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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141333	Period: From 03/01/2013 To 02/28/2014	Worksheet S Parts I-III Date/Time Prepared: 7/24/2014 11:27 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 7/24/2014 Time: 11:27 am
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 03/01/2013 and ending 02/28/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	44,533	-34,730	0	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	135,825	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		11,274		0	10.00
200.00	Total	0	180,358	-23,456	0	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 03/01/2013 To 02/28/2014 | Worksheet S-2 Part I | Date/Time Prepared: 7/24/2014 11:22 am

	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)	03/01/2013	02/28/2014	20.00
21.00	Type of Control (see instructions)	11		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)			22.01
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	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		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 03/01/2013 To 02/28/2014 | Worksheet S-2 Part I Date/Time Prepared: 7/24/2014 11:22 am

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

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)			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	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet S-2 Part I Date/Time Prepared: 7/24/2014 11:22 am

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

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in 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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet S-2 Part I | Date/Time Prepared: 7/24/2014 11:22 am

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	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 5th or 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 5th or 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet S-2 Part I Date/Time Prepared: 7/24/2014 11:22 am

		V	XIX	
		1.00	2.00	
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	N	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

		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 high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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	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

		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)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2012	09/30/2013	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet S-2 Part II | Date/Time Prepared: 7/24/2014 11:22 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	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 03/01/2013 To 02/28/2014 | Worksheet S-2 Part II Date/Time Prepared: 7/24/2014 11:22 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				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.	DAN	LINHART	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.	563-888-4404	DAN.LINHART@MCGLADREY.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet S-2 Part II Date/Time Prepared: 7/24/2014 11:22 am

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)				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.		MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet S-3 Part I Date/Time Prepared: 7/24/2014 11:22 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	22	8,030	12,377.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		22	8,030	12,377.00	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)		22	8,030	12,377.00	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						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (Consolidated)	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		22				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet S-3 Part I | Date/Time Prepared: 7/24/2014 11:22 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	384	28	516			1.00
2.00	HMO and other (see instructions)	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	643	0	768			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	51			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,027	28	1,335			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)	1,027	28	1,335	0.00	116.77	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						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (Consolidated)	4,299	0	14,616	0.00	21.73	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	138.50	27.00
28.00	Observation Bed Days		0	115			28.00
29.00	Ambulance Trips	1					29.00
30.00	Employee discount days (see instruction)			47			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet S-3 Part I Date/Time Prepared: 7/24/2014 11:22 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	117	12	176	1.00
2.00	HMO and other (see instructions)			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	117	12	176	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						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (Consolidated)	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

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

Provider CCN: 141333 Component CCN: 143483 | Period: From 03/01/2013 To 02/28/2014 | Worksheet S-8 Date/Time Prepared: 7/24/2014 11:22 am

		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			0800	1700	0800 11.00
					1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?				N	12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				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	1700	0800	1700	0800	1700	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141333 Component CCN: 143483	Period: From 03/01/2013 To 02/28/2014	Worksheet S-8 Date/Time Prepared: 7/24/2014 11:22 am
		Rural Health Clinic (RHC) I	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	0800	1700				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet S-10 | Date/Time Prepared: 7/24/2014 11:22 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.562496	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	804,528	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	1,464,846	5.00
6.00	Medicaid charges	3,520,838	6.00
7.00	Medicaid cost (line 1 times line 6)	1,980,457	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	558,701	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	218,916	20,454	239,370	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	123,139	11,505	134,644	21.00
22.00	Partial payment by patients approved for charity care	18,456	6,224	24,680	22.00
23.00	Cost of charity care (line 21 minus line 22)	104,683	5,281	109,964	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)	849,142	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	440,282	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	408,860	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	229,982	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	339,946	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	339,946	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet A | Date/Time Prepared: 7/24/2014 11:22 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		270,730	270,730	8,930	279,660	1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME		108,275	108,275	2,316	110,591	1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME		28,687	28,687	971	29,658	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		673,028	673,028	8,318	681,346	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,359,687	3,359,687	0	3,359,687	4.00
5.02	00511	BUSINESS OFFICE - HOSPITAL	185,021	54,038	239,059	0	239,059	5.02
5.04	00513	HOSPITAL ONLY ADMIN & GENERAL	332,180	182,759	514,939	0	514,939	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	587,119	1,247,068	1,834,187	-24,002	1,810,185	5.05
6.00	00600	MAINTENANCE & REPAIRS	193,963	72,211	266,174	0	266,174	6.00
7.00	00700	OPERATION OF PLANT	58,800	122,037	180,837	0	180,837	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	24,917	24,917	0	24,917	7.01
9.00	00900	HOUSEKEEPING	254,720	26,917	281,637	57,488	339,125	9.00
10.00	01000	DIETARY	296,053	279,873	575,926	0	575,926	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	99,562	9,654	109,216	3,268	112,484	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	280,645	59,084	339,729	0	339,729	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	734,993	278,078	1,013,071	215	1,013,286	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	175,835	97,852	273,687	-25,393	248,294	50.00
53.00	05300	ANESTHESIOLOGY	248,977	25,051	274,028	0	274,028	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	379,357	565,710	945,067	43,277	988,344	54.00
60.00	06000	LABORATORY	374,841	497,495	872,336	33,938	906,274	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	52,988	52,988	0	52,988	62.00
65.00	06500	RESPIRATORY THERAPY	18,727	44,325	63,052	0	63,052	65.00
66.00	06600	PHYSICAL THERAPY	400,163	65,983	466,146	-108,638	357,508	66.00
67.00	06700	OCCUPATIONAL THERAPY	192,874	0	192,874	84,461	277,335	67.00
68.00	06800	SPEECH PATHOLOGY	60,194	0	60,194	24,177	84,371	68.00
69.00	06900	ELECTROCARDIOLOGY	92,944	183,741	276,685	0	276,685	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	54,063	54,063	0	54,063	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,544	11,544	0	11,544	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	684,183	684,183	0	684,183	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,248,008	547,220	1,795,228	-103,953	1,691,275	88.00
90.00	09000	CLINIC	135,686	1,034,355	1,170,041	19,401	1,189,442	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	516,194	110,540	626,734	-30,750	595,984	90.01
90.02	09002	GEROPSYCH	115,117	91,760	206,877	0	206,877	90.02
91.00	09100	EMERGENCY	485,444	1,741,546	2,226,990	2,509	2,229,499	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,467,417	12,605,399	20,072,816	-3,467	20,069,349	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	173,913	174,145	348,058	3,467	351,525	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	16,236	46,253	62,489	0	62,489	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)	7,657,566	12,825,797	20,483,363	0	20,483,363	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet A | Date/Time Prepared: 7/24/2014 11:22 am

		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	279,660		1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME	0	110,591		1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	29,658		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-189,897	491,449		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-842,293	2,517,394		4.00
5.02	00511	BUSINESS OFFICE - HOSPITAL	-10,415	228,644		5.02
5.04	00513	HOSPITAL ONLY ADMIN & GENERAL	-108,476	406,463		5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	-107,712	1,702,473		5.05
6.00	00600	MAINTENANCE & REPAIRS	4,594	270,768		6.00
7.00	00700	OPERATION OF PLANT	-493	180,344		7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	24,917		7.01
9.00	00900	HOUSEKEEPING	0	339,125		9.00
10.00	01000	DIETARY	-134,365	441,561		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	112,484		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-9,035	330,694		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,013,286		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-32,846	215,448		50.00
53.00	05300	ANESTHESIOLOGY	0	274,028		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	988,344		54.00
60.00	06000	LABORATORY	0	906,274		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	52,988		62.00
65.00	06500	RESPIRATORY THERAPY	0	63,052		65.00
66.00	06600	PHYSICAL THERAPY	0	357,508		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	277,335		67.00
68.00	06800	SPEECH PATHOLOGY	0	84,371		68.00
69.00	06900	ELECTROCARDIOLOGY	-35,086	241,599		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	54,063		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,544		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	684,183		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-20,021	1,671,254		88.00
90.00	09000	CLINIC	-499,119	690,323		90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	-406,140	189,844		90.01
90.02	09002	GEROPSYCH	0	206,877		90.02
91.00	09100	EMERGENCY	-254,530	1,974,969		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,645,834	17,423,515		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	CULBERTSON GARDENS	-22,546	328,979		194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0		194.01
194.02	07952	FOUNDATION	0	62,489		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)	-2,668,380	17,814,983		200.00

RECLASSIFICATIONS | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet A-6 | Date/Time Prepared: 7/24/2014 11:22 am

		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	20,535	1.00
2.00	CULBERTSON GARDENS	194.00	0	3,467	2.00
	TOTALS		0	24,002	
	B - CLIENT/ER/INF CNTR/MED SURG SALARIES				
1.00	NURSING ADMINISTRATION	13.00	3,268	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	215	0	2.00
3.00	CLINIC	90.00	19,401	0	3.00
4.00	EMERGENCY	91.00	2,509	0	4.00
	TOTALS		25,393	0	
	C - RHC PHYSICIAN EXPENSE				
1.00	RURAL HEALTH CLINIC	88.00	30,750	0	1.00
	TOTALS		30,750	0	
	D - RHC EXPENSES				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	43,277	0	1.00
2.00	LABORATORY	60.00	33,938	0	2.00
3.00	HOUSEKEEPING	9.00	47,954	9,534	3.00
	TOTALS		125,169	9,534	
	E - THERAPY RECLASS				
1.00	OCCUPATIONAL THERAPY	67.00	63,012	21,449	1.00
2.00	SPEECH PATHOLOGY	68.00	18,037	6,140	2.00
	TOTALS		81,049	27,589	
500.00	Grand Total: Increases		262,361	61,125	500.00

RECLASSIFICATIONS | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet A-6 | Date/Time Prepared: 7/24/2014 11:22 am

	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	24,002	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	24,002			
	B - CLIENT/ER/INF CNTR/MED SURG SALARIES						
1.00	OPERATING ROOM	50.00	25,393	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		25,393	0			
	C - RHC PHYSICIAN EXPENSE						
1.00	RUSHVILLE FAMILY CLINIC	90.01	30,750	0	0		1.00
	TOTALS		30,750	0			
	D - RHC EXPENSES						
1.00	RURAL HEALTH CLINIC	88.00	125,169	9,534	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		125,169	9,534			
	E - THERAPY RECLASS						
1.00	PHYSICAL THERAPY	66.00	81,049	27,589	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		81,049	27,589			
500.00	Grand Total: Decreases		262,361	61,125			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet A-7 Part I Date/Time Prepared: 7/24/2014 11:22 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	411,152	0	0	0	0	1.00
2.00	Land Improvements	937,976	55,457	0	55,457	0	2.00
3.00	Buildings and Fixtures	9,128,328	216,236	0	216,236	0	3.00
4.00	Building Improvements	61,467	553,785	0	553,785	0	4.00
5.00	Fixed Equipment	155,140	29,500	0	29,500	0	5.00
6.00	Movable Equipment	6,117,548	107,928	0	107,928	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	16,811,611	962,906	0	962,906	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	16,811,611	962,906	0	962,906	0	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	993,433	0	2.00
3.00	Buildings and Fixtures	9,344,564	0	3.00
4.00	Building Improvements	615,252	0	4.00
5.00	Fixed Equipment	184,640	0	5.00
6.00	Movable Equipment	6,225,476	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	17,774,517	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	17,774,517	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet A-7 Part II | Date/Time Prepared: 7/24/2014 11:22 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	257,434	13,296	0	0	0	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	98,675	9,600	0	0	0	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	28,687	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	509,869	163,159	0	0	0	2.00
3.00	Total (sum of lines 1-2)	894,665	186,055	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	270,730	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	0	108,275	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	28,687	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	673,028	2.00
3.00	Total (sum of lines 1-2)	0	1,080,720	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet A-7 Part III Date/Time Prepared: 7/24/2014 11:22 am

	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	6,259,732	0	6,259,732	0.434844	8,930	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	1,623,618	0	1,623,618	0.112787	2,316	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	680,962	0	680,962	0.047304	971	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	5,831,061	0	5,831,061	0.405065	8,318	2.00
3.00	Total (sum of lines 1-2)	14,395,373	0	14,395,373	1.000000	20,535	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	8,930	257,434	13,296	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	0	0	2,316	98,675	9,600	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	0	971	28,687	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	8,318	319,972	163,159	2.00
3.00	Total (sum of lines 1-2)	0	0	20,535	704,768	186,055	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	8,930	0	0	279,660	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	0	2,316	0	0	110,591	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	971	0	0	29,658	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	8,318	0	0	491,449	2.00
3.00	Total (sum of lines 1-2)	0	20,535	0	0	911,358	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet A-8 | Date/Time Prepared: 7/24/2014 11:22 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - 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	-34,483	HOSPITAL ONLY ADMIN & GENERAL	5.04	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-3,467	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	-5,267	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	7.00
8.00	Television and radio service (chapter 21)	A	-493	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	-1,225,559			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	-133,843	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	-9,035	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	-522	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
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet A-8 | Date/Time Prepared: 7/24/2014 11:22 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-187,841	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	INTEREST INCOME	B	-32,681	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.00
33.01	INTEREST INCOME	B	-22,546	CULBERTSON GARDENS	194.00	0	33.01
33.02	OPC RENT	B	-34,272	HOSPITAL ONLY ADMIN & GENERAL	5.04	0	33.02
33.03	MISCELLANEOUS INCOME	B	-5,403	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.03
33.04	MARKETING SALARY EXPENSE	A	-15,580	HOSPITAL ONLY ADMIN & GENERAL	5.04	0	33.04
33.05	MARKETING BENEFITS EXPENSE	A	-6,795	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.05
33.06	MARKETING OTHER EXPENSE	A	-58,182	HOSPITAL ONLY ADMIN & GENERAL	5.04	0	33.06
33.07	MARKETING OTHER EXPENSE	A	-13,968	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.07
33.08	MARKETING OTHER EXPENSE	A	-11,464	RURAL HEALTH CLINIC	88.00	0	33.08
33.09	MARKETING OTHER EXPENSE	A	-2,056	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.09
33.10	LOBBYING PORTION OF DUES	A	-8,906	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.10
33.11	HEALTHLINK ADMINISTRATIVE FEES	A	34,041	HOSPITAL ONLY ADMIN & GENERAL	5.04	0	33.11
33.12	SELF INSURANCE OFFSET	A	-830,956	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	PART B PHYSICIAN BILLING SALARIES	A	-10,415	BUSINESS OFFICE - HOSPITAL	5.02	0	33.13
33.14	PART B PHYSICIAN BILLING EMP BENEFIT	A	-4,542	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15	NONALLOWABLE COSTS-FISCAL SERVICES	A	-6,830	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.15
33.16	NON-RHC PHYSICIAN ASSISTANT SALARIES	A	-601	RURAL HEALTH CLINIC	88.00	0	33.16
33.17	MARKETING OTHER EXPENSE	A	-8,403	RUSHVILLE FAMILY CLINIC	90.01	0	33.17
33.18	NON-RHC NURSE PRACTITIONER SALARIES	A	-1,715	RURAL HEALTH CLINIC	88.00	0	33.18
33.19	PATIENT COLLECTION FEES	B	-25,016	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	PROPERTY TAXES	A	-6,174	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.21
33.22			0		0.00	0	33.22
33.23			0		0.00	0	33.23
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,668,380				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet A-8-2 | Date/Time Prepared: 7/24/2014 11:22 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	32,846	32,846	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	35,086	35,086	0	0	0	5.00
6.00	90.00	CLINIC	220,000	220,000	0	0	0	6.00
7.00	90.00	CLINIC	200,000	200,000	0	0	0	7.00
8.00	90.00	CLINIC	5,964	0	5,964	0	0	8.00
9.00	90.00	CLINIC	79,119	79,119	0	0	0	9.00
10.00	91.00	EMERGENCY	1,687,938	254,530	1,433,408	0	0	10.00
11.00	88.00	RURAL HEALTH CLINIC	6,241	6,241	0	0	0	11.00
12.00	90.01	RUSHVILLE FAMILY CLINIC	397,737	397,737	0	0	0	12.00
200.00			2,698,531	1,225,559	1,472,972		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	32,846		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	35,086		5.00
6.00	90.00	CLINIC	0	0	0	220,000		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	79,119		9.00
10.00	91.00	EMERGENCY	0	0	0	254,530		10.00
11.00	88.00	RURAL HEALTH CLINIC	0	0	0	6,241		11.00
12.00	90.01	RUSHVILLE FAMILY CLINIC	0	0	0	397,737		12.00
200.00			0	0	0	1,225,559		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet B Part I Date/Time Prepared: 7/24/2014 11:22 am

		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	279,660	279,660				1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME	110,591	0	110,591			1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME	29,658	0	0	29,658		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	491,449				491,449	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,517,394	0	0	0	0	4.00
5.02	00511	BUSINESS OFFICE - HOSPITAL	228,644	0	0	0	0	5.02
5.04	00513	HOSPITAL ONLY ADMIN & GENERAL	406,463	16,705	0	0	29,356	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	1,702,473	24,314	0	0	42,728	5.05
6.00	00600	MAINTENANCE & REPAIRS	270,768	27,201	0	0	47,801	6.00
7.00	00700	OPERATION OF PLANT	180,344	0	0	0	0	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	24,917	0	0	0	0	7.01
9.00	00900	HOUSEKEEPING	339,125	11,047	0	0	19,412	9.00
10.00	01000	DIETARY	441,561	13,838	0	0	24,318	10.00
11.00	01100	CAFETERIA	0	4,728	0	0	8,308	11.00
13.00	01300	NURSING ADMINISTRATION	112,484	600	0	0	1,055	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	330,694	12,122	0	0	21,302	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,013,286	29,943	0	0	52,619	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	215,448	21,157	0	0	37,180	50.00
53.00	05300	ANESTHESIOLOGY	274,028	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	988,344	15,774	0	0	27,720	54.00
60.00	06000	LABORATORY	906,274	5,974	0	0	10,497	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	52,988	500	0	0	879	62.00
65.00	06500	RESPIRATORY THERAPY	63,052	3,782	0	0	6,647	65.00
66.00	06600	PHYSICAL THERAPY	357,508	8,580	0	0	15,078	66.00
67.00	06700	OCCUPATIONAL THERAPY	277,335	5,133	0	0	9,020	67.00
68.00	06800	SPEECH PATHOLOGY	84,371	2,336	0	0	4,106	68.00
69.00	06900	ELECTROCARDIOLOGY	241,599	2,521	0	0	4,431	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	54,063	7,760	0	0	13,636	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,544	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	684,183	3,457	0	0	6,075	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,671,254	0	110,591	0	0	88.00
90.00	09000	CLINIC	690,323	36,988	0	0	64,997	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	189,844	0	0	27,443	0	90.01
90.02	09002	GEROPSYCH	206,877	13,663	0	0	24,010	90.02
91.00	09100	EMERGENCY	1,974,969	11,537	0	0	20,274	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,423,515	279,660	110,591	27,443	491,449	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	328,979	0	0	0	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	2,215	0	194.01
194.02	07952	FOUNDATION	62,489	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)	17,814,983	279,660	110,591	29,658	491,449	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet B Part I Date/Time Prepared: 7/24/2014 11:22 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	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 DEPARTMENT	2,517,394					4.00
5.02	00511	BUSINESS OFFICE - HOSPITAL	60,340	288,984				5.02
5.04	00513	HOSPITAL ONLY ADMIN & GENERAL	109,410	0	561,934	561,934		5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	202,895	0	1,972,410	65,999	2,038,409	5.05
6.00	00600	MAINTENANCE & REPAIRS	67,029	0	412,799	13,813	426,612	6.00
7.00	00700	OPERATION OF PLANT	20,320	0	200,664	6,714	207,378	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	24,917	834	25,751	7.01
9.00	00900	HOUSEKEEPING	104,597	0	474,181	15,867	490,048	9.00
10.00	01000	DIETARY	102,309	0	582,026	19,475	601,501	10.00
11.00	01100	CAFETERIA	0	0	13,036	436	13,472	11.00
13.00	01300	NURSING ADMINISTRATION	35,536	0	149,675	5,008	154,683	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	96,984	0	461,102	15,429	476,531	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	254,071	13,240	1,363,159	45,613	1,408,772	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	51,989	13,091	338,865	11,339	350,204	50.00
53.00	05300	ANESTHESIOLOGY	86,041	4,656	364,725	12,204	376,929	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	146,053	69,559	1,247,450	41,741	1,289,191	54.00
60.00	06000	LABORATORY	141,265	55,714	1,119,724	37,467	1,157,191	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,162	55,529	1,858	57,387	62.00
65.00	06500	RESPIRATORY THERAPY	6,472	1,885	81,838	2,738	84,576	65.00
66.00	06600	PHYSICAL THERAPY	110,278	15,244	506,688	16,954	523,642	66.00
67.00	06700	OCCUPATIONAL THERAPY	88,428	8,492	388,408	12,997	401,405	67.00
68.00	06800	SPEECH PATHOLOGY	27,035	2,142	119,990	4,015	124,005	68.00
69.00	06900	ELECTROCARDIOLOGY	32,119	18,349	299,019	10,005	309,024	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,284	77,743	2,601	80,344	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	168	11,712	392	12,104	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,633	717,348	24,003	741,351	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	397,853	16,404	2,196,102	73,485	2,269,587	88.00
90.00	09000	CLINIC	53,595	19,750	865,653	28,966	894,619	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	48,657	2,116	268,060	8,970	277,030	90.01
90.02	09002	GEROPSYCH	39,782	2,122	286,454	9,585	296,039	90.02
91.00	09100	EMERGENCY	168,625	18,973	2,194,378	73,426	2,267,804	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,451,683	288,984	17,355,589	561,934	17,355,589	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	60,100	0	389,079	0	389,079	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	2,215	0	2,215	194.01
194.02	07952	FOUNDATION	5,611	0	68,100	0	68,100	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)	2,517,394	288,984	17,814,983	561,934	17,814,983	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet B Part I | Date/Time Prepared: 7/24/2014 11:22 am

		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 DEPARTMENT						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	2,038,409					5.05
6.00	00600	MAINTENANCE & REPAIRS	55,120	481,732				6.00
7.00	00700	OPERATION OF PLANT	26,794	0	234,172			7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	3,327	0	0	29,078		7.01
9.00	00900	HOUSEKEEPING	63,317	25,168	12,234	0	590,767	9.00
10.00	01000	DIETARY	77,717	31,528	15,326	0	40,795	10.00
11.00	01100	CAFETERIA	1,741	10,772	5,236	0	13,938	11.00
13.00	01300	NURSING ADMINISTRATION	19,986	1,368	665	0	1,770	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	61,570	27,618	13,425	0	35,737	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	182,020	68,220	33,162	0	88,272	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,248	48,204	23,432	0	62,373	50.00
53.00	05300	ANESTHESIOLOGY	48,701	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	166,570	35,939	17,470	0	46,503	54.00
60.00	06000	LABORATORY	149,515	13,610	6,616	0	17,610	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	7,415	1,140	554	0	1,475	62.00
65.00	06500	RESPIRATORY THERAPY	10,928	8,617	4,189	0	11,150	65.00
66.00	06600	PHYSICAL THERAPY	67,657	19,548	9,503	0	25,294	66.00
67.00	06700	OCCUPATIONAL THERAPY	51,864	11,695	5,685	0	15,132	67.00
68.00	06800	SPEECH PATHOLOGY	16,022	5,323	2,588	0	6,888	68.00
69.00	06900	ELECTROCARDIOLOGY	39,927	5,745	2,793	0	7,433	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,381	17,679	8,594	0	22,876	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,564	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	95,786	7,876	3,829	0	10,191	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	293,238	0	0	29,078	0	88.00
90.00	09000	CLINIC	115,589	84,268	40,962	0	109,040	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	35,794	0	0	0	0	90.01
90.02	09002	GEROPSYCH	38,250	31,129	15,132	0	40,279	90.02
91.00	09100	EMERGENCY	293,012	26,285	12,777	0	34,011	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,979,053	481,732	234,172	29,078	590,767	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	50,271	0	0	0	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	286	0	0	0	0	194.01
194.02	07952	FOUNDATION	8,799	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)	2,038,409	481,732	234,172	29,078	590,767	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet B Part I | Date/Time Prepared: 7/24/2014 11:22 am

		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 DEPARTMENT						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	766,867					10.00
11.00	01100	CAFETERIA	374,296	419,455				11.00
13.00	01300	NURSING ADMINISTRATION	0	6,312	184,784			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	44,788	0	659,669		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	97,298	93,879	86,610	156,497	2,214,730	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	15,680	14,478	0	559,619	50.00
53.00	05300	ANESTHESIOLOGY	0	9,850	0	0	435,480	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	46,919	0	48,621	1,651,213	54.00
60.00	06000	LABORATORY	0	49,331	0	45,835	1,439,708	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	67,971	62.00
65.00	06500	RESPIRATORY THERAPY	0	2,251	2,086	16,713	140,510	65.00
66.00	06600	PHYSICAL THERAPY	0	39,963	0	24,563	710,170	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	15,037	0	0	500,818	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,910	0	0	160,736	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,091	9,292	12,915	397,220	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	139,874	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	13,668	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	859,033	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	164,602	2,756,505	88.00
90.00	09000	CLINIC	0	22,796	21,028	63,814	1,352,116	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	0	0	0	312,824	90.01
90.02	09002	GEROPSYCH	0	1,045	0	0	421,874	90.02
91.00	09100	EMERGENCY	0	55,603	51,290	126,109	2,866,891	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	471,594	419,455	184,784	659,669	17,000,960	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	273,355	0	0	0	712,705	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	2,501	194.01
194.02	07952	FOUNDATION	0	0	0	0	76,899	194.02
194.03	07953	OUTPATIENT MEALS	21,918	0	0	0	21,918	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)	766,867	419,455	184,784	659,669	17,814,983	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet B Part I | Date/Time Prepared: 7/24/2014 11:22 am

		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 DEPARTMENT				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	2,214,730		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	559,619		50.00
53.00	05300	ANESTHESIOLOGY	0	435,480		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,651,213		54.00
60.00	06000	LABORATORY	0	1,439,708		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	67,971		62.00
65.00	06500	RESPIRATORY THERAPY	0	140,510		65.00
66.00	06600	PHYSICAL THERAPY	0	710,170		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	500,818		67.00
68.00	06800	SPEECH PATHOLOGY	0	160,736		68.00
69.00	06900	ELECTROCARDIOLOGY	0	397,220		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	139,874		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	13,668		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	859,033		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	2,756,505		88.00
90.00	09000	CLINIC	0	1,352,116		90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	312,824		90.01
90.02	09002	GEROPSYCH	0	421,874		90.02
91.00	09100	EMERGENCY	0	2,866,891		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	17,000,960		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	CULBERTSON GARDENS	0	712,705		194.00
194.01	07951	MEDICAL ARTS BUILDING	0	2,501		194.01
194.02	07952	FOUNDATION	0	76,899		194.02
194.03	07953	OUTPATIENT MEALS	0	21,918		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	17,814,983		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet B Part II Date/Time Prepared: 7/24/2014 11:22 am

		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 DEPARTMENT	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	16,705	0	0	29,356	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	0	24,314	0	0	42,728	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	27,201	0	0	47,801	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	11,047	0	0	19,412	9.00
10.00	01000	DIETARY	0	13,838	0	0	24,318	10.00
11.00	01100	CAFETERIA	0	4,728	0	0	8,308	11.00
13.00	01300	NURSING ADMINISTRATION	0	600	0	0	1,055	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,122	0	0	21,302	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	29,943	0	0	52,619	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	21,157	0	0	37,180	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,774	0	0	27,720	54.00
60.00	06000	LABORATORY	0	5,974	0	0	10,497	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	500	0	0	879	62.00
65.00	06500	RESPIRATORY THERAPY	0	3,782	0	0	6,647	65.00
66.00	06600	PHYSICAL THERAPY	0	8,580	0	0	15,078	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,133	0	0	9,020	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,336	0	0	4,106	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,521	0	0	4,431	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,760	0	0	13,636	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	3,457	0	0	6,075	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	110,591	0	0	88.00
90.00	09000	CLINIC	0	36,988	0	0	64,997	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	0	0	27,443	0	90.01
90.02	09002	GEROPSYCH	0	13,663	0	0	24,010	90.02
91.00	09100	EMERGENCY	0	11,537	0	0	20,274	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	279,660	110,591	27,443	491,449	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	2,215	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	279,660	110,591	29,658	491,449	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet B Part II Date/Time Prepared: 7/24/2014 11:22 am

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	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 DEPARTMENT	0	0				4.00
5.02	00511	BUSINESS OFFICE - HOSPITAL	0	0	0			5.02
5.04	00513	HOSPITAL ONLY ADMIN & GENERAL	46,061	0	0	46,061		5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	67,042	0	0	5,410	72,452	5.05
6.00	00600	MAINTENANCE & REPAIRS	75,002	0	0	1,132	1,959	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	550	952	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	0	68	118	7.01
9.00	00900	HOUSEKEEPING	30,459	0	0	1,301	2,250	9.00
10.00	01000	DIETARY	38,156	0	0	1,596	2,762	10.00
11.00	01100	CAFETERIA	13,036	0	0	36	62	11.00
13.00	01300	NURSING ADMINISTRATION	1,655	0	0	411	710	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	33,424	0	0	1,265	2,188	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	82,562	0	0	3,739	6,469	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	58,337	0	0	930	1,608	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,000	1,731	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	43,494	0	0	3,422	5,920	54.00
60.00	06000	LABORATORY	16,471	0	0	3,071	5,314	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,379	0	0	152	264	62.00
65.00	06500	RESPIRATORY THERAPY	10,429	0	0	224	388	65.00
66.00	06600	PHYSICAL THERAPY	23,658	0	0	1,390	2,405	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,153	0	0	1,065	1,843	67.00
68.00	06800	SPEECH PATHOLOGY	6,442	0	0	329	569	68.00
69.00	06900	ELECTROCARDIOLOGY	6,952	0	0	820	1,419	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,396	0	0	213	369	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	32	56	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,532	0	0	1,968	3,404	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	110,591	0	0	6,023	10,429	88.00
90.00	09000	CLINIC	101,985	0	0	2,374	4,108	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	27,443	0	0	735	1,272	90.01
90.02	09002	GEROPSYCH	37,673	0	0	786	1,359	90.02
91.00	09100	EMERGENCY	31,811	0	0	6,019	10,414	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	909,143	0	0	46,061	70,342	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	1,787	194.00
194.01	07951	MEDICAL ARTS BUILDING	2,215	0	0	0	10	194.01
194.02	07952	FOUNDATION	0	0	0	0	313	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)	911,358	0	0	46,061	72,452	202.00

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		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 DEPARTMENT						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	78,093					6.00
7.00	00700	OPERATION OF PLANT	0	1,502				7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	186			7.01
9.00	00900	HOUSEKEEPING	4,080	78	0	38,168		9.00
10.00	01000	DIETARY	5,111	98	0	2,636	50,359	10.00
11.00	01100	CAFETERIA	1,746	34	0	900	24,580	11.00
13.00	01300	NURSING ADMINISTRATION	222	4	0	114	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,477	86	0	2,309	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,059	213	0	5,703	6,389	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,814	150	0	4,030	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,826	112	0	3,004	0	54.00
60.00	06000	LABORATORY	2,206	42	0	1,138	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	185	4	0	95	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,397	27	0	720	0	65.00
66.00	06600	PHYSICAL THERAPY	3,169	61	0	1,634	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,896	36	0	978	0	67.00
68.00	06800	SPEECH PATHOLOGY	863	17	0	445	0	68.00
69.00	06900	ELECTROCARDIOLOGY	931	18	0	480	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,866	55	0	1,478	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	1,277	25	0	658	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	186	0	0	88.00
90.00	09000	CLINIC	13,661	263	0	7,047	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	0	0	0	0	90.01
90.02	09002	GEROPSYCH	5,046	97	0	2,602	0	90.02
91.00	09100	EMERGENCY	4,261	82	0	2,197	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	78,093	1,502	186	38,168	30,969	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	17,951	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	1,439	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)	78,093	1,502	186	38,168	50,359	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet B Part II Date/Time Prepared: 7/24/2014 11:22 am

		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 DEPARTMENT						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	40,394					11.00
13.00	01300	NURSING ADMINISTRATION	608	3,724				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,313	0	48,062			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,039	1,745	11,402	138,320	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,510	292	0	74,671	0	50.00
53.00	05300	ANESTHESIOLOGY	949	0	0	3,680	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,518	0	3,542	69,838	0	54.00
60.00	06000	LABORATORY	4,751	0	3,339	36,332	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	2,079	0	62.00
65.00	06500	RESPIRATORY THERAPY	217	42	1,218	14,662	0	65.00
66.00	06600	PHYSICAL THERAPY	3,849	0	1,790	37,956	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,448	0	0	21,419	0	67.00
68.00	06800	SPEECH PATHOLOGY	569	0	0	9,234	0	68.00
69.00	06900	ELECTROCARDIOLOGY	972	187	941	12,720	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	26,377	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	88	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	16,864	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	11,993	139,222	0	88.00
90.00	09000	CLINIC	2,195	424	4,649	136,706	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	0	0	29,450	0	90.01
90.02	09002	GEROPSYCH	101	0	0	47,664	0	90.02
91.00	09100	EMERGENCY	5,355	1,034	9,188	70,361	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	40,394	3,724	48,062	887,643	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	19,738	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	2,225	0	194.01
194.02	07952	FOUNDATION	0	0	0	313	0	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	1,439	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)	40,394	3,724	48,062	911,358	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet B Part II | Date/Time Prepared: 7/24/2014 11:22 am

		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 DEPARTMENT			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	138,320		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	74,671		50.00
53.00	05300	ANESTHESIOLOGY	3,680		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	69,838		54.00
60.00	06000	LABORATORY	36,332		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,079		62.00
65.00	06500	RESPIRATORY THERAPY	14,662		65.00
66.00	06600	PHYSICAL THERAPY	37,956		66.00
67.00	06700	OCCUPATIONAL THERAPY	21,419		67.00
68.00	06800	SPEECH PATHOLOGY	9,234		68.00
69.00	06900	ELECTROCARDIOLOGY	12,720		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	26,377		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	88		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,864		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	139,222		88.00
90.00	09000	CLINIC	136,706		90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	29,450		90.01
90.02	09002	GEROPSYCH	47,664		90.02
91.00	09100	EMERGENCY	70,361		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	887,643		118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
194.00	07950	CULBERTSON GARDENS	19,738		194.00
194.01	07951	MEDICAL ARTS BUILDING	2,225		194.01
194.02	07952	FOUNDATION	313		194.02
194.03	07953	OUTPATIENT MEALS	1,439		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)	911,358		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet B-1 | Date/Time Prepared: 7/24/2014 11:22 am

		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 DEPARTMENT (GROSS SALARIE)	
			1.00	1.01	1.02	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	55,899					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				55,899		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	7,284,611	4.00
5.02	00511	BUSINESS OFFICE - HOSPITAL	0	0	0	0	174,606	5.02
5.04	00513	HOSPITAL ONLY ADMIN & GENERAL	3,339	0	0	3,339	316,600	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	4,860	0	0	4,860	587,119	5.05
6.00	00600	MAINTENANCE & REPAIRS	5,437	0	0	5,437	193,963	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	58,800	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	302,674	9.00
10.00	01000	DIETARY	2,766	0	0	2,766	296,053	10.00
11.00	01100	CAFETERIA	945	0	0	945	0	11.00
13.00	01300	NURSING ADMINISTRATION	120	0	0	120	102,830	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,423	0	0	2,423	280,645	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,985	0	0	5,985	735,208	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,229	0	0	4,229	150,442	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	248,977	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,153	0	0	3,153	422,634	54.00
60.00	06000	LABORATORY	1,194	0	0	1,194	408,779	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	18,727	65.00
66.00	06600	PHYSICAL THERAPY	1,715	0	0	1,715	319,114	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,026	0	0	1,026	255,886	67.00
68.00	06800	SPEECH PATHOLOGY	467	0	0	467	78,231	68.00
69.00	06900	ELECTROCARDIOLOGY	504	0	0	504	92,944	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,551	0	0	1,551	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	1,151,273	88.00
90.00	09000	CLINIC	7,393	0	0	7,393	155,087	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	0	8,698	0	140,800	90.01
90.02	09002	GEROPSYCH	2,731	0	0	2,731	115,117	90.02
91.00	09100	EMERGENCY	2,306	0	0	2,306	487,953	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	55,899	11,800	8,698	55,899	7,094,462	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	173,913	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	702	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	16,236	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)	279,660	110,591	29,658	491,449	2,517,394	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.002952	9.372119	3.155106	8.791732	0.345577	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 03/01/2013 To 02/28/2014 | Worksheet B-1 | Date/Time Prepared: 7/24/2014 11:22 am

		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 DEPARTMENT						4.00
5.02	00511	BUSINESS OFFICE - HOSPITAL	30,224,145					5.02
5.04	00513	HOSPITAL ONLY ADMIN & GENERAL	0	-561,934	16,793,655			5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	0	0	1,972,410	-2,038,409	15,776,574	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	412,799	0	426,612	6.00
7.00	00700	OPERATION OF PLANT	0	0	200,664	0	207,378	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	24,917	0	25,751	7.01
9.00	00900	HOUSEKEEPING	0	0	474,181	0	490,048	9.00
10.00	01000	DIETARY	0	0	582,026	0	601,501	10.00
11.00	01100	CAFETERIA	0	0	13,036	0	13,472	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	149,675	0	154,683	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	461,102	0	476,531	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,384,812	0	1,363,159	0	1,408,772	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,369,244	0	338,865	0	350,204	50.00
53.00	05300	ANESTHESIOLOGY	486,969	0	364,725	0	376,929	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,274,190	0	1,247,450	0	1,289,191	54.00
60.00	06000	LABORATORY	5,827,198	0	1,119,724	0	1,157,191	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	121,506	0	55,529	0	57,387	62.00
65.00	06500	RESPIRATORY THERAPY	197,107	0	81,838	0	84,576	65.00
66.00	06600	PHYSICAL THERAPY	1,594,425	0	506,688	0	523,642	66.00
67.00	06700	OCCUPATIONAL THERAPY	888,143	0	388,408	0	401,405	67.00
68.00	06800	SPEECH PATHOLOGY	224,064	0	119,990	0	124,005	68.00
69.00	06900	ELECTROCARDIOLOGY	1,919,103	0	299,019	0	309,024	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	238,926	0	77,743	0	80,344	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,600	0	11,712	0	12,104	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,471,778	0	717,348	0	741,351	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,715,749	0	2,196,102	0	2,269,587	88.00
90.00	09000	CLINIC	2,065,640	0	865,653	0	894,619	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	221,303	0	268,060	0	277,030	90.01
90.02	09002	GEROPSYCH	221,929	0	286,454	0	296,039	90.02
91.00	09100	EMERGENCY	1,984,459	0	2,194,378	0	2,267,804	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	30,224,145	-561,934	16,793,655	-2,038,409	15,317,180	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	-389,079	0	0	389,079	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	-2,215	0	0	2,215	194.01
194.02	07952	FOUNDATION	0	-68,100	0	0	68,100	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)	288,984		561,934		2,038,409	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.009561		0.033461		0.129205	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		46,061		72,452	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		0.002743		0.004592	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet B-1 | Date/Time Prepared: 7/24/2014 11:22 am

		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 DEPARTMENT						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	42,263					6.00
7.00	00700	OPERATION OF PLANT	0	42,263				7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	11,800			7.01
9.00	00900	HOUSEKEEPING	2,208	2,208	0	40,055		9.00
10.00	01000	DIETARY	2,766	2,766	0	2,766	37,682	10.00
11.00	01100	CAFETERIA	945	945	0	945	18,392	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	4,781	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,229	4,229	0	4,229	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	1,194	1,194	0	1,194	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	1,715	1,715	0	1,715	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,026	1,026	0	1,026	0	67.00
68.00	06800	SPEECH PATHOLOGY	467	467	0	467	0	68.00
69.00	06900	ELECTROCARDIOLOGY	504	504	0	504	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,551	1,551	0	1,551	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
90.00	09000	CLINIC	7,393	7,393	0	7,393	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	0	0	0	0	90.01
90.02	09002	GEROPSYCH	2,731	2,731	0	2,731	0	90.02
91.00	09100	EMERGENCY	2,306	2,306	0	2,306	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	42,263	42,263	11,800	40,055	23,173	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	13,432	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	1,077	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)	481,732	234,172	29,078	590,767	766,867	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.398434	5.540828	2.464237	14.748895	20.351016	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	78,093	1,502	186	38,168	50,359	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.847786	0.035539	0.015763	0.952890	1.336421	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet B-1 | Date/Time Prepared: 7/24/2014 11:22 am

		Cost Center Description	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRS ING)	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 DEPARTMENT					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	10,433				11.00
13.00	01300	NURSING ADMINISTRATION	157	61,109			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,114	0	2,605		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,335	28,642	618		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	390	4,788	0		50.00
53.00	05300	ANESTHESIOLOGY	245	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,167	0	192		54.00
60.00	06000	LABORATORY	1,227	0	181		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	56	690	66		65.00
66.00	06600	PHYSICAL THERAPY	994	0	97		66.00
67.00	06700	OCCUPATIONAL THERAPY	374	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	147	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	251	3,073	51		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	650		88.00
90.00	09000	CLINIC	567	6,954	252		90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	0	0		90.01
90.02	09002	GEROPSYCH	26	0	0		90.02
91.00	09100	EMERGENCY	1,383	16,962	498		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,433	61,109	2,605		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)	419,455	184,784	659,669		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	40.204639	3.023843	253.231862		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	40,394	3,724	48,062		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.871753	0.060940	18.449904		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet C Part I Date/Time Prepared: 7/24/2014 11:22 am

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	2,214,730		2,214,730	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	559,619		559,619	0	0	50.00
53.00	05300	ANESTHESIOLOGY	435,480		435,480	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,651,213		1,651,213	0	0	54.00
60.00	06000	LABORATORY	1,439,708		1,439,708	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	67,971		67,971	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	140,510	0	140,510	0	0	65.00
66.00	06600	PHYSICAL THERAPY	710,170	0	710,170	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	500,818	0	500,818	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	160,736	0	160,736	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	397,220		397,220	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	139,874		139,874	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,668		13,668	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	859,033		859,033	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,756,505		2,756,505	0	0	88.00
90.00	09000	CLINIC	1,352,116		1,352,116	0	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	312,824		312,824	0	0	90.01
90.02	09002	GEROPSYCH	421,874		421,874	0	0	90.02
91.00	09100	EMERGENCY	2,866,891		2,866,891	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	181,516		181,516		0	92.00
200.00		Subtotal (see instructions)	17,182,476	0	17,182,476	0	0	200.00
201.00		Less Observation Beds	181,516		181,516		0	201.00
202.00		Total (see instructions)	17,000,960	0	17,000,960	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet C Part I Date/Time Prepared: 7/24/2014 11:22 am

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	1,191,508		1,191,508			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,951	1,345,293	1,369,244	0.408707	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	13,090	473,879	486,969	0.894266	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	122,653	7,151,537	7,274,190	0.226996	0.000000	54.00
60.00	06000	LABORATORY	282,018	5,545,180	5,827,198	0.247067	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	19,941	101,565	121,506	0.559404	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	13	197,094	197,107	0.712862	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	100,655	1,493,770	1,594,425	0.445408	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	117,510	770,633	888,143	0.563893	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	20,631	203,433	224,064	0.717366	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	75,304	1,843,799	1,919,103	0.206982	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	147,244	91,682	238,926	0.585428	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	17,600	17,600	0.776591	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	461,184	2,010,594	2,471,778	0.347536	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,715,749	1,715,749			88.00
90.00	09000	CLINIC	1,459	2,064,181	2,065,640	0.654575	0.000000	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	221,303	221,303	1.413555	0.000000	90.01
90.02	09002	GEROPSYCH	0	221,929	221,929	1.900941	0.000000	90.02
91.00	09100	EMERGENCY	21,003	1,963,456	1,984,459	1.444671	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,367	188,937	193,304	0.939018	0.000000	92.00
200.00		Subtotal (see instructions)	2,602,531	27,621,614	30,224,145			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,602,531	27,621,614	30,224,145			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet C Part I Date/Time Prepared: 7/24/2014 11:22 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		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
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
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 03/01/2013 To 02/28/2014 | Worksheet C Part I Date/Time Prepared: 7/24/2014 11:22 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,214,730		2,214,730	0	2,214,730	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	559,619		559,619	0	559,619	50.00
53.00	05300	ANESTHESIOLOGY	435,480		435,480	0	435,480	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,651,213		1,651,213	0	1,651,213	54.00
60.00	06000	LABORATORY	1,439,708		1,439,708	0	1,439,708	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	67,971		67,971	0	67,971	62.00
65.00	06500	RESPIRATORY THERAPY	140,510	0	140,510	0	140,510	65.00
66.00	06600	PHYSICAL THERAPY	710,170	0	710,170	0	710,170	66.00
67.00	06700	OCCUPATIONAL THERAPY	500,818	0	500,818	0	500,818	67.00
68.00	06800	SPEECH PATHOLOGY	160,736	0	160,736	0	160,736	68.00
69.00	06900	ELECTROCARDIOLOGY	397,220		397,220	0	397,220	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	139,874		139,874	0	139,874	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,668		13,668	0	13,668	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	859,033		859,033	0	859,033	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,756,505		2,756,505	0	2,756,505	88.00
90.00	09000	CLINIC	1,352,116		1,352,116	0	1,352,116	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	312,824		312,824	0	312,824	90.01
90.02	09002	GEROPSYCH	421,874		421,874	0	421,874	90.02
91.00	09100	EMERGENCY	2,866,891		2,866,891	0	2,866,891	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	181,516		181,516		181,516	92.00
200.00		Subtotal (see instructions)	17,182,476	0	17,182,476	0	17,182,476	200.00
201.00		Less Observation Beds	181,516		181,516		181,516	201.00
202.00		Total (see instructions)	17,000,960	0	17,000,960	0	17,000,960	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet C Part I Date/Time Prepared: 7/24/2014 11:22 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,191,508		1,191,508			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,951	1,345,293	1,369,244	0.408707	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	13,090	473,879	486,969	0.894266	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	122,653	7,151,537	7,274,190	0.226996	0.000000	54.00
60.00	06000	LABORATORY	282,018	5,545,180	5,827,198	0.247067	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	19,941	101,565	121,506	0.559404	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	13	197,094	197,107	0.712862	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	100,655	1,493,770	1,594,425	0.445408	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	117,510	770,633	888,143	0.563893	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	20,631	203,433	224,064	0.717366	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	75,304	1,843,799	1,919,103	0.206982	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	147,244	91,682	238,926	0.585428	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	17,600	17,600	0.776591	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	461,184	2,010,594	2,471,778	0.347536	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,715,749	1,715,749	1.606590	0.000000	88.00
90.00	09000	CLINIC	1,459	2,064,181	2,065,640	0.654575	0.000000	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	221,303	221,303	1.413555	0.000000	90.01
90.02	09002	GEROPSYCH	0	221,929	221,929	1.900941	0.000000	90.02
91.00	09100	EMERGENCY	21,003	1,963,456	1,984,459	1.444671	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,367	188,937	193,304	0.939018	0.000000	92.00
200.00		Subtotal (see instructions)	2,602,531	27,621,614	30,224,145			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,602,531	27,621,614	30,224,145			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet C Part I Date/Time Prepared: 7/24/2014 11:22 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		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
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
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 03/01/2013 To 02/28/2014 | Worksheet D Part II Date/Time Prepared: 7/24/2014 11:22 am

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	74,671	1,369,244	0.054534	0	0	50.00
53.00	05300	ANESTHESIOLOGY	3,680	486,969	0.007557	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	69,838	7,274,190	0.009601	85,407	820	54.00
60.00	06000	LABORATORY	36,332	5,827,198	0.006235	156,960	979	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,079	121,506	0.017110	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	14,662	197,107	0.074386	13	1	65.00
66.00	06600	PHYSICAL THERAPY	37,956	1,594,425	0.023805	10,644	253	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,419	888,143	0.024117	11,232	271	67.00
68.00	06800	SPEECH PATHOLOGY	9,234	224,064	0.041211	5,163	213	68.00
69.00	06900	ELECTROCARDIOLOGY	12,720	1,919,103	0.006628	61,169	405	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	26,377	238,926	0.110398	81,910	9,043	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	88	17,600	0.005000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,864	2,471,778	0.006823	184,446	1,258	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	139,222	1,715,749	0.081144	0	0	88.00
90.00	09000	CLINIC	136,706	2,065,640	0.066181	0	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	29,450	221,303	0.133075	0	0	90.01
90.02	09002	GEROPSYCH	47,664	221,929	0.214771	0	0	90.02
91.00	09100	EMERGENCY	70,361	1,984,459	0.035456	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	25,209	193,304	0.130411	0	0	92.00
200.00		Total (lines 50-199)	774,532	29,032,637		596,944	13,243	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet D Part IV Date/Time Prepared: 7/24/2014 11:22 am

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
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 03/01/2013 To 02/28/2014 | Worksheet D Part IV Date/Time Prepared: 7/24/2014 11:22 am

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	1,369,244	0.000000	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	0	486,969	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,274,190	0.000000	0.000000	85,407	54.00
60.00	06000	LABORATORY	0	5,827,198	0.000000	0.000000	156,960	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	121,506	0.000000	0.000000	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	197,107	0.000000	0.000000	13	65.00
66.00	06600	PHYSICAL THERAPY	0	1,594,425	0.000000	0.000000	10,644	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	888,143	0.000000	0.000000	11,232	67.00
68.00	06800	SPEECH PATHOLOGY	0	224,064	0.000000	0.000000	5,163	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,919,103	0.000000	0.000000	61,169	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	238,926	0.000000	0.000000	81,910	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	17,600	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,471,778	0.000000	0.000000	184,446	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,715,749	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	2,065,640	0.000000	0.000000	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	221,303	0.000000	0.000000	0	90.01
90.02	09002	GEROPSYCH	0	221,929	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	1,984,459	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	193,304	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	29,032,637			596,944	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet D Part IV | Date/Time Prepared: 7/24/2014 11:22 am

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
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 03/01/2013 To 02/28/2014 | Worksheet D Part V Date/Time Prepared: 7/24/2014 11:22 am

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	0.408707	0	529,688	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.894266	0	160,305	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.226996	0	2,913,446	6	0	54.00
60.00	06000	LABORATORY	0.247067	0	2,806,189	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.559404	0	4,123	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.712862	0	82,692	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.445408	0	648,992	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.563893	0	363,848	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.717366	0	22,519	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.206982	0	1,074,242	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.585428	0	61,225	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.776591	0	9,856	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.347536	0	1,554,184	2,522	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.654575	0	1,356,465	4,464	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	1.413555	0	91,245	41	0	90.01
90.02	09002	GEROPSYCH	1.900941	0	215,531	0	0	90.02
91.00	09100	EMERGENCY	1.444671	0	678,098	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.939018	0	121,780	0	0	92.00
200.00		Subtotal (see instructions)		0	12,694,428	7,033	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	12,694,428	7,033	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet D Part V Date/Time Prepared: 7/24/2014 11:22 am

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	216,487	0		50.00
53.00	05300	ANESTHESIOLOGY	143,355	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	661,341	1		54.00
60.00	06000	LABORATORY	693,317	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,306	0		62.00
65.00	06500	RESPIRATORY THERAPY	58,948	0		65.00
66.00	06600	PHYSICAL THERAPY	289,066	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	205,171	0		67.00
68.00	06800	SPEECH PATHOLOGY	16,154	0		68.00
69.00	06900	ELECTROCARDIOLOGY	222,349	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	35,843	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,654	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	540,135	876		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	887,908	2,922		90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	128,980	58		90.01
90.02	09002	GEROPSYCH	409,712	0		90.02
91.00	09100	EMERGENCY	979,629	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	114,354	0		92.00
200.00		Subtotal (see instructions)	5,612,709	3,857		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,612,709	3,857		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141333 | Component CCN: 14Z333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet D Part V | Date/Time Prepared: 7/24/2014 11:22 am

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	0.408707	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.894266	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.226996	0	0	0	0	54.00
60.00	06000	LABORATORY	0.247067	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.559404	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.712862	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.445408	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.563893	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.717366	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.206982	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.585428	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.776591	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.347536	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.654575	0	0	0	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	1.413555	0	0	0	0	90.01
90.02	09002	GEROPSYCH	1.900941	0	0	0	0	90.02
91.00	09100	EMERGENCY	1.444671	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.939018	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 03/01/2013 To 02/28/2014 | Worksheet D Part V | Date/Time Prepared: 7/24/2014 11:22 am

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
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 03/01/2013 To 02/28/2014	Worksheet D-1 Date/Time Prepared: 7/24/2014 11:22 am
	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)	1,450	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	631	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)	516	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	594	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)	174	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	51	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	384	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)	594	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	128.38	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	132.23	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,214,730	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)	6,547	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	1,218,758	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	995,972	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	995,972	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)	1,578.40	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	606,106	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)	606,106	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet D-1 | Date/Time Prepared: 7/24/2014 11:22 am

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)	197,670	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	803,776	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)	937,570	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	77,342	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,014,912	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)	115	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,578.40	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	181,516	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141333	Period: From 03/01/2013 To 02/28/2014	Worksheet D-1 Date/Time Prepared: 7/24/2014 11:22 am
	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	138,320	995,972	0.138879	181,516	25,209	90.00
91.00	Nursing School cost	0	995,972	0.000000	181,516	0	91.00
92.00	Allied health cost	0	995,972	0.000000	181,516	0	92.00
93.00	All other Medical Education	0	995,972	0.000000	181,516	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet D-3 | Date/Time Prepared: 7/24/2014 11:22 am

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		542,455		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.408707	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.894266	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.226996	85,407	19,387	54.00
60.00	06000	LABORATORY	0.247067	156,960	38,780	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.559404	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.712862	13	9	65.00
66.00	06600	PHYSICAL THERAPY	0.445408	10,644	4,741	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.563893	11,232	6,334	67.00
68.00	06800	SPEECH PATHOLOGY	0.717366	5,163	3,704	68.00
69.00	06900	ELECTROCARDIOLOGY	0.206982	61,169	12,661	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.585428	81,910	47,952	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.776591	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.347536	184,446	64,102	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.654575	0	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	1.413555	0	0	90.01
90.02	09002	GEROPSYCH	1.900941	0	0	90.02
91.00	09100	EMERGENCY	1.444671	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.939018	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		596,944	197,670	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)		596,944		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141333 | Component CCN: 14Z333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet D-3 | Date/Time Prepared: 7/24/2014 11:22 am

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	0.408707	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.894266	210	188	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.226996	11,622	2,638	54.00
60.00	06000	LABORATORY	0.247067	95,445	23,581	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.559404	4,273	2,390	62.00
65.00	06500	RESPIRATORY THERAPY	0.712862	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.445408	74,333	33,109	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.563893	88,820	50,085	67.00
68.00	06800	SPEECH PATHOLOGY	0.717366	12,151	8,717	68.00
69.00	06900	ELECTROCARDIOLOGY	0.206982	12,792	2,648	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.585428	51,482	30,139	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.776591	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.347536	219,999	76,458	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.654575	0	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	1.413555	0	0	90.01
90.02	09002	GEROPSYCH	1.900941	0	0	90.02
91.00	09100	EMERGENCY	1.444671	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.939018	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		571,127	229,953	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)		571,127		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141333	Period: From 03/01/2013 To 02/28/2014	Worksheet E Part B Date/Time Prepared: 7/24/2014 11:22 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,616,566	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)	5,616,566	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)	5,672,732	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)	41,911	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,001,099	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)	3,629,722	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)	3,629,722	30.00
31.00	Primary payer payments	850	31.00
32.00	Subtotal (line 30 minus line 31)	3,628,872	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)	477,340	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	420,059	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	474,659	36.00
37.00	Subtotal (see instructions)	4,048,931	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	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,048,931	40.00
40.01	Sequestration adjustment (see instructions)	74,095	40.01
41.00	Interim payments	4,009,566	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-34,730	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 03/01/2013 To 02/28/2014 | Worksheet E-1 Part I | Date/Time Prepared: 7/24/2014 11:22 am

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		565,159		3,596,766	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	09/30/2013	103,200	09/30/2013	412,800	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)		103,200		412,800	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)		668,359		4,009,566	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		44,533		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		34,730	6.02
7.00	Total Medicare program liability (see instructions)		712,892		3,974,836	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet E-1 Part I | Date/Time Prepared: 7/24/2014 11:22 am

Component CCN: 14Z333 | 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		953,015		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	09/30/2013	130,500		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)		130,500		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,083,515		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		135,825		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,219,340		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 141333	Period: From 03/01/2013 To 02/28/2014	Worksheet E-1 Part II Date/Time Prepared: 7/24/2014 11:22 am
	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	176	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	384	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	516	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	30,224,145	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	239,370	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141333 Component CCN: 14Z333	Period: From 03/01/2013 To 02/28/2014	Worksheet E-2 Date/Time Prepared: 7/24/2014 11:22 am
	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)	1,025,061	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 6 and 7, line 202 for Part B) (For CAH, see instructions)	232,253	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	643	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)	1,257,314	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,257,314	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)	1,257,314	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	15,244	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)	1,242,070	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,242,070	0	19.00
19.01	Sequestration adjustment (see instructions)	22,730	0	19.01
20.00	Interim payments	1,083,515	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21	135,825	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141333	Period: From 03/01/2013 To 02/28/2014	Worksheet E-3 Part V Date/Time Prepared: 7/24/2014 11:22 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	803,776	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)	803,776	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	811,814	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)	811,814	19.00
20.00	Deductibles (exclude professional component)	105,856	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	705,958	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	705,958	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	22,981	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	20,223	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	18,592	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	726,181	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)	726,181	30.00
30.01	Sequestration adjustment (see instructions)	13,289	30.01
31.00	Interim payments	668,359	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program line 30 minus lines 30.01, 31, and 32	44,533	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 03/01/2013 To 02/28/2014 | Worksheet G | Date/Time Prepared: 7/24/2014 11:22 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	6,434,343	0	0	0	1.00
2.00	Temporary investments	164,090	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,337,834	0	0	0	4.00
5.00	Other receivable	651,818	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	407,048	0	0	0	7.00
8.00	Prepaid expenses	29,208	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	11,024,341	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	411,152	0	0	0	12.00
13.00	Land improvements	993,433	0	0	0	13.00
14.00	Accumulated depreciation	-575,861	0	0	0	14.00
15.00	Buildings	6,039,858	0	0	0	15.00
16.00	Accumulated depreciation	-3,186,676	0	0	0	16.00
17.00	Leasehold improvements	615,252	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	9,714,822	0	0	0	23.00
24.00	Accumulated depreciation	-7,905,925	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)	6,106,055	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	3,470,293	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	139,070	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,609,363	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	20,739,759	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	308,637	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,127,385	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	60,246	0	0	0	40.00
41.00	Deferred income	89,051	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	93,117	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,678,436	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	786,569	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	119,308	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	905,877	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	2,584,313	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	18,155,446				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)	18,155,446	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	20,739,759	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141333 | Period: From 03/01/2013 To 02/28/2014 | Worksheet G-1 | Date/Time Prepared: 7/24/2014 11:22 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		15,963,954		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,191,492				2.00
3.00	Total (sum of line 1 and line 2)		18,155,446		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		18,155,446		0		11.00
12.00	ROUNDING	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)		18,155,446		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	ROUNDING		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 03/01/2013 To 02/28/2014 | Worksheet G-2 Parts I & II | Date/Time Prepared: 7/24/2014 11:22 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,102,436		1,102,436	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	325,215		325,215	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,427,651		1,427,651	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)	1,427,651		1,427,651	17.00
18.00	Ancillary services	1,307,569	22,679,519	23,987,088	18.00
19.00	Outpatient services	33,886	6,638,892	6,672,778	19.00
20.00	RURAL HEALTH CLINIC	5,716	1,742,465	1,748,181	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	CULBERTSON GARDENS	0	420,492	420,492	27.00
27.01	DIETARY	0	2,754	2,754	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,774,822	31,484,122	34,258,944	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		20,483,363		29.00
30.00		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	PATIENT COLLECTION FEES	25,016			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)		25,016		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		20,458,347		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141333	Period: From 03/01/2013 To 02/28/2014	Worksheet G-3 Date/Time Prepared: 7/24/2014 11:22 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	34,258,944	1.00
2.00	Less contractual allowances and discounts on patients' accounts	11,583,130	2.00
3.00	Net patient revenues (line 1 minus line 2)	22,675,814	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	20,458,347	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,217,467	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	97,761	6.00
7.00	Income from investments	115,361	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	3,627	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	494,158	24.00
24.01	TAX REVENUE	563,681	24.01
24.02	EHR REIMBURSEMENT	106,330	24.02
25.00	Total other income (sum of lines 6-24)	1,380,918	25.00
26.00	Total (line 5 plus line 25)	3,598,385	26.00
27.00	BAD DEBTS	1,195,313	27.00
27.01	CHARITY CARE	211,580	27.01
27.02		0	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	1,406,893	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,191,492	29.00

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

Provider CCN: 141333 Component CCN: 143483 | Period: From 03/01/2013 To 02/28/2014 | Worksheet M-1 | Date/Time Prepared: 7/24/2014 11:22 am

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	297,447	0	297,447	30,750	328,197	1.00
2.00	Physician Assistant	106,178	0	106,178	0	106,178	2.00
3.00	Nurse Practitioner	172,856	0	172,856	0	172,856	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	291,377	0	291,377	0	291,377	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	77,215	0	77,215	-77,215	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)	945,073	0	945,073	-46,465	898,608	10.00
11.00	Physician Services Under Agreement	0	421,140	421,140	0	421,140	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	27,848	27,848	0	27,848	13.00
14.00	Subtotal (sum of lines 11-13)	0	448,988	448,988	0	448,988	14.00
15.00	Medical Supplies	0	28,436	28,436	0	28,436	15.00
16.00	Transportation (Health Care Staff)	0	7,536	7,536	0	7,536	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	35,972	35,972	0	35,972	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	945,073	484,960	1,430,033	-46,465	1,383,568	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	302,935	62,260	365,195	-57,488	307,707	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	302,935	62,260	365,195	-57,488	307,707	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,248,008	547,220	1,795,228	-103,953	1,691,275	32.00

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

Provider CCN: 141333 Component CCN: 143483 | Period: From 03/01/2013 To 02/28/2014 | Worksheet M-1 | Date/Time Prepared: 7/24/2014 11:22 am

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-6,241	321,956		1.00
2.00	Physician Assistant	-601	105,577		2.00
3.00	Nurse Practitioner	-1,715	171,141		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	291,377		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)	-8,557	890,051		10.00
11.00	Physician Services Under Agreement	0	421,140		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	27,848		13.00
14.00	Subtotal (sum of lines 11-13)	0	448,988		14.00
15.00	Medical Supplies	0	28,436		15.00
16.00	Transportation (Health Care Staff)	0	7,536		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	35,972		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-8,557	1,375,011		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	-11,464	296,243		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-11,464	296,243		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-20,021	1,671,254		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141333 | Component CCN: 143483 | Period: From 03/01/2013 To 02/28/2014 | Worksheet M-2 | Date/Time Prepared: 7/24/2014 11:22 am

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.36	8,352	4,200	9,912		1.00
2.00	Physician Assistant	0.77	2,436	2,100	1,617		2.00
3.00	Nurse Practitioner	1.49	3,828	2,100	3,129		3.00
4.00	Subtotal (sum of lines 1-3)	4.62	14,616		14,658	14,658	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)	4.62	14,616			14,658	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)					1,375,011	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)					1,375,011	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)					296,243	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,085,251	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,381,494	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					1,381,494	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					1,381,494	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					2,756,505	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141333 Component CCN: 143483	Period: From 03/01/2013 To 02/28/2014	Worksheet M-3 Date/Time Prepared: 7/24/2014 11:22 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		2,756,505	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		24,657	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,731,848	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		14,658	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)		14,658	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		186.37	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.17	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	186.37	186.37	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	4,299	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	801,205	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) *		801,205	16.00
16.01	Total program charges (see instructions)(from contractor's records)		522,632	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		4,318	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		6,620	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.)		588,073	16.04
16.05	Total program cost (see instructions)		594,693	16.05
17.00	Primary payer amounts		237	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		59,494	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		91,764	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		594,456	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		15,011	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		609,467	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (see instructions)		609,467	26.00
26.01	Sequestration adjustment (see instructions)		11,153	26.01
27.00	Interim payments		587,040	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program line 26 minus lines 26.01, 27 and 28		11,274	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 03/01/2013 To 02/28/2014	Worksheet M-4 Date/Time Prepared: 7/24/2014 11:22 am
	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)	890,051	890,051	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000178	0.002457	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	158	2,187	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,865	8,090	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	2,023	10,277	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	1,375,011	1,375,011	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	1,381,494	1,381,494	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001471	0.007474	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	2,032	10,325	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	4,055	20,602	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	23	317	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	176.30	64.99	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	14	193	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	2,468	12,543	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)		24,657	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)		15,011	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 03/01/2013 To 02/28/2014 | Worksheet M-5 | Date/Time Prepared: 7/24/2014 11:22 am

Rural Health Clinic (RHC) I | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		587,040	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		587,040	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		11,274	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		598,314	7.00

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