333 Component CCN: 143483 | Period: From 03/01/2012 To 02/28/2013 | Worksheet M-5 | Date/Time Prepared: 7/23/2013 12:21 pm

Rural Health Clinic (RHC) I | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		529,529	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		10/02/2012	92,200	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		92,200	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		621,729	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		64,021	6.02
7.00	Total Medicare program liability (see instructions)		557,708	7.00

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

www.mcgladrey.com

McGladrey is the brand under which McGladrey LLP serves clients' business needs.

McGladrey LLP is the U.S. member of the McGladrey International ("McGladrey") network of independent accounting, tax and consulting firms. The member firms of McGladrey collaborate to provide services to global clients, but are separate and distinct legal entities which cannot obligate each other. Each member firm is responsible only for its own acts and omissions, and not those of any other party.