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
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1333	Period: From 03/01/2017 To 02/28/2018	Worksheet S Parts I-III Date/Time Prepared: 7/18/2018 12:26 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 7/18/2018 Time: 12:26 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 CHIEF FINANCIAL 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 (14-1333) for the cost reporting period beginning 03/01/2017 and ending 02/28/2018 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.

[ ] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(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	42,585	-11,102	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	222,758	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		240,889		0	10.00
200.00	Total	0	265,343	229,787	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet S-2 Part I Date/Time Prepared: 7/17/2018 8:31 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)	03/01/2017	02/28/2018	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 §412.106(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: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet S-2 Part I Date/Time Prepared: 7/17/2018 8:31 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 is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (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)(i) or (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(b) 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, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (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)						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)						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)						61.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet S-2 Part I | Date/Time Prepared: 7/17/2018 8:31 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						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)						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)						61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the 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. Enter in column 4, the 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 through 67. (see instructions)	N	63.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet S-2 Part I Date/Time Prepared: 7/17/2018 8:31 pm

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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N		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

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		1.00	2.00	3.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			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
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a 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	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet S-2 Part I Date/Time Prepared: 7/17/2018 8:31 pm

		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 Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	61,917	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.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1333	Period: From 03/01/2017 To 02/28/2018	Worksheet S-2 Part I Date/Time Prepared: 7/17/2018 8:31 pm

		1.00	2.00	
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2017	12/31/2017	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1333	Period: From 03/01/2017 To 02/28/2018	Worksheet S-2 Part I Date/Time Prepared: 7/17/2018 8:31 pm

		1.00	2.00	
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 in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet S-2 Part II | Date/Time Prepared: 7/17/2018 8:31 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 Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	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)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	05/30/2018	Y	05/30/2018	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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet S-2 Part II Date/Time Prepared: 7/17/2018 8:31 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
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

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
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	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	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.	RSM US 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@RSMUS.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1333	Period: From 03/01/2017 To 02/28/2018	Worksheet S-2 Part II Date/Time Prepared: 7/17/2018 8:31 pm

		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: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet S-3 Part I Date/Time Prepared: 7/17/2018 8:31 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	16,586.00	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	16,586.00	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	16,586.00	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	89.00				0	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
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet S-3 Part I | Date/Time Prepared: 7/17/2018 8:31 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)	542	31	720			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	798	0	842			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	9			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,340	31	1,571			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)	1,340	31	1,571	0.00	131.37	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)	3,340	5,765	14,104	0.00	23.30	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	154.67	27.00
28.00	Observation Bed Days		0	135			28.00
29.00	Ambulance Trips	0					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
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet S-3 Part I | Date/Time Prepared: 7/17/2018 8:31 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	146	21	211	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	146	21	211	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	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1333 | Component CCN: 14-3483 | Period: From 03/01/2017 To 02/28/2018 | Worksheet S-8 | Date/Time Prepared: 7/17/2018 8:31 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			135 WEST BROADWAY		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	RUSHVILLE		IL	61501	2.00
					1.00	
3.00	HOSPITAL-BASED 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)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based 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	4	13.00
				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC name, CCN number			COMMUNITY MEDICAL CLINIC		143484	14.00
14.01				ELMER HUGH TAYLOR CLINIC		143483	14.01
14.02				RUSHVILLE FAMILY PRACTICE		148578	14.02
14.03				COMMUNITY MEDICAL CLINIC OF TABLE GR		148585	14.03
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
			County				
			4.00				
2.00	City, State, ZIP Code, County		FULTON				2.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1333
Component CCN: 14-3483

Period:
From 03/01/2017
To 02/28/2018

Worksheet S-8

Date/Time Prepared:
7/17/2018 8:31 pm

RHC I | Cost

		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

		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: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet S-10 | Date/Time Prepared: 7/17/2018 8:31 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)	0.614915	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,435,842	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 and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1,959,775	5.00
6.00	Medicaid charges	5,821,086	6.00
7.00	Medicaid cost (line 1 times line 6)	3,579,473	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)	183,856	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (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
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	183,856	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	22,526	20,821	43,347	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	13,852	20,821	34,673	21.00
22.00	Payments received from patients for amounts previously written off as charity care	10,518	5,854	16,372	22.00
23.00	Cost of charity care (line 21 minus line 22)	3,334	14,967	18,301	23.00

		1.00	
24.00	Does the amount on 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, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	645,885	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	191,738	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	294,982	27.01
28.00	Non-Medicare bad debt expense (see instructions)	350,903	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	319,020	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	337,321	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	521,177	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet A | Date/Time Prepared: 7/17/2018 8:31 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		456,702	456,702	14,898	471,600	1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME		110,330	110,330	2,779	113,109	1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME		24,418	24,418	1,573	25,991	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		439,848	439,848	11,388	451,236	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,519,661	3,519,661	-73,089	3,446,572	4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	217,059	83,344	300,403	0	300,403	5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	383,450	260,451	643,901	0	643,901	5.04
5.05	00590	OTHER ADMIN. & GENERAL	636,108	1,491,063	2,127,171	-35,114	2,092,057	5.05
6.00	00600	MAINTENANCE & REPAIRS	200,325	79,927	280,252	0	280,252	6.00
7.00	00700	OPERATION OF PLANT	50,468	173,597	224,065	0	224,065	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	21,832	21,832	80,543	102,375	7.01
9.00	00900	HOUSEKEEPING	276,242	28,222	304,464	0	304,464	9.00
10.00	01000	DIETARY	351,526	338,266	689,792	0	689,792	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	92,903	4,814	97,717	0	97,717	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	405,460	52,463	457,923	0	457,923	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	204,661	0	204,661	0	204,661	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	833,403	111,278	944,681	0	944,681	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	132,204	370,421	502,625	0	502,625	50.00
53.00	05300	ANESTHESIOLOGY	0	15,883	15,883	0	15,883	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	479,030	547,465	1,026,495	45,853	1,072,348	54.00
60.00	06000	LABORATORY	516,794	611,147	1,127,941	35,197	1,163,138	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	58,993	58,993	0	58,993	62.00
65.00	06500	RESPIRATORY THERAPY	31,936	46,696	78,632	0	78,632	65.00
66.00	06600	PHYSICAL THERAPY	305,508	149,396	454,904	-141,375	313,529	66.00
67.00	06700	OCCUPATIONAL THERAPY	120,147	0	120,147	73,649	193,796	67.00
68.00	06800	SPEECH PATHOLOGY	68,680	0	68,680	67,726	136,406	68.00
69.00	06900	ELECTROCARDIOLOGY	94,198	154,365	248,563	0	248,563	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	43,889	43,889	0	43,889	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	804,749	804,749	0	804,749	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,530,040	322,806	1,852,846	487,722	2,340,568	88.00
90.00	09000	CLINIC	198,612	1,734,406	1,933,018	0	1,933,018	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	878,897	126,387	1,005,284	-576,226	429,058	90.01
90.02	09002	GEROPSYCH	138,309	107,803	246,112	0	246,112	90.02
91.00	09100	EMERGENCY	477,251	2,118,286	2,595,537	0	2,595,537	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,623,211	14,408,908	23,032,119	-4,476	23,027,643	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	208,005	129,986	337,991	4,476	342,467	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	21,454	46,157	67,611	0	67,611	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 through 199)	8,852,670	14,585,051	23,437,721	0	23,437,721	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet A | Date/Time Prepared: 7/17/2018 8:31 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	471,600		1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME	-1,925	111,184		1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	25,991		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-33,527	417,709		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-119,245	3,327,327		4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	-12,254	288,149		5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	-97,486	546,415		5.04
5.05	00590	OTHER ADMIN. & GENERAL	-112,228	1,979,829		5.05
6.00	00600	MAINTENANCE & REPAIRS	0	280,252		6.00
7.00	00700	OPERATION OF PLANT	-578	223,487		7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	102,375		7.01
9.00	00900	HOUSEKEEPING	0	304,464		9.00
10.00	01000	DIETARY	-196,675	493,117		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	97,717		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-8,461	449,462		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	204,661		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	944,681		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-298,010	204,615		50.00
53.00	05300	ANESTHESIOLOGY	0	15,883		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,072,348		54.00
60.00	06000	LABORATORY	0	1,163,138		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	58,993		62.00
65.00	06500	RESPIRATORY THERAPY	0	78,632		65.00
66.00	06600	PHYSICAL THERAPY	0	313,529		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	193,796		67.00
68.00	06800	SPEECH PATHOLOGY	0	136,406		68.00
69.00	06900	ELECTROCARDIOLOGY	-30,600	217,963		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	43,889		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	804,749		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-15,664	2,324,904		88.00
90.00	09000	CLINIC	-514,639	1,418,379		90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	-251,357	177,701		90.01
90.02	09002	GEROPSYCH	0	246,112		90.02
91.00	09100	EMERGENCY	-260,893	2,334,644		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,953,542	21,074,101		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	CULBERTSON GARDENS	0	342,467		194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0		194.01
194.02	07952	FOUNDATION	0	67,611		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 through 199)	-1,953,542	21,484,179		200.00

RECLASSIFICATIONS | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet A-6 | Date/Time Prepared: 7/17/2018 8:31 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	30,638		1.00
2.00	CULBERTSON GARDENS	194.00	0	4,476		2.00
	TOTALS		0	35,114		
	B - RHC PHYSICIAN EXPENSE					
1.00	RURAL HEALTH CLINIC	88.00	54,802	0		1.00
	TOTALS		54,802	0		
	C - RHC EXPENSES					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	45,853	0		1.00
2.00	LABORATORY	60.00	35,197	0		2.00
3.00	PLANT & HOUSEKEEPING-RHC	7.01	69,290	11,253		3.00
	TOTALS		150,340	11,253		
	D - THERAPY RECLASS					
1.00	OCCUPATIONAL THERAPY	67.00	44,724	28,925		1.00
2.00	SPEECH PATHOLOGY	68.00	41,127	26,599		2.00
	TOTALS		85,851	55,524		
	E - PHYSICIAN BENEFITS					
1.00	RUSHVILLE FAMILY CLINIC	90.01	0	30,637		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	42,452		2.00
	TOTALS		0	73,089		
	F - RUSHVILLE RHC RECLASS 8-1-17					
1.00	RURAL HEALTH CLINIC	88.00	478,653	73,408		1.00
	TOTALS		478,653	73,408		
500.00	Grand Total: Increases		769,646	248,388		500.00

RECLASSIFICATIONS | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet A-6 | Date/Time Prepared: 7/17/2018 8:31 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	35,114	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	35,114			
	B - RHC PHYSICIAN EXPENSE						
1.00	RUSHVILLE FAMILY CLINIC	90.01	54,802	0	0		1.00
	TOTALS		54,802	0			
	C - RHC EXPENSES						
1.00	RURAL HEALTH CLINIC	88.00	150,340	11,253	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		150,340	11,253			
	D - THERAPY RECLASS						
1.00	PHYSICAL THERAPY	66.00	85,851	55,524	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		85,851	55,524			
	E - PHYSICIAN BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	73,089	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	73,089			
	F - RUSHVILLE RHC RECLASS 8-1-17						
1.00	RUSHVILLE FAMILY CLINIC	90.01	478,653	73,408	0		1.00
	TOTALS		478,653	73,408			
500.00	Grand Total: Decreases		769,646	248,388			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet A-7 Part I | Date/Time Prepared: 7/17/2018 8:31 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	426,152	0	0	0	0	1.00
2.00	Land Improvements	1,005,060	160,235	0	160,235	0	2.00
3.00	Buildings and Fixtures	6,235,110	77,935	0	77,935	0	3.00
4.00	Building Improvements	12,546	21,560	0	21,560	0	4.00
5.00	Fixed Equipment	5,812,618	21,569	0	21,569	0	5.00
6.00	Movable Equipment	6,395,258	141,401	0	141,401	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	19,886,744	422,700	0	422,700	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	19,886,744	422,700	0	422,700	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	426,152	0	1.00
2.00	Land Improvements	1,165,295	0	2.00
3.00	Buildings and Fixtures	6,313,045	0	3.00
4.00	Building Improvements	34,106	0	4.00
5.00	Fixed Equipment	5,834,187	0	5.00
6.00	Movable Equipment	6,536,659	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	20,309,444	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	20,309,444	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet A-7 Part II | Date/Time Prepared: 7/17/2018 8:31 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	443,406	13,296	0	0	0	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	100,730	9,600	0	0	0	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	24,418	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	316,974	122,874	0	0	0	2.00
3.00	Total (sum of lines 1-2)	885,528	145,770	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	456,702	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	0	110,330	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	24,418	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	439,848	2.00
3.00	Total (sum of lines 1-2)	0	1,031,298	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet A-7 Part III Date/Time Prepared: 7/17/2018 8:31 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	8,203,661	0	8,203,661	0.486267	14,898	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	1,530,364	0	1,530,364	0.090711	2,779	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	866,056	0	866,056	0.051335	1,573	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	6,270,622	0	6,270,622	0.371687	11,388	2.00
3.00	Total (sum of lines 1-2)	16,870,703	0	16,870,703	1.000000	30,638	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	14,898	443,406	13,296	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	0	0	2,779	98,805	9,600	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	0	1,573	24,418	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	11,388	283,447	122,874	2.00
3.00	Total (sum of lines 1-2)	0	0	30,638	850,076	145,770	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	14,898	0	0	471,600	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	0	2,779	0	0	111,184	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	1,573	0	0	25,991	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	11,388	0	0	417,709	2.00
3.00	Total (sum of lines 1-2)	0	30,638	0	0	1,026,484	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet A-8 | Date/Time Prepared: 7/17/2018 8:31 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	-29,130	HOSPITAL ONLY ADMIN & GENERAL	5.04	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-1,829	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	-936	OTHER ADMIN. & GENERAL	5.05	0	7.00
8.00	Television and radio service (chapter 21)	A	-578	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	-1,340,592			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	-196,529	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	-8,461	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-146	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

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet A-8 | Date/Time Prepared: 7/17/2018 8:31 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	
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	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	-9,341	OTHER ADMIN. & GENERAL	5.05	0	33.00
33.01	MISCELLANEOUS INCOME	B	-10,318	OTHER ADMIN. & GENERAL	5.05	0	33.01
33.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.02
33.03	MARKETING SALARY EXPENSE	A	-18,556	HOSPITAL ONLY ADMIN & GENERAL	5.04	0	33.03
33.04	MARKETING BENEFITS EXPENSE	A	-7,152	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05	MARKETING OTHER EXPENSE	A	-75,652	HOSPITAL ONLY ADMIN & GENERAL	5.04	0	33.05
33.06	MARKETING OTHER EXPENSE	A	-11,627	OTHER ADMIN. & GENERAL	5.05	0	33.06
33.07	MARKETING OTHER EXPENSE	A	-15,664	RURAL HEALTH CLINIC	88.00	0	33.07
33.08	MARKETING OTHER EXPENSE	A	-824	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.08
33.09	LOBBYING PORTION OF DUES	A	-9,704	OTHER ADMIN. & GENERAL	5.05	0	33.09
33.10	HEALTHLINK ADMINISTRATIVE FEES	A	25,852	HOSPITAL ONLY ADMIN & GENERAL	5.04	0	33.10
33.11	PART B PHYSICIAN BILLING SALARIES	A	-12,254	HOSPITAL BUSINESS OFFICE	5.02	0	33.11
33.12	PART B PHYSICIAN BILLING EMP BENEFIT	A	-4,723	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	MARKETING OTHER EXPENSE	A	-2,819	RUSHVILLE FAMILY CLINIC	90.01	0	33.13
33.14	PATIENT COLLECTION FEES	B	-68,000	OTHER ADMIN. & GENERAL	5.05	0	33.14
33.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.15
33.16	PROPERTY TAXES	A	-473	OTHER ADMIN. & GENERAL	5.05	0	33.16
33.17	IMRF CONTRIBUTION	A	-107,370	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.17
33.18	OPC RENT - CLINIC	B	-12,088	CLINIC	90.00	0	33.18
33.19	OPC RENT - RHC	B	-1,925	NEW CAP REL COSTS-RHCS BLDG/MME	1.01	9	33.19
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,953,542				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: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet A-8-2 | Date/Time Prepared: 7/17/2018 8:31 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	298,010	298,010	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	12,000	0	12,000	0	0	2.00
3.00	60.00	LABORATORY	15,600	0	15,600	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	6,000	0	6,000	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	30,600	30,600	0	0	0	5.00
6.00	90.00	CLINIC	210,000	210,000	0	0	0	6.00
7.00	90.00	CLINIC	252,000	252,000	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	90.00	CLINIC	40,551	40,551	0	0	0	9.00
10.00	91.00	EMERGENCY	1,875,079	260,893	1,614,186	0	0	10.00
12.00	90.01	RUSHVILLE FAMILY CLINIC	248,538	248,538	0	0	0	12.00
200.00			2,988,378	1,340,592	1,647,786		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	0.00		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
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	298,010		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	30,600		5.00
6.00	90.00	CLINIC	0	0	0	210,000		6.00
7.00	90.00	CLINIC	0	0	0	252,000		7.00
8.00	0.00		0	0	0	0		8.00
9.00	90.00	CLINIC	0	0	0	40,551		9.00
10.00	91.00	EMERGENCY	0	0	0	260,893		10.00
12.00	90.01	RUSHVILLE FAMILY CLINIC	0	0	0	248,538		12.00
200.00			0	0	0	1,340,592		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 14-1333	Period: From 03/01/2017 To 02/28/2018	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/17/2018 8:31 pm

Physical Therapy — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					32	1.00
2.00	Line 1 multiplied by 15 hours per week					480	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					224	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	1,342.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	80.98	60.73	38.50	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)	40.49	40.49	30.37			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)					108,675	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)					108,675	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)					108,675	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)					108,675	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)					9,070	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)					9,070	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)					9,070	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: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 7/17/2018 8:31 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)	80.98	60.73	38.50	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)	108,675		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)	108,675		63.00
64.00	Total cost of outside supplier services (from your records)	85,391		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	9,070		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	9,070		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: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet B Part I Date/Time Prepared: 7/17/2018 8:31 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	471,600	471,600				1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME	111,184	0	111,184			1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME	25,991	0	0	25,991		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	417,709				417,709	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,327,327	0	0	0	0	4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	288,149	0	0	0	0	5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	546,415	28,170	0	0	24,951	5.04
5.05	00590	OTHER ADMIN. & GENERAL	1,979,829	41,002	0	0	36,317	5.05
6.00	00600	MAINTENANCE & REPAIRS	280,252	47,338	0	0	41,929	6.00
7.00	00700	OPERATION OF PLANT	223,487	0	0	0	0	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	102,375	0	0	0	0	7.01
9.00	00900	HOUSEKEEPING	304,464	17,160	0	0	15,199	9.00
10.00	01000	DIETARY	493,117	23,336	0	0	20,669	10.00
11.00	01100	CAFETERIA	0	7,973	0	0	7,062	11.00
13.00	01300	NURSING ADMINISTRATION	97,717	1,012	0	0	897	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	449,462	20,442	0	0	18,106	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	204,661	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	944,681	50,493	0	0	44,723	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	204,615	35,679	0	0	31,601	50.00
53.00	05300	ANESTHESIOLOGY	15,883	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,072,348	26,609	0	0	23,568	54.00
60.00	06000	LABORATORY	1,163,138	10,073	0	0	8,922	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	58,993	844	0	0	747	62.00
65.00	06500	RESPIRATORY THERAPY	78,632	6,378	0	0	5,649	65.00
66.00	06600	PHYSICAL THERAPY	313,529	15,338	0	0	13,585	66.00
67.00	06700	OCCUPATIONAL THERAPY	193,796	7,779	0	0	6,890	67.00
68.00	06800	SPEECH PATHOLOGY	136,406	3,940	0	0	3,490	68.00
69.00	06900	ELECTROCARDIOLOGY	217,963	911	0	0	807	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	43,889	13,085	0	0	11,590	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	804,749	5,830	0	0	5,164	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,324,904	0	111,184	0	0	88.00
90.00	09000	CLINIC	1,418,379	65,713	0	0	58,203	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	177,701	0	0	25,991	0	90.01
90.02	09002	GEROPSYCH	246,112	23,040	0	0	20,408	90.02
91.00	09100	EMERGENCY	2,334,644	19,455	0	0	17,232	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,074,101	471,600	111,184	25,991	417,709	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	342,467	0	0	0	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	67,611	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 through 201)	21,484,179	471,600	111,184	25,991	417,709	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet B Part I Date/Time Prepared: 7/17/2018 8:31 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	3,327,327					4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	79,263	367,412				5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	141,220	0	740,756	740,756		5.04
5.05	00590	OTHER ADMIN. & GENERAL	246,184	0	2,303,332	84,279	2,387,611	5.05
6.00	00600	MAINTENANCE & REPAIRS	77,529	0	447,048	16,357	463,405	6.00
7.00	00700	OPERATION OF PLANT	19,532	0	243,019	8,892	251,911	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	26,816	0	129,191	4,727	133,918	7.01
9.00	00900	HOUSEKEEPING	106,910	0	443,733	16,236	459,969	9.00
10.00	01000	DIETARY	136,046	0	673,168	24,631	697,799	10.00
11.00	01100	CAFETERIA	0	0	15,035	550	15,585	11.00
13.00	01300	NURSING ADMINISTRATION	35,955	0	135,581	4,961	140,542	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	156,920	0	644,930	23,598	668,528	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	79,207	0	283,868	10,387	294,255	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	322,540	20,268	1,382,705	50,593	1,433,298	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	51,165	11,523	334,583	12,242	346,825	50.00
53.00	05300	ANESTHESIOLOGY	0	4,449	20,332	744	21,076	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	203,138	87,196	1,412,859	51,697	1,464,556	54.00
60.00	06000	LABORATORY	213,629	70,171	1,465,933	53,638	1,519,571	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,547	62,131	2,273	64,404	62.00
65.00	06500	RESPIRATORY THERAPY	12,360	2,310	105,329	3,854	109,183	65.00
66.00	06600	PHYSICAL THERAPY	85,011	12,956	440,419	16,115	456,534	66.00
67.00	06700	OCCUPATIONAL THERAPY	63,808	4,642	276,915	10,132	287,047	67.00
68.00	06800	SPEECH PATHOLOGY	42,497	4,269	190,602	6,974	197,576	68.00
69.00	06900	ELECTROCARDIOLOGY	36,456	21,128	277,265	10,145	287,410	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,787	72,351	2,647	74,998	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	31,924	847,667	31,016	878,683	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	740,417	24,312	3,200,817	117,128	3,317,945	88.00
90.00	09000	CLINIC	76,866	39,726	1,658,887	60,699	1,719,586	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	46,822	3,219	253,733	9,284	263,017	90.01
90.02	09002	GEROPSYCH	53,528	605	343,693	12,576	356,269	90.02
91.00	09100	EMERGENCY	184,704	23,380	2,579,415	94,381	2,673,796	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 through 117)	3,238,523	367,412	20,985,297	740,756	20,985,297	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	80,501	0	422,968	0	422,968	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	8,303	0	75,914	0	75,914	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 through 201)	3,327,327	367,412	21,484,179	740,756	21,484,179	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet B Part I | Date/Time Prepared: 7/17/2018 8:31 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	2,387,611					5.05
6.00	00600	MAINTENANCE & REPAIRS	57,939	521,344				6.00
7.00	00700	OPERATION OF PLANT	31,496	0	283,407			7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	16,743	0	0	150,661		7.01
9.00	00900	HOUSEKEEPING	57,509	25,195	13,696	0	556,369	9.00
10.00	01000	DIETARY	87,244	34,262	18,625	0	38,420	10.00
11.00	01100	CAFETERIA	1,949	11,705	6,363	0	13,126	11.00
13.00	01300	NURSING ADMINISTRATION	17,572	1,486	808	0	1,667	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	83,585	30,013	16,315	0	33,656	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	36,790	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	179,202	74,134	40,300	0	83,132	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	43,363	52,383	28,476	0	58,741	50.00
53.00	05300	ANESTHESIOLOGY	2,635	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	183,111	39,068	21,238	0	43,809	54.00
60.00	06000	LABORATORY	189,989	14,790	8,040	0	16,585	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	8,052	1,239	673	0	1,389	62.00
65.00	06500	RESPIRATORY THERAPY	13,651	9,364	5,091	0	10,501	65.00
66.00	06600	PHYSICAL THERAPY	57,080	22,519	12,242	0	25,252	66.00
67.00	06700	OCCUPATIONAL THERAPY	35,889	11,421	6,208	0	12,807	67.00
68.00	06800	SPEECH PATHOLOGY	24,703	5,785	3,145	0	6,487	68.00
69.00	06900	ELECTROCARDIOLOGY	35,934	1,338	727	0	1,500	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,377	19,212	10,444	0	21,544	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	109,860	8,559	4,653	0	9,598	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	414,841	0	0	150,661	0	88.00
90.00	09000	CLINIC	214,996	96,479	52,447	0	108,190	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	32,884	0	0	0	0	90.01
90.02	09002	GEROPSYCH	44,544	33,828	18,389	0	37,934	90.02
91.00	09100	EMERGENCY	334,299	28,564	15,527	0	32,031	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,325,237	521,344	283,407	150,661	556,369	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	52,883	0	0	0	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	9,491	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 through 201)	2,387,611	521,344	283,407	150,661	556,369	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet B Part I | Date/Time Prepared: 7/17/2018 8:31 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			10.00	11.00	13.00	16.00	19.00	
		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	876,350					10.00
11.00	01100	CAFETERIA	436,231	484,959				11.00
13.00	01300	NURSING ADMINISTRATION	0	6,824	168,899			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	62,671	0	894,768		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	331,045	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	106,845	112,101	79,922	85,749	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	14,053	10,027	15,978	0	50.00
53.00	05300	ANESTHESIOLOGY	0	7,108	0	0	331,045	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	56,416	0	50,597	0	54.00
60.00	06000	LABORATORY	0	63,971	0	45,804	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	3,452	2,450	7,456	0	65.00
66.00	06600	PHYSICAL THERAPY	0	35,539	0	22,636	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,748	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,768	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	11,901	8,474	13,315	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	264,168	0	88.00
90.00	09000	CLINIC	0	23,151	16,500	146,998	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	0	0	0	0	90.01
90.02	09002	GEROPSYCH	0	17,668	12,601	0	0	90.02
91.00	09100	EMERGENCY	0	54,588	38,925	242,067	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	543,076	484,959	168,899	894,768	331,045	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	310,558	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	22,716	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 through 201)	876,350	484,959	168,899	894,768	331,045	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet B Part I | Date/Time Prepared: 7/17/2018 8:31 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	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
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,194,683	0	2,194,683		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	569,846	0	569,846		50.00
53.00	05300	ANESTHESIOLOGY	361,864	0	361,864		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,858,795	0	1,858,795		54.00
60.00	06000	LABORATORY	1,858,750	0	1,858,750		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	75,757	0	75,757		62.00
65.00	06500	RESPIRATORY THERAPY	161,148	0	161,148		65.00
66.00	06600	PHYSICAL THERAPY	631,802	0	631,802		66.00
67.00	06700	OCCUPATIONAL THERAPY	363,120	0	363,120		67.00
68.00	06800	SPEECH PATHOLOGY	243,464	0	243,464		68.00
69.00	06900	ELECTROCARDIOLOGY	360,599	0	360,599		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	135,575	0	135,575		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,011,353	0	1,011,353		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	4,147,615	0	4,147,615		88.00
90.00	09000	CLINIC	2,378,347	0	2,378,347		90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	295,901	0	295,901		90.01
90.02	09002	GEROPSYCH	521,233	0	521,233		90.02
91.00	09100	EMERGENCY	3,419,797	0	3,419,797		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,589,649	0	20,589,649		118.00
		NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
194.00	07950	CULBERTSON GARDENS	786,409	0	786,409		194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0		194.01
194.02	07952	FOUNDATION	85,405	0	85,405		194.02
194.03	07953	OUTPATIENT MEALS	22,716	0	22,716		194.03
194.04	07954	VACANT SPACE	0	0	0		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	21,484,179	0	21,484,179		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet B Part II Date/Time Prepared: 7/17/2018 8:31 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	28,170	0	0	24,951	5.04
5.05	00590	OTHER ADMIN. & GENERAL	0	41,002	0	0	36,317	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	47,338	0	0	41,929	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	17,160	0	0	15,199	9.00
10.00	01000	DIETARY	0	23,336	0	0	20,669	10.00
11.00	01100	CAFETERIA	0	7,973	0	0	7,062	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,012	0	0	897	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,442	0	0	18,106	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	50,493	0	0	44,723	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	35,679	0	0	31,601	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	26,609	0	0	23,568	54.00
60.00	06000	LABORATORY	0	10,073	0	0	8,922	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	844	0	0	747	62.00
65.00	06500	RESPIRATORY THERAPY	0	6,378	0	0	5,649	65.00
66.00	06600	PHYSICAL THERAPY	0	15,338	0	0	13,585	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,779	0	0	6,890	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,940	0	0	3,490	68.00
69.00	06900	ELECTROCARDIOLOGY	0	911	0	0	807	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	13,085	0	0	11,590	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	5,830	0	0	5,164	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	111,184	0	0	88.00
90.00	09000	CLINIC	0	65,713	0	0	58,203	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	0	0	25,991	0	90.01
90.02	09002	GEROPSYCH	0	23,040	0	0	20,408	90.02
91.00	09100	EMERGENCY	0	19,455	0	0	17,232	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	471,600	111,184	25,991	417,709	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 through 201)	0	471,600	111,184	25,991	417,709	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet B Part II | Date/Time Prepared: 7/17/2018 8:31 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	53,121	0	0	53,121		5.04
5.05	00590	OTHER ADMIN. & GENERAL	77,319	0	0	6,044	83,363	5.05
6.00	00600	MAINTENANCE & REPAIRS	89,267	0	0	1,173	2,023	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	638	1,100	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	0	339	585	7.01
9.00	00900	HOUSEKEEPING	32,359	0	0	1,164	2,008	9.00
10.00	01000	DIETARY	44,005	0	0	1,766	3,046	10.00
11.00	01100	CAFETERIA	15,035	0	0	39	68	11.00
13.00	01300	NURSING ADMINISTRATION	1,909	0	0	356	613	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	38,548	0	0	1,692	2,918	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	745	1,284	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	95,216	0	0	3,628	6,256	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	67,280	0	0	878	1,514	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53	92	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	50,177	0	0	3,707	6,393	54.00
60.00	06000	LABORATORY	18,995	0	0	3,847	6,633	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,591	0	0	163	281	62.00
65.00	06500	RESPIRATORY THERAPY	12,027	0	0	276	477	65.00
66.00	06600	PHYSICAL THERAPY	28,923	0	0	1,156	1,993	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,669	0	0	727	1,253	67.00
68.00	06800	SPEECH PATHOLOGY	7,430	0	0	500	862	68.00
69.00	06900	ELECTROCARDIOLOGY	1,718	0	0	728	1,255	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	24,675	0	0	190	327	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,994	0	0	2,224	3,835	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	111,184	0	0	8,399	14,490	88.00
90.00	09000	CLINIC	123,916	0	0	4,353	7,506	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	25,991	0	0	666	1,148	90.01
90.02	09002	GEROPSYCH	43,448	0	0	902	1,555	90.02
91.00	09100	EMERGENCY	36,687	0	0	6,768	11,671	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,026,484	0	0	53,121	81,186	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	1,846	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	331	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 through 201)	1,026,484	0	0	53,121	83,363	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet B Part II | Date/Time Prepared: 7/17/2018 8:31 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	92,463					6.00
7.00	00700	OPERATION OF PLANT	0	1,738				7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	924			7.01
9.00	00900	HOUSEKEEPING	4,468	84	0	40,083		9.00
10.00	01000	DIETARY	6,076	114	0	2,768	57,775	10.00
11.00	01100	CAFETERIA	2,076	39	0	946	28,759	11.00
13.00	01300	NURSING ADMINISTRATION	264	5	0	120	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,323	100	0	2,425	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,148	247	0	5,989	7,044	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,290	175	0	4,232	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,929	130	0	3,156	0	54.00
60.00	06000	LABORATORY	2,623	49	0	1,195	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	220	4	0	100	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,661	31	0	757	0	65.00
66.00	06600	PHYSICAL THERAPY	3,994	75	0	1,819	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,025	38	0	923	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,026	19	0	467	0	68.00
69.00	06900	ELECTROCARDIOLOGY	237	4	0	108	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,407	64	0	1,552	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	1,518	29	0	691	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	924	0	0	88.00
90.00	09000	CLINIC	17,112	323	0	7,794	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	0	0	0	0	90.01
90.02	09002	GEROPSYCH	6,000	113	0	2,733	0	90.02
91.00	09100	EMERGENCY	5,066	95	0	2,308	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	92,463	1,738	924	40,083	35,803	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	20,474	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	1,498	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 through 201)	92,463	1,738	924	40,083	57,775	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet B Part II Date/Time Prepared: 7/17/2018 8:31 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
			11.00	13.00	16.00	19.00	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						10.00
11.00	01100	CAFETERIA	46,962					11.00
13.00	01300	NURSING ADMINISTRATION	661	3,928				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,069	0	57,075			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	2,029		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,855	1,859	5,470		149,712	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,361	233	1,019		85,982	50.00
53.00	05300	ANESTHESIOLOGY	688	0	0		833	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,463	0	3,227		79,182	54.00
60.00	06000	LABORATORY	6,195	0	2,922		42,459	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0		2,359	62.00
65.00	06500	RESPIRATORY THERAPY	334	57	476		16,096	65.00
66.00	06600	PHYSICAL THERAPY	3,442	0	1,444		42,846	66.00
67.00	06700	OCCUPATIONAL THERAPY	944	0	0		20,579	67.00
68.00	06800	SPEECH PATHOLOGY	559	0	0		10,863	68.00
69.00	06900	ELECTROCARDIOLOGY	1,152	197	849		6,248	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		30,215	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		19,291	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	16,850		151,847	88.00
90.00	09000	CLINIC	2,242	384	9,377		173,007	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	0	0		27,805	90.01
90.02	09002	GEROPSYCH	1,711	293	0		56,755	90.02
91.00	09100	EMERGENCY	5,286	905	15,441		84,227	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	46,962	3,928	57,075	0	1,000,306	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0		22,320	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0		0	194.01
194.02	07952	FOUNDATION	0	0	0		331	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0		1,498	194.03
194.04	07954	VACANT SPACE	0	0	0		0	194.04
200.00		Cross Foot Adjustments				2,029	2,029	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	46,962	3,928	57,075	2,029	1,026,484	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet B Part II Date/Time Prepared: 7/17/2018 8:31 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
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	149,712		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	85,982		50.00
53.00	05300	ANESTHESIOLOGY	0	833		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	79,182		54.00
60.00	06000	LABORATORY	0	42,459		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	2,359		62.00
65.00	06500	RESPIRATORY THERAPY	0	16,096		65.00
66.00	06600	PHYSICAL THERAPY	0	42,846		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	20,579		67.00
68.00	06800	SPEECH PATHOLOGY	0	10,863		68.00
69.00	06900	ELECTROCARDIOLOGY	0	6,248		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	30,215		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,291		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	151,847		88.00
90.00	09000	CLINIC	0	173,007		90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	27,805		90.01
90.02	09002	GEROPSYCH	0	56,755		90.02
91.00	09100	EMERGENCY	0	84,227		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,000,306		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	CULBERTSON GARDENS	0	22,320		194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0		194.01
194.02	07952	FOUNDATION	0	331		194.02
194.03	07953	OUTPATIENT MEALS	0	1,498		194.03
194.04	07954	VACANT SPACE	0	0		194.04
200.00		Cross Foot Adjustments	0	2,029		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,026,484		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet B-1 | Date/Time Prepared: 7/17/2018 8:31 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	12,421				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	8,597,399	4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	0	0	0	0	204,805	5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	3,339	0	0	3,339	364,894	5.04
5.05	00590	OTHER ADMIN. & GENERAL	4,860	0	0	4,860	636,108	5.05
6.00	00600	MAINTENANCE & REPAIRS	5,611	0	0	5,611	200,325	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	50,468	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	0	0	69,290	7.01
9.00	00900	HOUSEKEEPING	2,034	0	0	2,034	276,242	9.00
10.00	01000	DIETARY	2,766	0	0	2,766	351,526	10.00
11.00	01100	CAFETERIA	945	0	0	945	0	11.00
13.00	01300	NURSING ADMINISTRATION	120	0	0	120	92,903	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,423	0	0	2,423	405,460	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	204,661	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,985	0	0	5,985	833,403	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,229	0	0	4,229	132,204	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,154	0	0	3,154	524,883	54.00
60.00	06000	LABORATORY	1,194	0	0	1,194	551,991	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	31,936	65.00
66.00	06600	PHYSICAL THERAPY	1,818	0	0	1,818	219,657	66.00
67.00	06700	OCCUPATIONAL THERAPY	922	0	0	922	164,871	67.00
68.00	06800	SPEECH PATHOLOGY	467	0	0	467	109,807	68.00
69.00	06900	ELECTROCARDIOLOGY	108	0	0	108	94,198	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	12,421	0	0	1,913,154	88.00
90.00	09000	CLINIC	7,789	0	0	7,789	198,612	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	0	9,400	0	120,982	90.01
90.02	09002	GEROPSYCH	2,731	0	0	2,731	138,309	90.02
91.00	09100	EMERGENCY	2,306	0	0	2,306	477,251	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	55,899	12,421	9,400	55,899	8,367,940	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	208,005	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	21,454	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)	471,600	111,184	25,991	417,709	3,327,327	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.436645	8.951292	2.765000	7.472567	0.387016	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
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet B-1 | Date/Time Prepared: 7/17/2018 8:31 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	33,483,728					5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	0	-740,756	20,244,541			5.04
5.05	00590	OTHER ADMIN. & GENERAL	0	0	2,303,332	-2,387,611	19,096,568	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	447,048	0	463,405	6.00
7.00	00700	OPERATION OF PLANT	0	0	243,019	0	251,911	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	129,191	0	133,918	7.01
9.00	00900	HOUSEKEEPING	0	0	443,733	0	459,969	9.00
10.00	01000	DIETARY	0	0	673,168	0	697,799	10.00
11.00	01100	CAFETERIA	0	0	15,035	0	15,585	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	135,581	0	140,542	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	644,930	0	668,528	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	283,868	0	294,255	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,847,035	0	1,382,705	0	1,433,298	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,050,120	0	334,583	0	346,825	50.00
53.00	05300	ANESTHESIOLOGY	405,469	0	20,332	0	21,076	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,946,780	0	1,412,859	0	1,464,556	54.00
60.00	06000	LABORATORY	6,394,899	0	1,465,933	0	1,519,571	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	140,998	0	62,131	0	64,404	62.00
65.00	06500	RESPIRATORY THERAPY	210,535	0	105,329	0	109,183	65.00
66.00	06600	PHYSICAL THERAPY	1,180,727	0	440,419	0	456,534	66.00
67.00	06700	OCCUPATIONAL THERAPY	423,055	0	276,915	0	287,047	67.00
68.00	06800	SPEECH PATHOLOGY	389,034	0	190,602	0	197,576	68.00
69.00	06900	ELECTROCARDIOLOGY	1,925,411	0	277,265	0	287,410	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	345,153	0	72,351	0	74,998	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,909,313	0	847,667	0	878,683	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,215,642	0	3,200,817	0	3,317,945	88.00
90.00	09000	CLINIC	3,620,335	0	1,658,887	0	1,719,586	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	293,326	0	253,733	0	263,017	90.01
90.02	09002	GEROPSYCH	55,175	0	343,693	0	356,269	90.02
91.00	09100	EMERGENCY	2,130,721	0	2,579,415	0	2,673,796	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,483,728	-740,756	20,244,541	-2,387,611	18,597,686	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	-422,968	0	0	422,968	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	-75,914	0	0	75,914	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)	367,412		740,756		2,387,611	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.010973		0.036590		0.125028	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		53,121		83,363	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		0.002624		0.004365	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet B-1 | Date/Time Prepared: 7/17/2018 8:31 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	42,089					6.00
7.00	00700	OPERATION OF PLANT	0	42,089				7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	12,421			7.01
9.00	00900	HOUSEKEEPING	2,034	2,034	0	40,055		9.00
10.00	01000	DIETARY	2,766	2,766	0	2,766	42,167	10.00
11.00	01100	CAFETERIA	945	945	0	945	20,990	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
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,985	5,985	0	5,985	5,141	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	3,154	3,154	0	3,154	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	1,818	1,818	0	1,818	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	922	922	0	922	0	67.00
68.00	06800	SPEECH PATHOLOGY	467	467	0	467	0	68.00
69.00	06900	ELECTROCARDIOLOGY	108	108	0	108	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	12,421	0	0	88.00
90.00	09000	CLINIC	7,789	7,789	0	7,789	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 through 117)	42,089	42,089	12,421	40,055	26,131	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	14,943	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	1,093	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)	521,344	283,407	150,661	556,369	876,350	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.386704	6.733517	12.129539	13.890126	20.782840	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	92,463	1,738	924	40,083	57,775	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.196845	0.041293	0.074390	1.000699	1.370147	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet B-1 | Date/Time Prepared: 7/17/2018 8:31 pm

		Cost Center Description	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			11.00	13.00	16.00	19.00		
		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	11,940					11.00
13.00	01300	NURSING ADMINISTRATION	168	68,102				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,543	0	3,360			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,760	32,225	322	0		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	346	4,043	60	0		50.00
53.00	05300	ANESTHESIOLOGY	175	0	0	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,389	0	190	0		54.00
60.00	06000	LABORATORY	1,575	0	172	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	85	988	28	0		65.00
66.00	06600	PHYSICAL THERAPY	875	0	85	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	240	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	142	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	293	3,417	50	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	992	0		88.00
90.00	09000	CLINIC	570	6,653	552	0		90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	0	0	0		90.01
90.02	09002	GEROPSYCH	435	5,081	0	0		90.02
91.00	09100	EMERGENCY	1,344	15,695	909	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,940	68,102	3,360	100		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	CULBERTSON GARDENS	0	0	0	0		194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0		194.01
194.02	07952	FOUNDATION	0	0	0	0		194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0		194.03
194.04	07954	VACANT SPACE	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)	484,959	168,899	894,768	331,045		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	40.616332	2.480089	266.300000	3,310.450000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	46,962	3,928	57,075	2,029		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.933166	0.057678	16.986607	20.290000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet C Part I Date/Time Prepared: 7/17/2018 8:31 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	2,194,683		2,194,683	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	569,846		569,846	0	0	50.00
53.00	05300	ANESTHESIOLOGY	361,864		361,864	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,858,795		1,858,795	0	0	54.00
60.00	06000	LABORATORY	1,858,750		1,858,750	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	75,757		75,757	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	161,148	0	161,148	0	0	65.00
66.00	06600	PHYSICAL THERAPY	631,802	0	631,802	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	363,120	0	363,120	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	243,464	0	243,464	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	360,599		360,599	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	135,575		135,575	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,011,353		1,011,353	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,147,615		4,147,615	0	0	88.00
90.00	09000	CLINIC	2,378,347		2,378,347	0	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	295,901		295,901	0	0	90.01
90.02	09002	GEROPSYCH	521,233		521,233	0	0	90.02
91.00	09100	EMERGENCY	3,419,797		3,419,797	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	174,458		174,458		0	92.00
200.00		Subtotal (see instructions)	20,764,107	0	20,764,107	0	0	200.00
201.00		Less Observation Beds	174,458		174,458		0	201.00
202.00		Total (see instructions)	20,589,649	0	20,589,649	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet C Part I Date/Time Prepared: 7/17/2018 8:31 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges					
			Inpatient	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	1,689,256		1,689,256			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,064	1,049,056	1,050,120	0.542648	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	405,469	405,469	0.892458	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	103,207	7,843,573	7,946,780	0.233905	0.000000	54.00
60.00	06000	LABORATORY	374,019	6,020,880	6,394,899	0.290661	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	7,025	133,973	140,998	0.537291	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	210,535	210,535	0.765421	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	113,350	1,067,377	1,180,727	0.535096	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	147,440	275,615	423,055	0.858328	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	10,164	378,870	389,034	0.625817	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	65,101	1,860,310	1,925,411	0.187284	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	303,530	41,623	345,153	0.392797	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	840,249	2,069,064	2,909,313	0.347626	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,215,642	2,215,642			88.00
90.00	09000	CLINIC	891	3,619,444	3,620,335	0.656941	0.000000	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	326	293,000	293,326	1.008779	0.000000	90.01
90.02	09002	GEROPSYCH	0	55,175	55,175	9.446905	0.000000	90.02
91.00	09100	EMERGENCY	7,263	2,123,458	2,130,721	1.604995	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	157,779	157,779	1.105711	0.000000	92.00
200.00		Subtotal (see instructions)	3,662,885	29,820,843	33,483,728			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,662,885	29,820,843	33,483,728			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet C Part I Date/Time Prepared: 7/17/2018 8:31 pm

Title XVIII | Hospital | Cost

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

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet C Part I Date/Time Prepared: 7/17/2018 8:31 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	2,194,683		2,194,683	0	2,194,683	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	569,846		569,846	0	569,846	50.00
53.00	05300	ANESTHESIOLOGY	361,864		361,864	0	361,864	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,858,795		1,858,795	0	1,858,795	54.00
60.00	06000	LABORATORY	1,858,750		1,858,750	0	1,858,750	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	75,757		75,757	0	75,757	62.00
65.00	06500	RESPIRATORY THERAPY	161,148	0	161,148	0	161,148	65.00
66.00	06600	PHYSICAL THERAPY	631,802	0	631,802	0	631,802	66.00
67.00	06700	OCCUPATIONAL THERAPY	363,120	0	363,120	0	363,120	67.00
68.00	06800	SPEECH PATHOLOGY	243,464	0	243,464	0	243,464	68.00
69.00	06900	ELECTROCARDIOLOGY	360,599		360,599	0	360,599	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	135,575		135,575	0	135,575	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,011,353		1,011,353	0	1,011,353	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,147,615		4,147,615	0	4,147,615	88.00
90.00	09000	CLINIC	2,378,347		2,378,347	0	2,378,347	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	295,901		295,901	0	295,901	90.01
90.02	09002	GEROPSYCH	521,233		521,233	0	521,233	90.02
91.00	09100	EMERGENCY	3,419,797		3,419,797	0	3,419,797	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	174,458		174,458		174,458	92.00
200.00		Subtotal (see instructions)	20,764,107	0	20,764,107	0	20,764,107	200.00
201.00		Less Observation Beds	174,458		174,458		174,458	201.00
202.00		Total (see instructions)	20,589,649	0	20,589,649	0	20,589,649	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet C Part I Date/Time Prepared: 7/17/2018 8:31 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges					
			Inpatient	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	1,689,256		1,689,256			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,064	1,049,056	1,050,120	0.542648	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	405,469	405,469	0.892458	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	103,207	7,843,573	7,946,780	0.233905	0.000000	54.00
60.00	06000	LABORATORY	374,019	6,020,880	6,394,899	0.290661	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	7,025	133,973	140,998	0.537291	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	210,535	210,535	0.765421	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	113,350	1,067,377	1,180,727	0.535096	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	147,440	275,615	423,055	0.858328	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	10,164	378,870	389,034	0.625817	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	65,101	1,860,310	1,925,411	0.187284	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	303,530	41,623	345,153	0.392797	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	840,249	2,069,064	2,909,313	0.347626	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,215,642	2,215,642	1.871970	0.000000	88.00
90.00	09000	CLINIC	891	3,619,444	3,620,335	0.656941	0.000000	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	326	293,000	293,326	1.008779	0.000000	90.01
90.02	09002	GEROPSYCH	0	55,175	55,175	9.446905	0.000000	90.02
91.00	09100	EMERGENCY	7,263	2,123,458	2,130,721	1.604995	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	157,779	157,779	1.105711	0.000000	92.00
200.00		Subtotal (see instructions)	3,662,885	29,820,843	33,483,728			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,662,885	29,820,843	33,483,728			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet C Part I Date/Time Prepared: 7/17/2018 8:31 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: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D Part II Date/Time Prepared: 7/17/2018 8:31 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	85,982	1,050,120	0.081878	1,064	87	50.00
53.00	05300	ANESTHESIOLOGY	833	405,469	0.002054	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	79,182	7,946,780	0.009964	77,072	768	54.00
60.00	06000	LABORATORY	42,459	6,394,899	0.006640	184,678	1,226	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,359	140,998	0.016731	4,582	77	62.00
65.00	06500	RESPIRATORY THERAPY	16,096	210,535	0.076453	0	0	65.00
66.00	06600	PHYSICAL THERAPY	42,846	1,180,727	0.036288	6,960	253	66.00
67.00	06700	OCCUPATIONAL THERAPY	20,579	423,055	0.048644	4,560	222	67.00
68.00	06800	SPEECH PATHOLOGY	10,863	389,034	0.027923	4,860	136	68.00
69.00	06900	ELECTROCARDIOLOGY	6,248	1,925,411	0.003245	53,313	173	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	30,215	345,153	0.087541	140,947	12,339	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,291	2,909,313	0.006631	317,319	2,104	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	151,847	2,215,642	0.068534	0	0	88.00
90.00	09000	CLINIC	173,007	3,620,335	0.047788	0	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	27,805	293,326	0.094792	0	0	90.01
90.02	09002	GEROPSYCH	56,755	55,175	1.028636	0	0	90.02
91.00	09100	EMERGENCY	84,227	2,130,721	0.039530	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	11,901	157,779	0.075428	0	0	92.00
200.00		Total (lines 50 through 199)	862,495	31,794,472		795,355	17,385	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D Part IV | Date/Time Prepared: 7/17/2018 8:31 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	331,045	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	92.00
200.00		Total (lines 50 through 199)	331,045	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D Part IV Date/Time Prepared: 7/17/2018 8:31 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	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)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	1,050,120	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	331,045	0	405,469	0.816450	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	7,946,780	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	6,394,899	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	140,998	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	210,535	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,180,727	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	423,055	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	389,034	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,925,411	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	345,153	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,909,313	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,215,642	0.000000	88.00
90.00	09000	CLINIC	0	0	0	3,620,335	0.000000	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	0	0	293,326	0.000000	90.01
90.02	09002	GEROPSYCH	0	0	0	55,175	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	2,130,721	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	157,779	0.000000	92.00
200.00		Total (lines 50 through 199)	0	331,045	0	31,794,472		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D Part IV | Date/Time Prepared: 7/17/2018 8:31 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	1,064	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	77,072	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	184,678	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	4,582	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	6,960	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	4,560	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	4,860	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	53,313	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	140,947	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	317,319	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	GEROPSYCH	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		795,355	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D Part V Date/Time Prepared: 7/17/2018 8:31 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	0.542648	0	351,967	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.892458	0	123,507	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.233905	0	3,066,429	6	0	54.00
60.00	06000	LABORATORY	0.290661	0	2,414,876	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.537291	0	26,137	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.765421	0	51,992	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.535096	0	415,304	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.858328	0	49,168	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.625817	0	34,263	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.187284	0	960,576	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.392797	0	40,895	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.347626	0	1,350,718	2,885	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.656941	0	1,579,990	3,607	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	1.008779	0	62,213	569	0	90.01
90.02	09002	GEROPSYCH	9.446905	0	55,030	0	0	90.02
91.00	09100	EMERGENCY	1.604995	0	690,568	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.105711	0	73,282	0	0	92.00
200.00		Subtotal (see instructions)		0	11,346,915	7,067	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	11,346,915	7,067	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D Part V Date/Time Prepared: 7/17/2018 8:31 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	190,994	0		50.00
53.00	05300	ANESTHESIOLOGY	110,225	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	717,253	1		54.00
60.00	06000	LABORATORY	701,910	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	14,043	0		62.00
65.00	06500	RESPIRATORY THERAPY	39,796	0		65.00
66.00	06600	PHYSICAL THERAPY	222,228	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	42,202	0		67.00
68.00	06800	SPEECH PATHOLOGY	21,442	0		68.00
69.00	06900	ELECTROCARDIOLOGY	179,901	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,063	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	469,545	1,003		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	1,037,960	2,370		90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	62,759	574		90.01
90.02	09002	GEROPSYCH	519,863	0		90.02
91.00	09100	EMERGENCY	1,108,358	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	81,029	0		92.00
200.00		Subtotal (see instructions)	5,535,571	3,948		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,535,571	3,948		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1333 | Component CCN: 14-Z333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D Part V | Date/Time Prepared: 7/17/2018 8:31 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	0.542648	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.892458	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.233905	0	0	0	0	54.00
60.00	06000	LABORATORY	0.290661	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.537291	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.765421	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.535096	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.858328	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.625817	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.187284	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.392797	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.347626	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	0.656941	0	0	0	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	1.008779	0	0	0	0	90.01
90.02	09002	GEROPSYCH	9.446905	0	0	0	0	90.02
91.00	09100	EMERGENCY	1.604995	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.105711	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: 14-1333 | Component CCN: 14-Z333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D Part V | Date/Time Prepared: 7/17/2018 8:31 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: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D-1 | Date/Time Prepared: 7/17/2018 8:31 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)	1,706	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	855	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)	720	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	346	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)	496	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	9	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	542	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)	346	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)	452	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	187.13	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	187.13	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,194,683	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)	1,684	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	1,089,784	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,104,899	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)	1,104,899	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)	1,292.28	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	700,416	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)	700,416	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D-1 | Date/Time Prepared: 7/17/2018 8:31 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)	261,082	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	961,498	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)	447,129	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	584,111	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,031,240	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	135	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,292.28	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	174,458	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D-1 | Date/Time Prepared: 7/17/2018 8:31 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	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	149,712	2,194,683	0.068216	174,458	11,901	90.00
91.00	Nursing School cost	0	2,194,683	0.000000	174,458	0	91.00
92.00	Allied health cost	0	2,194,683	0.000000	174,458	0	92.00
93.00	All other Medical Education	0	2,194,683	0.000000	174,458	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D-3 | Date/Time Prepared: 7/17/2018 8:31 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		862,622		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.542648	1,064	577	50.00
53.00	05300	ANESTHESIOLOGY	0.892458	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.233905	77,072	18,028	54.00
60.00	06000	LABORATORY	0.290661	184,678	53,679	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.537291	4,582	2,462	62.00
65.00	06500	RESPIRATORY THERAPY	0.765421	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.535096	6,960	3,724	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.858328	4,560	3,914	67.00
68.00	06800	SPEECH PATHOLOGY	0.625817	4,860	3,041	68.00
69.00	06900	ELECTROCARDIOLOGY	0.187284	53,313	9,985	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.392797	140,947	55,364	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.347626	317,319	110,308	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.656941	0	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	1.008779	0	0	90.01
90.02	09002	GEROPSYCH	9.446905	0	0	90.02
91.00	09100	EMERGENCY	1.604995	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.105711	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		795,355	261,082	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)		795,355		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1333 | Component CCN: 14-Z333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet D-3 | Date/Time Prepared: 7/17/2018 8:31 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		706		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.542648	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.892458	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.233905	14,290	3,343	54.00
60.00	06000	LABORATORY	0.290661	127,244	36,985	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.537291	1,004	539	62.00
65.00	06500	RESPIRATORY THERAPY	0.765421	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.535096	98,735	52,833	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.858328	131,725	113,063	67.00
68.00	06800	SPEECH PATHOLOGY	0.625817	4,916	3,077	68.00
69.00	06900	ELECTROCARDIOLOGY	0.187284	5,506	1,031	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.392797	102,167	40,131	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.347626	515,874	179,331	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.656941	0	0	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	1.008779	0	0	90.01
90.02	09002	GEROPSYCH	9.446905	0	0	90.02
91.00	09100	EMERGENCY	1.604995	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.105711	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,001,461	430,333	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,001,461		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1333	Period: From 03/01/2017 To 02/28/2018	Worksheet E Part B Date/Time Prepared: 7/17/2018 8:31 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,539,519	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
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 lines 3, 4, and 4.01, 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)	5,539,519	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, col. 4, line 69)	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 (see instructions)	5,594,914	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, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	51,052	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,781,797	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,762,065	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)	3,762,065	30.00
31.00	Primary payer payments	1,424	31.00
32.00	Subtotal (line 30 minus line 31)	3,760,641	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)	271,903	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	176,737	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	141,686	36.00
37.00	Subtotal (see instructions)	3,937,378	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)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
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)	3,937,378	40.00
40.01	Sequestration adjustment (see instructions)	78,748	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	3,869,732	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-11,102	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: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet E-1 Part I | Date/Time Prepared: 7/17/2018 8:31 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		766,229		3,751,632	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0	09/15/2017	118,100	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		118,100	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)		766,229		3,869,732	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		42,585		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		11,102	6.02
7.00	Total Medicare program liability (see instructions)		808,814		3,858,630	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: 14-1333 | Component CCN: 14-Z333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet E-1 Part I | Date/Time Prepared: 7/17/2018 8:31 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,179,133		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,179,133		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		222,758		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,401,891		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: 14-1333	Period: From 03/01/2017 To 02/28/2018	Worksheet E-1 Part II Date/Time Prepared: 7/17/2018 8:31 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 14-1333 | Component CCN: 14-Z333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet E-2 | Date/Time Prepared: 7/17/2018 8:31 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)	1,041,552	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 Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	434,636	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	798	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)	1,476,188	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,476,188	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)	1,476,188	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	45,687	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)	1,430,501	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
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)	1,430,501	0	19.00
19.01	Sequestration adjustment (see instructions)	28,610	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	1,179,133	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)	222,758	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1333	Period: From 03/01/2017 To 02/28/2018	Worksheet E-3 Part V Date/Time Prepared: 7/17/2018 8:31 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	961,498	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)	961,498	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	971,113	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)	971,113	19.00
20.00	Deductibles (exclude professional component)	160,794	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	810,319	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	810,319	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	23,079	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	15,001	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	19,460	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	825,320	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	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	825,320	30.00
30.01	Sequestration adjustment (see instructions)	16,506	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	766,229	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, 30.02, 31, and 32)	42,585	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: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet G | Date/Time Prepared: 7/17/2018 8:31 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	8,878,007	0	0	0	1.00
2.00	Temporary investments	166,444	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,235,012	0	0	0	4.00
5.00	Other receivable	759,619	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	525,149	0	0	0	7.00
8.00	Prepaid expenses	42,999	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)	13,607,230	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	426,152	0	0	0	12.00
13.00	Land improvements	1,240,691	0	0	0	13.00
14.00	Accumulated depreciation	-834,231	0	0	0	14.00
15.00	Buildings	6,286,759	0	0	0	15.00
16.00	Accumulated depreciation	-4,139,655	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	12,355,842	0	0	0	19.00
20.00	Accumulated depreciation	-8,689,908	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	6,645,650	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	4,089,323	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	1,716,033	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,805,356	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	26,058,236	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	299,279	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,182,824	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	84,157	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	200,448	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,766,708	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	490,330	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	3,557,155	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	4,047,485	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	5,814,193	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	20,244,043				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)	20,244,043	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	26,058,236	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet G-1 | Date/Time Prepared: 7/17/2018 8:31 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		20,812,556		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-568,513				2.00
3.00	Total (sum of line 1 and line 2)		20,244,043		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)		20,244,043		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)		20,244,043		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: 14-1333 | Period: From 03/01/2017 To 02/28/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 7/17/2018 8:31 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,419,132		1,419,132	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	535,099		535,099	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)	1,954,231		1,954,231	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)	1,954,231		1,954,231	17.00
18.00	Ancillary services	1,735,060	21,999,617	23,734,677	18.00
19.00	Outpatient services	10,508	8,800,590	8,811,098	19.00
20.00	RURAL HEALTH CLINIC	0	1,695,600	1,695,600	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	460,413	460,413	27.00
27.01	DIETARY	0	2,016	2,016	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	3,699,799	32,958,236	36,658,035	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		23,437,721		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	PATIENT COLLECT FEES-OTHER REV	68,000			37.00
38.00	INTEREST EXPENSE	38,471			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)		106,471		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		23,331,250		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-1333	Period: From 03/01/2017 To 02/28/2018	Worksheet G-3 Date/Time Prepared: 7/17/2018 8:31 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	36,658,035	1.00
2.00	Less contractual allowances and discounts on patients' accounts	15,026,972	2.00
3.00	Net patient revenues (line 1 minus line 2)	21,631,063	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	23,331,250	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,700,187	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	70,719	6.00
7.00	Income from investments	100,507	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	308,157	24.00
24.01	PROPERTY TAXES	641,466	24.01
24.02	NONCAPITAL GRANTS AND GIFTS	49,296	24.02
25.00	Total other income (sum of lines 6-24)	1,170,145	25.00
26.00	Total (line 5 plus line 25)	-530,042	26.00
27.00	INTEREST EXPENSE	38,471	27.00
27.01	OTHER EXPENSES (SPECIFY)	0	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	38,471	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-568,513	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1333 | Component CCN: 14-3483 | Period: From 03/01/2017 To 02/28/2018 | Worksheet M-1 | Date/Time Prepared: 7/17/2018 8:31 pm

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	680,118	0	680,118	97,254	777,372	1.00
2.00	Physician Assistant	125,997	0	125,997	0	125,997	2.00
3.00	Nurse Practitioner	284,119	0	284,119	0	284,119	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	472,916	0	472,916	41,578	514,494	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	21,381	0	21,381	0	21,381	7.00
8.00	Laboratory Technician	81,050	0	81,050	-81,050	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)	1,665,581	0	1,665,581	57,782	1,723,363	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	81,279	81,279	0	81,279	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	81,279	81,279	0	81,279	14.00
15.00	Medical Supplies	0	156,379	156,379	0	156,379	15.00
16.00	Transportation (Health Care Staff)	0	13,217	13,217	0	13,217	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						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	169,596	169,596	0	169,596	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,665,581	250,875	1,916,456	57,782	1,974,238	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
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
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						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	374,942	71,931	446,873	-80,543	366,330	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	374,942	71,931	446,873	-80,543	366,330	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,040,523	322,806	2,363,329	-22,761	2,340,568	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1333 | Component CCN: 14-3483 | Period: From 03/01/2017 To 02/28/2018 | Worksheet M-1 | Date/Time Prepared: 7/17/2018 8:31 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	777,372		1.00
2.00	Physician Assistant	0	125,997		2.00
3.00	Nurse Practitioner	0	284,119		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	514,494		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	21,381		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)	0	1,723,363		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	81,279		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	81,279		14.00
15.00	Medical Supplies	0	156,379		15.00
16.00	Transportation (Health Care Staff)	0	13,217		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				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	169,596		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,974,238		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				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	-15,664	350,666		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-15,664	350,666		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-15,664	2,324,904		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1333 | Component CCN: 14-3483 | Period: From 03/01/2017 To 02/28/2018 | Worksheet M-2 | Date/Time Prepared: 7/17/2018 8:31 pm

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	2.22	5,240	4,200	9,324		1.00
2.00	Physician Assistant	1.02	2,686	2,100	2,142		2.00
3.00	Nurse Practitioner	2.45	5,967	2,100	5,145		3.00
4.00	Subtotal (sum of lines 1 through 3)	5.69	13,893		16,611	16,611	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	0.37	211			211	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)	6.06	14,104			16,822	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,974,238	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)					1,974,238	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					350,666	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,822,711	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,173,377	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,173,377	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,173,377	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					4,147,615	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1333 Component CCN: 14-3483	Period: From 03/01/2017 To 02/28/2018	Worksheet M-3 Date/Time Prepared: 7/17/2018 8:31 pm
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		4,147,615	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		30,360	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		4,117,255	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		16,822	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)		16,822	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		244.75	7.00

		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	82.30	83.45	8.00
9.00	Rate for Program covered visits (see instructions)	244.75	244.75	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	3,323	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	813,304	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	17	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	4,161	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	4,161	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	817,465	16.00
16.01	Total program charges (see instructions)(from contractor's records)		441,087	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		5,867	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		10,873	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.)		597,504	16.04
16.05	Total program cost (see instructions)	0	608,377	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		59,712	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		75,101	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		608,377	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,459	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		609,836	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
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		609,836	26.00
26.01	Sequestration adjustment (see instructions)		12,197	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		356,750	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, 26.02, 27, and 28)		240,889	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 HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 14-1333 Component CCN: 14-3483	Period: From 03/01/2017 To 02/28/2018	Worksheet M-4 Date/Time Prepared: 7/17/2018 8:31 pm
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,723,363	1,723,363	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000834	0.002312	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,437	3,984	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	3,046	5,984	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	4,483	9,968	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,974,238	1,974,238	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,173,377	2,173,377	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002271	0.005049	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	4,936	10,973	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	9,419	20,941	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	309	856	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	30.48	24.46	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	27	26	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	823	636	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)		30,360	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)		1,459	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1333 Component CCN: 14-3483	Period: From 03/01/2017 To 02/28/2018	Worksheet M-5 Date/Time Prepared: 7/17/2018 8:31 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		356,750	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)		356,750	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		240,889	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		597,639	7.00

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