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 03/01/2014 To 02/28/2015	Worksheet S Parts I-III Date/Time Prepared: 7/22/2015 4:07 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 7/22/2015 Time: 4:07 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SARAH D CULBERTSON (141333) for the cost reporting period beginning 03/01/2014 and ending 02/28/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	11,325	10,172	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	33,664	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		51,002		0	10.00
200.00	Total	0	44,989	61,174	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.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet S-2 Part I | Date/Time Prepared: 7/20/2015 1:16 pm

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

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

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	03/01/2014	02/28/2015	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)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	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 column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet S-2 Part I | Date/Time Prepared: 7/20/2015 1:16 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	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
		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)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet S-2 Part I | Date/Time Prepared: 7/20/2015 1:16 pm

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings					
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet S-2 Part I Date/Time Prepared: 7/20/2015 1:16 pm

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)	N		0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)			0	76.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet S-2 Part I | Date/Time Prepared: 7/20/2015 1:16 pm

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	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.	Y	N	N	N	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	263,384	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet S-2 Part I | Date/Time Prepared: 7/20/2015 1:16 pm

		1.00	2.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

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

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

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

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	N	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141333	Period: From 03/01/2014 To 02/28/2015	Worksheet S-2 Part I Date/Time Prepared: 7/20/2015 1:16 pm

		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)			170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet S-2 Part II | Date/Time Prepared: 7/20/2015 1:16 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		N		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		Y		5.00
				Y/N	Legal Oper.
				1.00	2.00
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N	6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N	7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N	8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.			N	9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.			N	10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N	11.00
					Y/N
					1.00
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y 12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N 13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N 14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				N 15.00
			Part A		Part B
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N 16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	04/21/2015	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 03/01/2014 To 02/28/2015 | Worksheet S-2 Part II | Date/Time Prepared: 7/20/2015 1:16 pm

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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 03/01/2014 To 02/28/2015 | Worksheet S-2 Part II | Date/Time Prepared: 7/20/2015 1:16 pm

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)				16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	04/21/2015			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 03/01/2014 To 02/28/2015 | Worksheet S-3 Part I Date/Time Prepared: 7/20/2015 1:16 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	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 03/01/2014 To 02/28/2015 | Worksheet S-3 Part I | Date/Time Prepared: 7/20/2015 1:16 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	438	32	570			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	616	0	616			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	366			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,054	32	1,552			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)	1,054	32	1,552	0.00	123.91	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)	3,786	0	15,082	0.00	22.35	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	146.26	27.00
28.00	Observation Bed Days		0	164			28.00
29.00	Ambulance Trips	1					29.00
30.00	Employee discount days (see instruction)			0			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 03/01/2014 To 02/28/2015 | Worksheet S-3 Part I | Date/Time Prepared: 7/20/2015 1:16 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	126	10	176	1.00
2.00	HMO and other (see instructions)			0	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	126	10	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 03/01/2014 To 02/28/2015 | Worksheet S-8 | Date/Time Prepared: 7/20/2015 1:16 pm

				Rural Health Clinic (RHC) I	Cost	
				1.00		
	Clinic Address and Identification					
1.00	Street			238 S. CONGRESS		1.00
		City		State	Zip Code	
		1.00		2.00	3.00	
2.00	City, State, Zip Code, County	RUSHVILLE		IL	62681	2.00
					1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
				Grant Award	Date	
				1.00	2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0		6.00
7.00	Appalachian Regional Commission			0		7.00
8.00	Look-Alikes			0		8.00
9.00	OTHER (SPECIFY)			0		9.00
				1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 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	17:00	08:00	17:00	08:00	17:00	11.00

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

Provider CCN: 141333
Component CCN: 143483

Period: From 03/01/2014 To 02/28/2015

Worksheet S-8
Date/Time Prepared: 7/20/2015 1:16 pm

Rural Health Clinic (RHC) I

Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet S-10 | Date/Time Prepared: 7/20/2015 1:16 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.556281	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,003,819	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?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	1,528,912	5.00
6.00	Medicaid charges	4,838,443	6.00
7.00	Medicaid cost (line 1 times line 6)	2,691,534	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)	158,803	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	575,725	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	158,803	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	65,986	33,588	99,574	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	36,707	18,684	55,391	21.00
22.00	Partial payment by patients approved for charity care	21,902	12,652	34,554	22.00
23.00	Cost of charity care (line 21 minus line 22)	14,805	6,032	20,837	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)	1,285,917	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	237,261	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,048,656	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	583,347	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	604,184	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	762,987	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet A | Date/Time Prepared: 7/20/2015 1:16 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		284,664	284,664	9,756	294,420	1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME		108,932	108,932	2,274	111,206	1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME		24,745	24,745	949	25,694	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		527,825	527,825	8,577	536,402	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,974,383	2,974,383	0	2,974,383	4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	210,030	77,649	287,679	0	287,679	5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	359,519	180,494	540,013	0	540,013	5.04
5.05	00590	OTHER ADMIN. & GENERAL	604,564	1,240,676	1,845,240	-25,192	1,820,048	5.05
6.00	00600	MAINTENANCE & REPAIRS	192,186	96,411	288,597	0	288,597	6.00
7.00	00700	OPERATION OF PLANT	56,494	145,164	201,658	0	201,658	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	17,131	17,131	0	17,131	7.01
9.00	00900	HOUSEKEEPING	259,882	28,808	288,690	59,368	348,058	9.00
10.00	01000	DIETARY	304,700	302,000	606,700	0	606,700	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	99,111	8,587	107,698	16,563	124,261	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	330,183	50,251	380,434	0	380,434	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	800,365	139,002	939,367	1,131	940,498	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	165,313	86,117	251,430	-39,904	211,526	50.00
53.00	05300	ANESTHESIOLOGY	255,220	21,679	276,899	0	276,899	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	378,932	562,869	941,801	43,252	985,053	54.00
60.00	06000	LABORATORY	412,528	589,249	1,001,777	36,571	1,038,348	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	44,266	44,266	0	44,266	62.00
65.00	06500	RESPIRATORY THERAPY	22,442	47,215	69,657	0	69,657	65.00
66.00	06600	PHYSICAL THERAPY	341,100	138,682	479,782	-122,408	357,374	66.00
67.00	06700	OCCUPATIONAL THERAPY	133,745	0	133,745	74,311	208,056	67.00
68.00	06800	SPEECH PATHOLOGY	62,963	0	62,963	48,097	111,060	68.00
69.00	06900	ELECTROCARDIOLOGY	99,112	175,952	275,064	0	275,064	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	50,788	50,788	0	50,788	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	705	705	0	705	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	669,868	669,868	0	669,868	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,256,858	566,974	1,823,832	-97,191	1,726,641	88.00
90.00	09000	CLINIC	125,629	1,257,232	1,382,861	16,132	1,398,993	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	531,870	67,547	599,417	-42,000	557,417	90.01
90.02	09002	GEROPSYCH	124,514	110,238	234,752	0	234,752	90.02
91.00	09100	EMERGENCY	519,371	1,823,443	2,342,814	6,078	2,348,892	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,646,631	12,419,546	20,066,177	-3,636	20,062,541	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	191,038	115,688	306,726	3,636	310,362	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	17,078	42,083	59,161	0	59,161	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)	7,854,747	12,577,317	20,432,064	0	20,432,064	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet A | Date/Time Prepared: 7/20/2015 1:16 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	294,420		1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME	0	111,206		1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	25,694		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-35,166	501,236		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-11,400	2,962,983		4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	-12,740	274,939		5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	-126,084	413,929		5.04
5.05	00590	OTHER ADMIN. & GENERAL	-110,552	1,709,496		5.05
6.00	00600	MAINTENANCE & REPAIRS	4,594	293,191		6.00
7.00	00700	OPERATION OF PLANT	-502	201,156		7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	17,131		7.01
9.00	00900	HOUSEKEEPING	0	348,058		9.00
10.00	01000	DIETARY	-135,020	471,680		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	124,261		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-10,971	369,463		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	940,498		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-26,414	185,112		50.00
53.00	05300	ANESTHESIOLOGY	0	276,899		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	985,053		54.00
60.00	06000	LABORATORY	0	1,038,348		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	44,266		62.00
65.00	06500	RESPIRATORY THERAPY	0	69,657		65.00
66.00	06600	PHYSICAL THERAPY	-6,068	351,306		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	208,056		67.00
68.00	06800	SPEECH PATHOLOGY	0	111,060		68.00
69.00	06900	ELECTROCARDIOLOGY	-29,911	245,153		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	50,788		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	705		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	669,868		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-8,290	1,718,351		88.00
90.00	09000	CLINIC	-453,658	945,335		90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	-404,529	152,888		90.01
90.02	09002	GEROPSYCH	0	234,752		90.02
91.00	09100	EMERGENCY	-266,536	2,082,356		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,633,247	18,429,294		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	CULBERTSON GARDENS	0	310,362		194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0		194.01
194.02	07952	FOUNDATION	0	59,161		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)	-1,633,247	18,798,817		200.00

RECLASSIFICATIONS | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet A-6 | Date/Time Prepared: 7/20/2015 1:16 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	21,556	1.00
2.00	CULBERTSON GARDENS	194.00	0	3,636	2.00
	TOTALS		0	25,192	
	B - CLIENT/ER/INF CNTR/MED SURG SALARIES				
1.00	NURSING ADMINISTRATION	13.00	16,563	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	1,131	0	2.00
3.00	CLINIC	90.00	16,132	0	3.00
4.00	EMERGENCY	91.00	6,078	0	4.00
	TOTALS		39,904	0	
	C - RHC PHYSICIAN EXPENSE				
1.00	RURAL HEALTH CLINIC	88.00	42,000	0	1.00
	TOTALS		42,000	0	
	D - RHC EXPENSES				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	43,252	0	1.00
2.00	LABORATORY	60.00	36,571	0	2.00
3.00	HOUSEKEEPING	9.00	50,912	8,456	3.00
	TOTALS		130,735	8,456	
	E - THERAPY RECLASS				
1.00	OCCUPATIONAL THERAPY	67.00	44,606	29,705	1.00
2.00	SPEECH PATHOLOGY	68.00	28,871	19,226	2.00
	TOTALS		73,477	48,931	
500.00	Grand Total: Increases		286,116	82,579	500.00

RECLASSIFICATIONS | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet A-6 | Date/Time Prepared: 7/20/2015 1:16 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - PROPERTY INSURANCE					
1.00	OTHER ADMIN. & GENERAL	5.05	0	25,192	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	25,192		
	B - CLIENT/ER/INF CNTR/MED SURG SALARIES					
1.00	OPERATING ROOM	50.00	39,904	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		39,904	0		
	C - RHC PHYSICIAN EXPENSE					
1.00	RUSHVILLE FAMILY CLINIC	90.01	42,000	0	0	1.00
	TOTALS		42,000	0		
	D - RHC EXPENSES					
1.00	RURAL HEALTH CLINIC	88.00	130,735	8,456	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		130,735	8,456		
	E - THERAPY RECLASS					
1.00	PHYSICAL THERAPY	66.00	73,477	48,931	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		73,477	48,931		
500.00	Grand Total: Decreases		286,116	82,579		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet A-7 Part I | Date/Time Prepared: 7/20/2015 1:16 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	411,152	0	0	0	0	1.00
2.00	Land Improvements	993,433	0	0	0	0	2.00
3.00	Buildings and Fixtures	9,344,564	1,306,356	0	1,306,356	0	3.00
4.00	Building Improvements	615,251	0	0	0	556,251	4.00
5.00	Fixed Equipment	184,640	0	0	0	0	5.00
6.00	Movable Equipment	6,225,476	339,913	0	339,913	15,180	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	17,774,516	1,646,269	0	1,646,269	571,431	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	17,774,516	1,646,269	0	1,646,269	571,431	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	10,650,920	0	3.00
4.00	Building Improvements	59,000	0	4.00
5.00	Fixed Equipment	184,640	0	5.00
6.00	Movable Equipment	6,550,209	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	18,849,354	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	18,849,354	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet A-7 Part II | Date/Time Prepared: 7/20/2015 1:16 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	271,368	13,296	0	0	0	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	99,332	9,600	0	0	0	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	24,745	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	367,824	160,001	0	0	0	2.00
3.00	Total (sum of lines 1-2)	763,269	182,897	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	284,664	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	0	108,932	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	24,745	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	527,825	2.00
3.00	Total (sum of lines 1-2)	0	946,166	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet A-7 Part III | Date/Time Prepared: 7/20/2015 1:16 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	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	7,001,786	0	7,001,786	0.452597	9,756	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	1,631,668	0	1,631,668	0.105472	2,274	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	680,962	0	680,962	0.044018	949	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	6,155,794	0	6,155,794	0.397913	8,577	2.00
3.00	Total (sum of lines 1-2)	15,470,210	0	15,470,210	1.000000	21,556	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	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	9,756	271,368	13,296	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	0	0	2,274	99,332	9,600	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	0	949	24,745	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	8,577	332,658	160,001	2.00
3.00	Total (sum of lines 1-2)	0	0	21,556	728,103	182,897	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	9,756	0	0	294,420	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	0	2,274	0	0	111,206	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	949	0	0	25,694	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	8,577	0	0	501,236	2.00
3.00	Total (sum of lines 1-2)	0	21,556	0	0	932,556	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet A-8 | Date/Time Prepared: 7/20/2015 1:16 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP REL COSTS-RHCS BLDG/MME (chapter 2)		0	NEW CAP REL COSTS-RHCS BLDG/MME	1.01	0	1.01
1.02	Investment income - NEW CAP REL COSTS-MED ARTS BLDG/MME (chapter 2)		0	NEW CAP REL COSTS-MED ARTS BLDG/MME	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-54,920	HOSPITAL ONLY ADMIN & GENERAL	5.04	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-2,734	OTHER ADMIN. & 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	-4,639	OTHER ADMIN. & GENERAL	5.05	0	7.00
8.00	Television and radio service (chapter 21)	A	-502	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	-1,172,777			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	-134,514	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-10,971	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	-506	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-RHCS BLDG/MME		0	NEW CAP REL COSTS-RHCS BLDG/MME	1.01	0	26.01
26.02	Depreciation - NEW CAP REL COSTS-MED ARTS BLDG/MME		0	NEW CAP REL COSTS-MED ARTS BLDG/MME	1.02	0	26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet A-8 | Date/Time Prepared: 7/20/2015 1:16 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
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	-32,703	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	INTEREST INCOME	B	-30,860	OTHER ADMIN. & GENERAL	5.05	0	33.00
33.01	OPC RENT	B	-26,417	HOSPITAL ONLY ADMIN & GENERAL	5.04	0	33.01
33.02	MISCELLANEOUS INCOME	B	-8,356	OTHER ADMIN. & GENERAL	5.05	0	33.02
33.03	MARKETING SALARY EXPENSE	A	-17,367	HOSPITAL ONLY ADMIN & GENERAL	5.04	0	33.03
33.04	MARKETING BENEFITS EXPENSE	A	-6,576	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05	MARKETING OTHER EXPENSE	A	-65,797	HOSPITAL ONLY ADMIN & GENERAL	5.04	0	33.05
33.06	MARKETING OTHER EXPENSE	A	-11,454	OTHER ADMIN. & GENERAL	5.05	0	33.06
33.07	MARKETING OTHER EXPENSE	A	-8,217	RURAL HEALTH CLINIC	88.00	0	33.07
33.08	MARKETING OTHER EXPENSE	A	-2,463	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.08
33.09	LOBBYING PORTION OF DUES	A	-8,810	OTHER ADMIN. & GENERAL	5.05	0	33.09
33.10	HEALTHLINK ADMINISTRATIVE FEES	A	38,417	HOSPITAL ONLY ADMIN & GENERAL	5.04	0	33.10
33.11	PART B PHYSICIAN BILLING SALARIES	A	-12,740	HOSPITAL BUSINESS OFFICE	5.02	0	33.11
33.12	PART B PHYSICIAN BILLING EMP BENEFIT	A	-4,824	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	MARKETING OTHER EXPENSE	A	-8,344	RUSHVILLE FAMILY CLINIC	90.01	0	33.13
33.14	PATIENT COLLECTION FEES	B	-36,248	OTHER ADMIN. & GENERAL	5.05	0	33.14
33.15	SPECIAL ASSESSMENTS ASBESTOS COSTS A	A	4,594	MAINTENANCE & REPAIRS	6.00	0	33.15
33.16	PROPERTY TAXES	A	-7,451	OTHER ADMIN. & GENERAL	5.05	0	33.16
33.17	MISCELLANEOUS INCOME - PT	A	-6,068	PHYSICAL THERAPY	66.00	0	33.17
33.18			0		0.00	0	33.18
33.19			0		0.00	0	33.19
33.20			0		0.00	0	33.20
33.21			0		0.00	0	33.21
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,633,247				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 03/01/2014 To 02/28/2015 | Worksheet A-8-2 | Date/Time Prepared: 7/20/2015 1:16 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	26,414	26,414	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	13,807	0	13,807	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	29,911	29,911	0	0	0	5.00
6.00	90.00	CLINIC	205,000	205,000	0	0	0	6.00
7.00	90.00	CLINIC	220,000	220,000	0	0	0	7.00
8.00	90.00	CLINIC	0	0	0	0	0	8.00
9.00	90.00	CLINIC	28,658	28,658	0	0	0	9.00
10.00	91.00	EMERGENCY	1,750,279	266,536	1,483,743	0	0	10.00
11.00	88.00	RURAL HEALTH CLINIC	73	73	0	0	0	11.00
12.00	90.01	RUSHVILLE FAMILY CLINIC	396,185	396,185	0	0	0	12.00
200.00			2,691,927	1,172,777	1,519,150		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	26,414		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	29,911		5.00
6.00	90.00	CLINIC	0	0	0	205,000		6.00
7.00	90.00	CLINIC	0	0	0	220,000		7.00
8.00	90.00	CLINIC	0	0	0	0		8.00
9.00	90.00	CLINIC	0	0	0	28,658		9.00
10.00	91.00	EMERGENCY	0	0	0	266,536		10.00
11.00	88.00	RURAL HEALTH CLINIC	0	0	0	73		11.00
12.00	90.01	RUSHVILLE FAMILY CLINIC	0	0	0	396,185		12.00
200.00			0	0	0	1,172,777		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 7/20/2015 1:16 pm

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					40	1.00
2.00	Line 1 multiplied by 15 hours per week					600	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,419.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.99	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.50	38.50	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					109,287	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					109,287	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					109,287	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					109,287	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 7/20/2015 1:16 pm

Physical Therapy | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.99	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	109,287		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	109,287		63.00
64.00	Total cost of outside supplier services (from your records)	86,563		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet B Part I | Date/Time Prepared: 7/20/2015 1:16 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	NEW RHCS BLDG/MME	NEW MED ARTS BLDG/MME	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	294,420	294,420				1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME	111,206	0	111,206			1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME	25,694	0	0	25,694		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	501,236				501,236	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,962,983	0	0	0	0	4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	274,939	0	0	0	0	5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	413,929	17,587	0	0	29,940	5.04
5.05	00590	OTHER ADMIN. & GENERAL	1,709,496	25,598	0	0	43,579	5.05
6.00	00600	MAINTENANCE & REPAIRS	293,191	28,637	0	0	48,753	6.00
7.00	00700	OPERATION OF PLANT	201,156	0	0	0	0	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	17,131	0	0	0	0	7.01
9.00	00900	HOUSEKEEPING	348,058	11,630	0	0	19,799	9.00
10.00	01000	DIETARY	471,680	14,569	0	0	24,802	10.00
11.00	01100	CAFETERIA	0	4,977	0	0	8,474	11.00
13.00	01300	NURSING ADMINISTRATION	124,261	632	0	0	1,076	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	369,463	12,762	0	0	21,727	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	940,498	31,523	0	0	53,666	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	185,112	22,274	0	0	37,921	50.00
53.00	05300	ANESTHESIOLOGY	276,899	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	985,053	16,607	0	0	28,272	54.00
60.00	06000	LABORATORY	1,038,348	6,289	0	0	10,706	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	44,266	527	0	0	897	62.00
65.00	06500	RESPIRATORY THERAPY	69,657	3,982	0	0	6,779	65.00
66.00	06600	PHYSICAL THERAPY	351,306	9,033	0	0	15,378	66.00
67.00	06700	OCCUPATIONAL THERAPY	208,056	5,404	0	0	9,200	67.00
68.00	06800	SPEECH PATHOLOGY	111,060	2,460	0	0	4,188	68.00
69.00	06900	ELECTROCARDIOLOGY	245,153	2,655	0	0	4,519	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	50,788	8,169	0	0	13,908	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	705	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	669,868	3,639	0	0	6,196	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,718,351	0	111,206	0	0	88.00
90.00	09000	CLINIC	945,335	38,936	0	0	66,291	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	152,888	0	0	25,694	0	90.01
90.02	09002	GEROPSYCH	234,752	14,384	0	0	24,488	90.02
91.00	09100	EMERGENCY	2,082,356	12,146	0	0	20,677	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,429,294	294,420	111,206	25,694	501,236	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	310,362	0	0	0	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	59,161	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)	18,798,817	294,420	111,206	25,694	501,236	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet B Part I Date/Time Prepared: 7/20/2015 1:16 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	HOSPITAL BUSINESS OFFICE	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	2,962,983					4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	78,227	353,166				5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	135,666	0	597,122	597,122		5.04
5.05	00590	OTHER ADMIN. & GENERAL	239,714	0	2,018,387	67,901	2,086,288	5.05
6.00	00600	MAINTENANCE & REPAIRS	76,203	0	446,784	15,030	461,814	6.00
7.00	00700	OPERATION OF PLANT	22,400	0	223,556	7,521	231,077	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	17,131	576	17,707	7.01
9.00	00900	HOUSEKEEPING	123,232	0	502,719	16,912	519,631	9.00
10.00	01000	DIETARY	120,816	0	631,867	21,257	653,124	10.00
11.00	01100	CAFETERIA	0	0	13,451	453	13,904	11.00
13.00	01300	NURSING ADMINISTRATION	45,866	0	171,835	5,781	177,616	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	130,920	0	534,872	17,994	552,866	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	317,820	17,012	1,360,519	45,769	1,406,288	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	49,006	10,844	305,157	10,266	315,423	50.00
53.00	05300	ANESTHESIOLOGY	101,197	4,432	382,528	12,869	395,397	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	167,399	85,168	1,282,499	43,145	1,325,644	54.00
60.00	06000	LABORATORY	178,071	73,622	1,307,036	43,970	1,351,006	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,309	46,999	1,581	48,580	62.00
65.00	06500	RESPIRATORY THERAPY	8,898	2,396	91,712	3,085	94,797	65.00
66.00	06600	PHYSICAL THERAPY	106,115	15,958	497,790	16,746	514,536	66.00
67.00	06700	OCCUPATIONAL THERAPY	70,718	5,247	298,625	10,046	308,671	67.00
68.00	06800	SPEECH PATHOLOGY	36,413	3,409	157,530	5,299	162,829	68.00
69.00	06900	ELECTROCARDIOLOGY	39,299	21,853	313,479	10,546	324,025	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,646	75,511	2,540	78,051	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	16	721	24	745	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	27,938	707,641	23,806	731,447	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	463,170	19,809	2,312,536	77,796	2,390,332	88.00
90.00	09000	CLINIC	56,209	33,183	1,139,954	38,349	1,178,303	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	55,388	3,409	237,379	7,986	245,365	90.01
90.02	09002	GEROPSYCH	49,371	1,002	323,997	10,900	334,897	90.02
91.00	09100	EMERGENCY	208,345	23,913	2,347,437	78,974	2,426,411	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)	2,880,463	353,166	18,346,774	597,122	18,346,774	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	75,748	0	386,110	0	386,110	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	6,772	0	65,933	0	65,933	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)	2,962,983	353,166	18,798,817	597,122	18,798,817	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet B Part I | Date/Time Prepared: 7/20/2015 1:16 pm

		Cost Center Description	OTHER ADMIN. & 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	00592	HOSPITAL BUSINESS OFFICE						5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL						5.04
5.05	00590	OTHER ADMIN. & GENERAL	2,086,288					5.05
6.00	00600	MAINTENANCE & REPAIRS	57,650	519,464				6.00
7.00	00700	OPERATION OF PLANT	28,846	0	259,923			7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	2,210	0	0	19,917		7.01
9.00	00900	HOUSEKEEPING	64,868	27,139	13,579	0	625,217	9.00
10.00	01000	DIETARY	81,532	33,998	17,011	0	43,174	10.00
11.00	01100	CAFETERIA	1,736	11,615	5,812	0	14,750	11.00
13.00	01300	NURSING ADMINISTRATION	22,173	1,475	738	0	1,873	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	69,016	29,782	14,902	0	37,821	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	175,553	73,563	36,809	0	93,420	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	39,376	51,980	26,009	0	66,010	50.00
53.00	05300	ANESTHESIOLOGY	49,359	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	165,485	38,754	19,391	0	49,215	54.00
60.00	06000	LABORATORY	168,651	14,676	7,343	0	18,637	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	6,064	1,229	615	0	1,561	62.00
65.00	06500	RESPIRATORY THERAPY	11,834	9,292	4,649	0	11,800	65.00
66.00	06600	PHYSICAL THERAPY	64,232	21,079	10,547	0	26,769	66.00
67.00	06700	OCCUPATIONAL THERAPY	38,533	12,611	6,310	0	16,015	67.00
68.00	06800	SPEECH PATHOLOGY	20,327	5,740	2,872	0	7,289	68.00
69.00	06900	ELECTROCARDIOLOGY	40,449	6,195	3,100	0	7,867	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,743	19,064	9,539	0	24,210	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	93	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	91,309	8,493	4,250	0	10,786	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	298,395	0	0	19,917	0	88.00
90.00	09000	CLINIC	147,092	90,868	45,469	0	115,398	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	30,630	0	0	0	0	90.01
90.02	09002	GEROPSYCH	41,807	33,567	16,796	0	42,628	90.02
91.00	09100	EMERGENCY	302,894	28,344	14,182	0	35,994	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,029,857	519,464	259,923	19,917	625,217	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	48,200	0	0	0	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	8,231	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)	2,086,288	519,464	259,923	19,917	625,217	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet B Part I | Date/Time Prepared: 7/20/2015 1:16 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	
			10.00	11.00	13.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00592	HOSPITAL BUSINESS OFFICE						5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL						5.04
5.05	00590	OTHER ADMIN. & 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	828,839					10.00
11.00	01100	CAFETERIA	403,086	450,903				11.00
13.00	01300	NURSING ADMINISTRATION	0	8,590	212,465			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	55,769	0	760,156		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	108,026	109,662	107,335	83,000	2,193,656	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	11,860	11,610	24,117	546,385	50.00
53.00	05300	ANESTHESIOLOGY	0	10,465	0	0	455,221	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	49,315	0	37,272	1,685,076	54.00
60.00	06000	LABORATORY	0	56,118	0	36,332	1,652,763	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	58,049	62.00
65.00	06500	RESPIRATORY THERAPY	0	2,529	2,477	2,819	140,197	65.00
66.00	06600	PHYSICAL THERAPY	0	37,499	0	8,770	683,432	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,851	0	0	390,991	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,974	0	0	205,031	68.00
69.00	06900	ELECTROCARDIOLOGY	0	11,162	10,917	8,770	412,485	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	140,607	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	838	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	846,285	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	279,068	2,987,712	88.00
90.00	09000	CLINIC	0	20,494	20,070	117,453	1,735,147	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	0	0	0	275,995	90.01
90.02	09002	GEROPSYCH	0	1,221	0	0	470,916	90.02
91.00	09100	EMERGENCY	0	61,394	60,056	162,555	3,091,830	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	511,112	450,903	212,465	760,156	17,972,616	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	294,142	0	0	0	728,452	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	74,164	194.02
194.03	07953	OUTPATIENT MEALS	23,585	0	0	0	23,585	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)	828,839	450,903	212,465	760,156	18,798,817	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet B Part I | Date/Time Prepared: 7/20/2015 1:16 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME				1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME				1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.02	00592	HOSPITAL BUSINESS OFFICE				5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL				5.04
5.05	00590	OTHER ADMIN. & 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	2,193,656		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	546,385		50.00
53.00	05300	ANESTHESIOLOGY	0	455,221		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,685,076		54.00
60.00	06000	LABORATORY	0	1,652,763		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	58,049		62.00
65.00	06500	RESPIRATORY THERAPY	0	140,197		65.00
66.00	06600	PHYSICAL THERAPY	0	683,432		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	390,991		67.00
68.00	06800	SPEECH PATHOLOGY	0	205,031		68.00
69.00	06900	ELECTROCARDIOLOGY	0	412,485		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	140,607		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	838		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	846,285		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	2,987,712		88.00
90.00	09000	CLINIC	0	1,735,147		90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	275,995		90.01
90.02	09002	GEROPSYCH	0	470,916		90.02
91.00	09100	EMERGENCY	0	3,091,830		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	17,972,616		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	CULBERTSON GARDENS	0	728,452		194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0		194.01
194.02	07952	FOUNDATION	0	74,164		194.02
194.03	07953	OUTPATIENT MEALS	0	23,585		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	18,798,817		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet B Part II | Date/Time Prepared: 7/20/2015 1:16 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	NEW RHCS BLDG/MME	NEW MED ARTS BLDG/MME	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	0	0	0	0	0	5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	0	17,587	0	0	29,940	5.04
5.05	00590	OTHER ADMIN. & GENERAL	0	25,598	0	0	43,579	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	28,637	0	0	48,753	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	11,630	0	0	19,799	9.00
10.00	01000	DIETARY	0	14,569	0	0	24,802	10.00
11.00	01100	CAFETERIA	0	4,977	0	0	8,474	11.00
13.00	01300	NURSING ADMINISTRATION	0	632	0	0	1,076	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,762	0	0	21,727	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	31,523	0	0	53,666	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	22,274	0	0	37,921	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,607	0	0	28,272	54.00
60.00	06000	LABORATORY	0	6,289	0	0	10,706	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	527	0	0	897	62.00
65.00	06500	RESPIRATORY THERAPY	0	3,982	0	0	6,779	65.00
66.00	06600	PHYSICAL THERAPY	0	9,033	0	0	15,378	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,404	0	0	9,200	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,460	0	0	4,188	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,655	0	0	4,519	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,169	0	0	13,908	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	3,639	0	0	6,196	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	111,206	0	0	88.00
90.00	09000	CLINIC	0	38,936	0	0	66,291	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	0	0	25,694	0	90.01
90.02	09002	GEROPSYCH	0	14,384	0	0	24,488	90.02
91.00	09100	EMERGENCY	0	12,146	0	0	20,677	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	294,420	111,206	25,694	501,236	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	0	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	294,420	111,206	25,694	501,236	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet B Part II | Date/Time Prepared: 7/20/2015 1:16 pm

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	HOSPITAL BUSINESS OFFICE	HOSPITAL ONLY ADMIN & GENERAL	OTHER ADMIN. & 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	00592	HOSPITAL BUSINESS OFFICE	0	0	0			5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	47,527	0	0	47,527		5.04
5.05	00590	OTHER ADMIN. & GENERAL	69,177	0	0	5,405	74,582	5.05
6.00	00600	MAINTENANCE & REPAIRS	77,390	0	0	1,196	2,061	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	599	1,031	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	0	46	79	7.01
9.00	00900	HOUSEKEEPING	31,429	0	0	1,346	2,319	9.00
10.00	01000	DIETARY	39,371	0	0	1,692	2,915	10.00
11.00	01100	CAFETERIA	13,451	0	0	36	62	11.00
13.00	01300	NURSING ADMINISTRATION	1,708	0	0	460	793	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	34,489	0	0	1,432	2,467	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	85,189	0	0	3,643	6,276	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	60,195	0	0	817	1,408	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,024	1,765	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	44,879	0	0	3,435	5,916	54.00
60.00	06000	LABORATORY	16,995	0	0	3,500	6,030	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,424	0	0	126	217	62.00
65.00	06500	RESPIRATORY THERAPY	10,761	0	0	246	423	65.00
66.00	06600	PHYSICAL THERAPY	24,411	0	0	1,333	2,296	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,604	0	0	800	1,378	67.00
68.00	06800	SPEECH PATHOLOGY	6,648	0	0	422	727	68.00
69.00	06900	ELECTROCARDIOLOGY	7,174	0	0	839	1,446	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	22,077	0	0	202	348	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2	3	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,835	0	0	1,895	3,264	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	111,206	0	0	6,193	10,668	88.00
90.00	09000	CLINIC	105,227	0	0	3,053	5,259	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	25,694	0	0	636	1,095	90.01
90.02	09002	GEROPSYCH	38,872	0	0	868	1,495	90.02
91.00	09100	EMERGENCY	32,823	0	0	6,281	10,824	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)	932,556	0	0	47,527	72,565	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	1,723	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	294	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)	932,556	0	0	47,527	74,582	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet B Part II | Date/Time Prepared: 7/20/2015 1:16 pm

		Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	PLANT & HOUSEKEEPING-RHC	HOUSEKEEPING	DIETARY	
			6.00	7.00	7.01	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00592	HOSPITAL BUSINESS OFFICE						5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL						5.04
5.05	00590	OTHER ADMIN. & GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS	80,647					6.00
7.00	00700	OPERATION OF PLANT	0	1,630				7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	125			7.01
9.00	00900	HOUSEKEEPING	4,213	85	0	39,392		9.00
10.00	01000	DIETARY	5,278	107	0	2,720	52,083	10.00
11.00	01100	CAFETERIA	1,803	36	0	929	25,330	11.00
13.00	01300	NURSING ADMINISTRATION	229	5	0	118	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,624	93	0	2,383	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,421	231	0	5,886	6,788	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,070	163	0	4,159	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,017	122	0	3,101	0	54.00
60.00	06000	LABORATORY	2,278	46	0	1,174	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	191	4	0	98	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,443	29	0	743	0	65.00
66.00	06600	PHYSICAL THERAPY	3,273	66	0	1,687	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,958	40	0	1,009	0	67.00
68.00	06800	SPEECH PATHOLOGY	891	18	0	459	0	68.00
69.00	06900	ELECTROCARDIOLOGY	962	19	0	496	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,960	60	0	1,525	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	1,319	27	0	680	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	125	0	0	88.00
90.00	09000	CLINIC	14,106	285	0	7,271	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	0	0	0	0	90.01
90.02	09002	GEROPSYCH	5,211	105	0	2,686	0	90.02
91.00	09100	EMERGENCY	4,400	89	0	2,268	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)	80,647	1,630	125	39,392	32,118	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	18,483	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	1,482	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)	80,647	1,630	125	39,392	52,083	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet B Part II | Date/Time Prepared: 7/20/2015 1:16 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00592	HOSPITAL BUSINESS OFFICE						5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL						5.04
5.05	00590	OTHER ADMIN. & 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	41,647					11.00
13.00	01300	NURSING ADMINISTRATION	793	4,106				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,151	0	50,639			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,127	2,074	5,529	137,164	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,095	224	1,607	77,738	0	50.00
53.00	05300	ANESTHESIOLOGY	967	0	0	3,756	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,555	0	2,483	70,508	0	54.00
60.00	06000	LABORATORY	5,183	0	2,420	37,626	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	2,060	0	62.00
65.00	06500	RESPIRATORY THERAPY	234	48	188	14,115	0	65.00
66.00	06600	PHYSICAL THERAPY	3,464	0	584	37,114	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	818	0	0	20,607	0	67.00
68.00	06800	SPEECH PATHOLOGY	552	0	0	9,717	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,031	211	584	12,762	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	27,172	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	17,020	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	18,591	146,783	0	88.00
90.00	09000	CLINIC	1,893	388	7,824	145,306	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	0	0	27,425	0	90.01
90.02	09002	GEROPSYCH	113	0	0	49,350	0	90.02
91.00	09100	EMERGENCY	5,671	1,161	10,829	74,346	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)	41,647	4,106	50,639	910,574	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	20,206	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	294	0	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	1,482	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)	41,647	4,106	50,639	932,556	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet B Part II | Date/Time Prepared: 7/20/2015 1:16 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME			1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.02	00592	HOSPITAL BUSINESS OFFICE			5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL			5.04
5.05	00590	OTHER ADMIN. & 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	137,164		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	77,738		50.00
53.00	05300	ANESTHESIOLOGY	3,756		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	70,508		54.00
60.00	06000	LABORATORY	37,626		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,060		62.00
65.00	06500	RESPIRATORY THERAPY	14,115		65.00
66.00	06600	PHYSICAL THERAPY	37,114		66.00
67.00	06700	OCCUPATIONAL THERAPY	20,607		67.00
68.00	06800	SPEECH PATHOLOGY	9,717		68.00
69.00	06900	ELECTROCARDIOLOGY	12,762		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,172		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,020		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	146,783		88.00
90.00	09000	CLINIC	145,306		90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	27,425		90.01
90.02	09002	GEROPSYCH	49,350		90.02
91.00	09100	EMERGENCY	74,346		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	910,574		118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
194.00	07950	CULBERTSON GARDENS	20,206		194.00
194.01	07951	MEDICAL ARTS BUILDING	0		194.01
194.02	07952	FOUNDATION	294		194.02
194.03	07953	OUTPATIENT MEALS	1,482		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)	932,556		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet B-1 | Date/Time Prepared: 7/20/2015 1:16 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW RHCS BLDG/MME (SQUARE FEET)	NEW MED ARTS BLDG/MME (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS 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	7,472,696	4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	0	0	0	0	197,290	5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	3,339	0	0	3,339	342,152	5.04
5.05	00590	OTHER ADMIN. & GENERAL	4,860	0	0	4,860	604,564	5.05
6.00	00600	MAINTENANCE & REPAIRS	5,437	0	0	5,437	192,186	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	56,494	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	310,794	9.00
10.00	01000	DIETARY	2,766	0	0	2,766	304,700	10.00
11.00	01100	CAFETERIA	945	0	0	945	0	11.00
13.00	01300	NURSING ADMINISTRATION	120	0	0	120	115,674	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,423	0	0	2,423	330,183	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,985	0	0	5,985	801,547	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,229	0	0	4,229	123,595	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	255,220	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,153	0	0	3,153	422,184	54.00
60.00	06000	LABORATORY	1,194	0	0	1,194	449,099	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	22,442	65.00
66.00	06600	PHYSICAL THERAPY	1,715	0	0	1,715	267,623	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,026	0	0	1,026	178,351	67.00
68.00	06800	SPEECH PATHOLOGY	467	0	0	467	91,834	68.00
69.00	06900	ELECTROCARDIOLOGY	504	0	0	504	99,112	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	1,168,123	88.00
90.00	09000	CLINIC	7,393	0	0	7,393	141,761	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	0	9,400	0	139,689	90.01
90.02	09002	GEROPSYCH	2,731	0	0	2,731	124,514	90.02
91.00	09100	EMERGENCY	2,306	0	0	2,306	525,449	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	9,400	55,899	7,264,580	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	191,038	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	17,078	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)	294,420	111,206	25,694	501,236	2,962,983	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.266999	9.424237	2.733404	8.966815	0.396508	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 03/01/2014 To 02/28/2015 | Worksheet B-1 | Date/Time Prepared: 7/20/2015 1:16 pm

		Cost Center Description	HOSPITAL BUSINESS OFFICE (GROSS CHARGES)	Reconciliation	HOSPITAL ONLY ADMIN & GENERAL (ACCUM. COST)	Reconciliation	OTHER ADMIN. & 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	00592	HOSPITAL BUSINESS OFFICE	32,308,496					5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	0	-597,122	17,749,652			5.04
5.05	00590	OTHER ADMIN. & GENERAL	0	0	2,018,387	-2,086,288	16,712,529	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	446,784	0	461,814	6.00
7.00	00700	OPERATION OF PLANT	0	0	223,556	0	231,077	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	17,131	0	17,707	7.01
9.00	00900	HOUSEKEEPING	0	0	502,719	0	519,631	9.00
10.00	01000	DIETARY	0	0	631,867	0	653,124	10.00
11.00	01100	CAFETERIA	0	0	13,451	0	13,904	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	171,835	0	177,616	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	534,872	0	552,866	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,556,264	0	1,360,519	0	1,406,288	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	992,033	0	305,157	0	315,423	50.00
53.00	05300	ANESTHESIOLOGY	405,484	0	382,528	0	395,397	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,791,378	0	1,282,499	0	1,325,644	54.00
60.00	06000	LABORATORY	6,735,115	0	1,307,036	0	1,351,006	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	119,781	0	46,999	0	48,580	62.00
65.00	06500	RESPIRATORY THERAPY	219,176	0	91,712	0	94,797	65.00
66.00	06600	PHYSICAL THERAPY	1,459,845	0	497,790	0	514,536	66.00
67.00	06700	OCCUPATIONAL THERAPY	479,967	0	298,625	0	308,671	67.00
68.00	06800	SPEECH PATHOLOGY	311,887	0	157,530	0	162,829	68.00
69.00	06900	ELECTROCARDIOLOGY	1,999,173	0	313,479	0	324,025	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	242,081	0	75,511	0	78,051	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,452	0	721	0	745	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,555,821	0	707,641	0	731,447	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,812,215	0	2,312,536	0	2,390,332	88.00
90.00	09000	CLINIC	3,035,711	0	1,139,954	0	1,178,303	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	311,844	0	237,379	0	245,365	90.01
90.02	09002	GEROPSYCH	91,658	0	323,997	0	334,897	90.02
91.00	09100	EMERGENCY	2,187,611	0	2,347,437	0	2,426,411	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	32,308,496	-597,122	17,749,652	-2,086,288	16,260,486	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	-386,110	0	0	386,110	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	-65,933	0	0	65,933	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)	353,166		597,122		2,086,288	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.010931		0.033641		0.124834	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		47,527		74,582	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		0.002678		0.004463	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet B-1 | Date/Time Prepared: 7/20/2015 1:16 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	PLANT & HOUSEKEEPING-RHC (SQUARE FEET)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	7.01	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00592	HOSPITAL BUSINESS OFFICE						5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL						5.04
5.05	00590	OTHER ADMIN. & 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	37,849	10.00
11.00	01100	CAFETERIA	945	945	0	945	18,407	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	4,933	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	23,340	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)	519,464	259,923	19,917	625,217	828,839	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.291224	6.150131	1.687881	15.608963	21.898571	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	80,647	1,630	125	39,392	52,083	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.908218	0.038568	0.010593	0.983448	1.376073	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet B-1 | Date/Time Prepared: 7/20/2015 1:16 pm

		Cost Center Description	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			11.00	13.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME					1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME					1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.02	00592	HOSPITAL BUSINESS OFFICE					5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL					5.04
5.05	00590	OTHER ADMIN. & 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	10,341				11.00
13.00	01300	NURSING ADMINISTRATION	197	64,416			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,279	0	2,427		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,515	32,542	265		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	272	3,520	77		50.00
53.00	05300	ANESTHESIOLOGY	240	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,131	0	119		54.00
60.00	06000	LABORATORY	1,287	0	116		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	58	751	9		65.00
66.00	06600	PHYSICAL THERAPY	860	0	28		66.00
67.00	06700	OCCUPATIONAL THERAPY	203	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	137	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	256	3,310	28		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	891		88.00
90.00	09000	CLINIC	470	6,085	375		90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	0	0		90.01
90.02	09002	GEROPSYCH	28	0	0		90.02
91.00	09100	EMERGENCY	1,408	18,208	519		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,341	64,416	2,427		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)	450,903	212,465	760,156		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	43.603423	3.298327	313.208076		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	41,647	4,106	50,639		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.027367	0.063742	20.864854		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet C Part I Date/Time Prepared: 7/20/2015 1:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,193,656		2,193,656	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	546,385		546,385	0	0	50.00
53.00	05300	ANESTHESIOLOGY	455,221		455,221	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,685,076		1,685,076	0	0	54.00
60.00	06000	LABORATORY	1,652,763		1,652,763	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	58,049		58,049	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	140,197	0	140,197	0	0	65.00
66.00	06600	PHYSICAL THERAPY	683,432	0	683,432	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	390,991	0	390,991	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	205,031	0	205,031	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	412,485		412,485	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	140,607		140,607	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	838		838	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	846,285		846,285	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,987,712		2,987,712	0	0	88.00
90.00	09000	CLINIC	1,735,147		1,735,147	0	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	275,995		275,995	0	0	90.01
90.02	09002	GEROPSYCH	470,916		470,916	0	0	90.02
91.00	09100	EMERGENCY	3,091,830		3,091,830	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	260,607		260,607		0	92.00
200.00		Subtotal (see instructions)	18,233,223	0	18,233,223	0	0	200.00
201.00		Less Observation Beds	260,607		260,607		0	201.00
202.00		Total (see instructions)	17,972,616	0	17,972,616	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet C Part I Date/Time Prepared: 7/20/2015 1:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,379,712		1,379,712			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,000	987,033	992,033	0.550773	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	405,484	405,484	1.122661	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	97,027	7,694,351	7,791,378	0.216274	0.000000	54.00
60.00	06000	LABORATORY	254,308	6,480,807	6,735,115	0.245395	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	9,099	110,682	119,781	0.484626	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	219,176	219,176	0.639655	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	78,618	1,381,227	1,459,845	0.468154	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	78,124	401,843	479,967	0.814621	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	13,104	298,783	311,887	0.657389	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	86,987	1,912,186	1,999,173	0.206328	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	171,048	71,033	242,081	0.580826	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,452	1,452	0.577135	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	583,867	1,971,954	2,555,821	0.331121	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,812,215	1,812,215			88.00
90.00	09000	CLINIC	429	3,035,282	3,035,711	0.571578	0.000000	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	311,844	311,844	0.885042	0.000000	90.01
90.02	09002	GEROPSYCH	0	91,658	91,658	5.137751	0.000000	90.02
91.00	09100	EMERGENCY	13,532	2,174,079	2,187,611	1.413336	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,472	174,080	176,552	1.476092	0.000000	92.00
200.00		Subtotal (see instructions)	2,773,327	29,535,169	32,308,496			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,773,327	29,535,169	32,308,496			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet C Part I Date/Time Prepared: 7/20/2015 1:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		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 03/01/2014 To 02/28/2015 | Worksheet C Part I Date/Time Prepared: 7/20/2015 1:16 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,193,656		2,193,656	0	2,193,656	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	546,385		546,385	0	546,385	50.00
53.00	05300	ANESTHESIOLOGY	455,221		455,221	0	455,221	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,685,076		1,685,076	0	1,685,076	54.00
60.00	06000	LABORATORY	1,652,763		1,652,763	0	1,652,763	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	58,049		58,049	0	58,049	62.00
65.00	06500	RESPIRATORY THERAPY	140,197	0	140,197	0	140,197	65.00
66.00	06600	PHYSICAL THERAPY	683,432	0	683,432	0	683,432	66.00
67.00	06700	OCCUPATIONAL THERAPY	390,991	0	390,991	0	390,991	67.00
68.00	06800	SPEECH PATHOLOGY	205,031	0	205,031	0	205,031	68.00
69.00	06900	ELECTROCARDIOLOGY	412,485		412,485	0	412,485	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	140,607		140,607	0	140,607	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	838		838	0	838	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	846,285		846,285	0	846,285	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,987,712		2,987,712	0	2,987,712	88.00
90.00	09000	CLINIC	1,735,147		1,735,147	0	1,735,147	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	275,995		275,995	0	275,995	90.01
90.02	09002	GEROPSYCH	470,916		470,916	0	470,916	90.02
91.00	09100	EMERGENCY	3,091,830		3,091,830	0	3,091,830	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	260,607		260,607		260,607	92.00
200.00		Subtotal (see instructions)	18,233,223	0	18,233,223	0	18,233,223	200.00
201.00		Less Observation Beds	260,607		260,607		260,607	201.00
202.00		Total (see instructions)	17,972,616	0	17,972,616	0	17,972,616	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet C Part I Date/Time Prepared: 7/20/2015 1:16 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,379,712		1,379,712			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,000	987,033	992,033	0.550773	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	405,484	405,484	1.122661	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	97,027	7,694,351	7,791,378	0.216274	0.000000	54.00
60.00	06000	LABORATORY	254,308	6,480,807	6,735,115	0.245395	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	9,099	110,682	119,781	0.484626	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	219,176	219,176	0.639655	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	78,618	1,381,227	1,459,845	0.468154	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	78,124	401,843	479,967	0.814621	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	13,104	298,783	311,887	0.657389	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	86,987	1,912,186	1,999,173	0.206328	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	171,048	71,033	242,081	0.580826	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,452	1,452	0.577135	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	583,867	1,971,954	2,555,821	0.331121	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,812,215	1,812,215	1.648652	0.000000	88.00
90.00	09000	CLINIC	429	3,035,282	3,035,711	0.571578	0.000000	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	311,844	311,844	0.885042	0.000000	90.01
90.02	09002	GEROPSYCH	0	91,658	91,658	5.137751	0.000000	90.02
91.00	09100	EMERGENCY	13,532	2,174,079	2,187,611	1.413336	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,472	174,080	176,552	1.476092	0.000000	92.00
200.00		Subtotal (see instructions)	2,773,327	29,535,169	32,308,496			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,773,327	29,535,169	32,308,496			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet C Part I Date/Time Prepared: 7/20/2015 1:16 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		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 03/01/2014 To 02/28/2015 | Worksheet D Part II Date/Time Prepared: 7/20/2015 1:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	77,738	992,033	0.078362	993	78	50.00
53.00	05300	ANESTHESIOLOGY	3,756	405,484	0.009263	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	70,508	7,791,378	0.009049	74,604	675	54.00
60.00	06000	LABORATORY	37,626	6,735,115	0.005587	163,053	911	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,060	119,781	0.017198	3,764	65	62.00
65.00	06500	RESPIRATORY THERAPY	14,115	219,176	0.064400	0	0	65.00
66.00	06600	PHYSICAL THERAPY	37,114	1,459,845	0.025423	15,782	401	66.00
67.00	06700	OCCUPATIONAL THERAPY	20,607	479,967	0.042934	15,242	654	67.00
68.00	06800	SPEECH PATHOLOGY	9,717	311,887	0.031156	6,456	201	68.00
69.00	06900	ELECTROCARDIOLOGY	12,762	1,999,173	0.006384	63,818	407	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,172	242,081	0.112243	94,740	10,634	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5	1,452	0.003444	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,020	2,555,821	0.006659	243,107	1,619	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	146,783	1,812,215	0.080996	0	0	88.00
90.00	09000	CLINIC	145,306	3,035,711	0.047866	0	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	27,425	311,844	0.087945	0	0	90.01
90.02	09002	GEROPSYCH	49,350	91,658	0.538415	0	0	90.02
91.00	09100	EMERGENCY	74,346	2,187,611	0.033985	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	30,647	176,552	0.173586	0	0	92.00
200.00		Total (lines 50-199)	804,057	30,928,784		681,559	15,645	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet D Part IV | Date/Time Prepared: 7/20/2015 1:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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 03/01/2014 To 02/28/2015 | Worksheet D Part IV | Date/Time Prepared: 7/20/2015 1:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	992,033	0.000000	0.000000	993	50.00
53.00	05300	ANESTHESIOLOGY	0	405,484	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,791,378	0.000000	0.000000	74,604	54.00
60.00	06000	LABORATORY	0	6,735,115	0.000000	0.000000	163,053	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	119,781	0.000000	0.000000	3,764	62.00
65.00	06500	RESPIRATORY THERAPY	0	219,176	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,459,845	0.000000	0.000000	15,782	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	479,967	0.000000	0.000000	15,242	67.00
68.00	06800	SPEECH PATHOLOGY	0	311,887	0.000000	0.000000	6,456	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,999,173	0.000000	0.000000	63,818	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	242,081	0.000000	0.000000	94,740	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,452	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,555,821	0.000000	0.000000	243,107	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,812,215	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	3,035,711	0.000000	0.000000	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	311,844	0.000000	0.000000	0	90.01
90.02	09002	GEROPSYCH	0	91,658	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	2,187,611	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	176,552	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	30,928,784			681,559	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet D Part IV | Date/Time Prepared: 7/20/2015 1:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
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 03/01/2014 To 02/28/2015 | Worksheet D Part V Date/Time Prepared: 7/20/2015 1:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.550773	0	288,097	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.122661	0	96,476	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.216274	0	2,681,199	33	0	54.00
60.00	06000	LABORATORY	0.245395	0	2,863,273	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.484626	0	100,381	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.639655	0	82,153	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.468154	0	474,905	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.814621	0	97,239	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.657389	0	7,126	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.206328	0	972,606	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.580826	0	43,234	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.577135	0	726	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.331121	0	1,234,332	5,039	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.571578	0	2,040,738	11,907	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0.885042	0	109,074	154	0	90.01
90.02	09002	GEROPSYCH	5.137751	0	77,472	0	0	90.02
91.00	09100	EMERGENCY	1.413336	0	717,900	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.476092	0	93,602	0	0	92.00
200.00		Subtotal (see instructions)		0	11,980,533	17,133	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	11,980,533	17,133	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet D Part V Date/Time Prepared: 7/20/2015 1:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	158,676	0		50.00
53.00	05300	ANESTHESIOLOGY	108,310	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	579,874	7		54.00
60.00	06000	LABORATORY	702,633	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	48,647	0		62.00
65.00	06500	RESPIRATORY THERAPY	52,550	0		65.00
66.00	06600	PHYSICAL THERAPY	222,329	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	79,213	0		67.00
68.00	06800	SPEECH PATHOLOGY	4,685	0		68.00
69.00	06900	ELECTROCARDIOLOGY	200,676	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25,111	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	419	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	408,713	1,669		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	1,166,441	6,806		90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	96,535	136		90.01
90.02	09002	GEROPSYCH	398,032	0		90.02
91.00	09100	EMERGENCY	1,014,634	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	138,165	0		92.00
200.00		Subtotal (see instructions)	5,405,643	8,618		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,405,643	8,618		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141333 | Component CCN: 14Z333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet D Part V | Date/Time Prepared: 7/20/2015 1:16 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.550773	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.122661	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.216274	0	0	0	0	54.00
60.00	06000	LABORATORY	0.245395	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.484626	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.639655	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.468154	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.814621	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.657389	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.206328	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.580826	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.577135	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.331121	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	0.571578	0	0	0	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0.885042	0	0	0	0	90.01
90.02	09002	GEROPSYCH	5.137751	0	0	0	0	90.02
91.00	09100	EMERGENCY	1.413336	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.476092	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 03/01/2014 To 02/28/2015 | Worksheet D Part V | Date/Time Prepared: 7/20/2015 1:16 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
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 03/01/2014 To 02/28/2015 | Worksheet D-1 | Date/Time Prepared: 7/20/2015 1:16 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,716	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	734	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)	570	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	476	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)	140	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	362	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)	4	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	438	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)	476	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)	140	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	132.23	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	136.20	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,193,656	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)	47,867	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)	545	25.00
26.00	Total swing-bed cost (see instructions)	1,027,279	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,166,377	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)	1,166,377	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)	1,589.07	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	696,013	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)	696,013	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet D-1 | Date/Time Prepared: 7/20/2015 1:16 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	231,258	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	927,271	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)	756,397	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	222,470	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	978,867	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)	164	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,589.07	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	260,607	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet D-1 | Date/Time Prepared: 7/20/2015 1:16 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	137,164	1,166,377	0.117598	260,607	30,647	90.00
91.00	Nursing School cost	0	1,166,377	0.000000	260,607	0	91.00
92.00	Allied health cost	0	1,166,377	0.000000	260,607	0	92.00
93.00	All other Medical Education	0	1,166,377	0.000000	260,607	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet D-3 | Date/Time Prepared: 7/20/2015 1:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		644,074		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.550773	993	547	50.00
53.00	05300	ANESTHESIOLOGY	1.122661	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.216274	74,604	16,135	54.00
60.00	06000	LABORATORY	0.245395	163,053	40,012	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.484626	3,764	1,824	62.00
65.00	06500	RESPIRATORY THERAPY	0.639655	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.468154	15,782	7,388	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.814621	15,242	12,416	67.00
68.00	06800	SPEECH PATHOLOGY	0.657389	6,456	4,244	68.00
69.00	06900	ELECTROCARDIOLOGY	0.206328	63,818	13,167	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.580826	94,740	55,027	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.577135	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.331121	243,107	80,498	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.571578	0	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0.885042	0	0	90.01
90.02	09002	GEROPSYCH	5.137751	0	0	90.02
91.00	09100	EMERGENCY	1.413336	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.476092	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		681,559	231,258	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)		681,559		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet D-3

Component CCN: 14Z333 | Date/Time Prepared: 7/20/2015 1:16 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.550773	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.122661	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.216274	13,856	2,997	54.00
60.00	06000	LABORATORY	0.245395	77,437	19,003	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.484626	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.639655	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.468154	62,076	29,061	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.814621	62,374	50,811	67.00
68.00	06800	SPEECH PATHOLOGY	0.657389	6,281	4,129	68.00
69.00	06900	ELECTROCARDIOLOGY	0.206328	8,697	1,794	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.580826	51,839	30,109	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.577135	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.331121	339,305	112,351	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.571578	0	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0.885042	0	0	90.01
90.02	09002	GEROPSYCH	5.137751	0	0	90.02
91.00	09100	EMERGENCY	1.413336	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.476092	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		621,865	250,255	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)		621,865		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141333	Period: From 03/01/2014 To 02/28/2015	Worksheet E Part B Date/Time Prepared: 7/20/2015 1:16 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,414,261	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 Wkst. D, Pt. IV, col. 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)	5,414,261	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 Wkst. D-4, Pt. 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)	5,468,404	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	45,133	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,836,538	26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	3,586,733	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,586,733	30.00
31.00	Primary payer payments	288	31.00
32.00	Subtotal (line 30 minus line 31)	3,586,445	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	311,394	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	236,659	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	288,357	36.00
37.00	Subtotal (see instructions)	3,823,104	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,823,104	40.00
40.01	Sequestration adjustment (see instructions)	76,462	40.01
41.00	Interim payments	3,736,470	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	10,172	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet E-1 Part I | Date/Time Prepared: 7/20/2015 1:16 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		802,712		3,736,470	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		802,712		3,736,470	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		11,325		10,172	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		814,037		3,746,642	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 03/01/2014 To 02/28/2015 | Worksheet E-1 Part I | Date/Time Prepared: 7/20/2015 1:16 pm

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		1,118,425		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	09/22/2014	39,900		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)		39,900		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)		1,158,325		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		33,664		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,191,989		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 03/01/2014 To 02/28/2015	Worksheet E-1 Part II Date/Time Prepared: 7/20/2015 1:16 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	176	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	438	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	0	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	570	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	32,308,496	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	99,574	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	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 03/01/2014 To 02/28/2015	Worksheet E-2 Date/Time Prepared: 7/20/2015 1:16 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	988,656	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200 for Pt. A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, see instructions)	252,758	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	616	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)	1,241,414	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,241,414	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)	1,241,414	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	25,099	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)	1,216,315	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
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)	1,216,315	0	19.00
19.01	Sequestration adjustment (see instructions)	24,326	0	19.01
20.00	Interim payments	1,158,325	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)	33,664	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141333	Period: From 03/01/2014 To 02/28/2015	Worksheet E-3 Part V Date/Time Prepared: 7/20/2015 1:16 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	927,271	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	927,271	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	936,544	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 physicians' services in a teaching hospital (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)	936,544	19.00
20.00	Deductibles (exclude professional component)	106,496	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	830,048	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	830,048	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	792	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	602	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	830,650	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	830,650	30.00
30.01	Sequestration adjustment (see instructions)	16,613	30.01
31.00	Interim payments	802,712	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)	11,325	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §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 03/01/2014 To 02/28/2015 | Worksheet G | Date/Time Prepared: 7/20/2015 1:16 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	7,329,562	0	0	0	1.00
2.00	Temporary investments	164,582	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,295,186	0	0	0	4.00
5.00	Other receivable	683,077	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	424,643	0	0	0	7.00
8.00	Prepaid expenses	141,225	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)	12,038,275	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	411,152	0	0	0	12.00
13.00	Land improvements	993,434	0	0	0	13.00
14.00	Accumulated depreciation	-633,372	0	0	0	14.00
15.00	Buildings	6,135,911	0	0	0	15.00
16.00	Accumulated depreciation	-3,481,574	0	0	0	16.00
17.00	Leasehold improvements	59,000	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	11,284,857	0	0	0	23.00
24.00	Accumulated depreciation	-8,347,382	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)	6,422,026	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	3,752,448	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	131,933	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,884,381	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	22,344,682	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	318,918	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,043,718	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	65,446	0	0	0	40.00
41.00	Deferred income	113,815	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	29,051	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,570,948	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	721,639	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	130,229	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	851,868	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	2,422,816	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	19,921,866				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)	19,921,866	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	22,344,682	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet G-1 | Date/Time Prepared: 7/20/2015 1:16 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		18,155,446		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,766,420				2.00
3.00	Total (sum of line 1 and line 2)		19,921,866		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)		19,921,866		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)		19,921,866		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 03/01/2014 To 02/28/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 7/20/2015 1:16 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,273,912		1,273,912	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	332,231		332,231	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)	1,606,143		1,606,143	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)	1,606,143		1,606,143	17.00
18.00	Ancillary services	1,235,692	22,426,541	23,662,233	18.00
19.00	Outpatient services	16,940	8,085,337	8,102,277	19.00
20.00	RURAL HEALTH CLINIC	0	1,813,163	1,813,163	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	424,832	424,832	27.00
27.01	DIETARY	0	3,959	3,959	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,858,775	32,753,832	35,612,607	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		20,432,064		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	36,248			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)		36,248		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		20,395,816		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141333 | Period: From 03/01/2014 To 02/28/2015 | Worksheet G-3 | Date/Time Prepared: 7/20/2015 1:16 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	35,612,607	1.00
2.00	Less contractual allowances and discounts on patients' accounts	13,760,240	2.00
3.00	Net patient revenues (line 1 minus line 2)	21,852,367	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	20,395,816	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,456,551	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	172,808	6.00
7.00	Income from investments	133,928	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC INCOME	185,933	24.00
24.01	TAX REVENUE	571,767	24.01
24.02	EHR REIMBURSEMENT	91,005	24.02
25.00	Total other income (sum of lines 6-24)	1,155,441	25.00
26.00	Total (line 5 plus line 25)	2,611,992	26.00
27.00	BAD DEBTS	754,600	27.00
27.01	CHARITY CARE	90,972	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	845,572	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,766,420	29.00

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

Provider CCN: 141333 Component CCN: 143483 | Period: From 03/01/2014 To 02/28/2015 | Worksheet M-1 | Date/Time Prepared: 7/20/2015 1:16 pm

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	349,484	0	349,484	42,000	391,484	1.00
2.00	Physician Assistant	111,928	0	111,928	0	111,928	2.00
3.00	Nurse Practitioner	92,957	0	92,957	0	92,957	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	339,787	0	339,787	0	339,787	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	79,823	0	79,823	-79,823	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 through 9)	973,979	0	973,979	-37,823	936,156	10.00
11.00	Physician Services Under Agreement	0	428,305	428,305	0	428,305	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	32,962	32,962	0	32,962	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	461,267	461,267	0	461,267	14.00
15.00	Medical Supplies	0	32,633	32,633	0	32,633	15.00
16.00	Transportation (Health Care Staff)	0	14,405	14,405	0	14,405	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	47,038	47,038	0	47,038	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	973,979	508,305	1,482,284	-37,823	1,444,461	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	282,880	58,668	341,548	-59,368	282,180	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	282,880	58,668	341,548	-59,368	282,180	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,256,859	566,973	1,823,832	-97,191	1,726,641	32.00

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

Provider CCN: 141333 | Component CCN: 143483 | Period: From 03/01/2014 To 02/28/2015 | Worksheet M-1 | Date/Time Prepared: 7/20/2015 1:16 pm

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-73	391,411		1.00
2.00	Physician Assistant	0	111,928		2.00
3.00	Nurse Practitioner	0	92,957		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	339,787		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 through 9)	-73	936,083		10.00
11.00	Physician Services Under Agreement	0	428,305		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	32,962		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	461,267		14.00
15.00	Medical Supplies	0	32,633		15.00
16.00	Transportation (Health Care Staff)	0	14,405		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	47,038		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-73	1,444,388		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-8,217	273,963		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-8,217	273,963		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-8,290	1,718,351		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141333 | Component CCN: 143483 | Period: From 03/01/2014 To 02/28/2015 | Worksheet M-2 | Date/Time Prepared: 7/20/2015 1:16 pm

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.34	9,222	4,200	9,828		1.00
2.00	Physician Assistant	0.84	2,578	2,100	1,764		2.00
3.00	Nurse Practitioner	1.31	3,282	2,100	2,751		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.49	15,082		14,343	15,082	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.49	15,082			15,082	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 Wkst. M-1, col. 7, line 22)					1,444,388	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,444,388	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)					273,963	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,269,361	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,543,324	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					1,543,324	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					1,543,324	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					2,987,712	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141333 Component CCN: 143483	Period: From 03/01/2014 To 02/28/2015	Worksheet M-3 Date/Time Prepared: 7/20/2015 1:16 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		2,987,712	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		14,706	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,973,006	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		15,082	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		15,082	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		197.12	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)	79.80	80.44	8.00
9.00	Rate for Program covered visits (see instructions)	197.12	197.12	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	2,844	942	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	560,609	185,687	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) *		746,296	16.00
16.01	Total program charges (see instructions)(from contractor's records)		479,721	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		11,020	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		17,144	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.)		532,931	16.04
16.05	Total program cost (see instructions)		550,075	16.05
17.00	Primary payer amounts		206	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		62,988	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		81,126	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		549,869	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		9,546	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		559,415	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		559,415	26.00
26.01	Sequestration adjustment (see instructions)		11,188	26.01
27.00	Interim payments		497,225	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)		51,002	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141333 | Component CCN: 143483 | Period: From 03/01/2014 To 02/28/2015 | Worksheet M-4 | Date/Time Prepared: 7/20/2015 1:16 pm

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	936,083	936,083	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000209	0.001776	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	196	1,662	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,318	3,934	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,514	5,596	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,444,388	1,444,388	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	1,543,324	1,543,324	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001048	0.003874	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,617	5,979	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	3,131	11,575	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	29	246	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	107.97	47.05	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	20	157	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	2,159	7,387	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		14,706	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		9,546	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 03/01/2014 To 02/28/2015 | Worksheet M-5 | Date/Time Prepared: 7/20/2015 1:16 pm

Rural Health Clinic (RHC) I | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		497,225	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)		497,225	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		51,002	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		548,227	7.00

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