

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141333	Period: From 03/01/2015 To 02/29/2016	Worksheet S Parts I-III Date/Time Prepared: 7/27/2016 9:37 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 7/27/2016 Time: 9:37 am
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SARAH D CULBERTSON (141333) for the cost reporting period beginning 03/01/2015 and ending 02/29/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-45,839	233,320	1	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	-9,154	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		73,254		0	10.00
200.00 Total	0	-54,993	306,574	1	0	200.00

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

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

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 141333		Period: From 03/01/2015 To 02/29/2016		Worksheet S-2 Part I Date/Time Prepared: 7/27/2016 9:29 am		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00 Street: 238 SOUTH CONGRESS		PO Box:		Zip Code: 62681		County: SCHUYLER				
2.00 City: RUSHVILLE		State: IL								
Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00		
V		XVIII	XIX							
Hospital and Hospital-Based Component Identification:										
3.00 Hospital		SARAH D CULBERTSON	141333	99914	1	05/01/2004	N	0	0	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	0	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	0	N	15.00
16.00 Hospital-Based Health Clinic - FOHC										16.00
17.00 Hospital-Based (CMHC) I										17.00
18.00 Renal Dialysis										18.00
19.00 Other										19.00
						From:	To:			
						1.00	2.00			
20.00 Cost Reporting Period (mm/dd/yyyy)						03/01/2015	02/29/2016		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		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	0		25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141333	Period: From 03/01/2015 To 02/29/2016	Worksheet S-2 Part I Date/Time Prepared: 7/27/2016 9:29 am			
		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.		0			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.					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)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)		N		N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)		N		N	40.00	
		V	XVII	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	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	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.		N		N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.		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	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)		N			60.00	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

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	Y/N	IME	Direct GME	IME	Direct GME		
	1.00	2.00	3.00	4.00	5.00		
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)	0.00	0.00				61.06
	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00	2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.		0.00	0.00		61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.		0.00	0.00		61.20	
						1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01	
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00	
	Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ col. 1 + col. 2))				
	1.00	2.00	3.00				
64.00	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. 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	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	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	

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		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
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, 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
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, 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 a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? 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

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		V 1.00	XIX 2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00		
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00		
Rural Providers						
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y		105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00		
107.00	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. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.	N		107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00		
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	N	N	N	109.00
				1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N		110.00
				1.00	2.00	3.00
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, 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 1.00	Losses 2.00	Insurance 3.00		
118.01	List amounts of malpractice premiums and paid losses:	109,708	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 state health or similar taxes? 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141333	Period: From 03/01/2015 To 02/29/2016	Worksheet S-2 Part I Date/Time Prepared: 7/27/2016 9:29 am		
		1.00	2.00			
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00
		1.00	2.00	3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00
142.00	Street:	PO Box:				142.00
143.00	City:	State:		Zip Code:		143.00
					1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y			144.00
					1.00	
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.	N				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
					1.00	
		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	
Multi campus						
165.00	Is this hospital part of a Multi campus 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
		0	1.00	2.00	3.00	4.00
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)					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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141333	Period: From 03/01/2015 To 02/29/2016	Worksheet S-2 Part I Date/Time Prepared: 7/27/2016 9:29 am	
			Beginning	Ending	
			1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		10/03/2015	12/31/2015	170.00
				1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)			N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141333	Period: From 03/01/2015 To 02/29/2016	Worksheet S-2 Part II Date/Time Prepared: 7/27/2016 9:29 am		
			Y/N	Date		
			1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.						
COMPLETED BY ALL HOSPITALS						
Provider Organization and Operation						
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00	
			Y/N	Date	V/I	
			1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00	
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00	
			Y/N	Type	Date	
			1.00	2.00	3.00	
Financial Data and Reports						
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00	
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00	
			Y/N	Legal Oper.		
			1.00	2.00		
Approved Educational Activities						
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00	
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00	
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00	
9.00	Are costs claimed for 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	06/01/2016	Y	06/01/2016	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: 141333	Period: From 03/01/2015 To 02/29/2016	Worksheet S-2 Part II Date/Time Prepared: 7/27/2016 9:29 am	
		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		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved 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		LI NHART	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.LI NHART@RSMUS.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141333	Period: From 03/01/2015 To 02/29/2016	Worksheet S-2 Part II Date/Time Prepared: 7/27/2016 9:29 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141333

Period:
From 03/01/2015
To 02/29/2016

Worksheet S-3
Part I
Date/Time Prepared:
7/27/2016 9:29 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					Ti tle 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	8,052	13,671.00	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	8,052	13,671.00	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	8,052	13,671.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		22				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141333

Period:
From 03/01/2015
To 02/29/2016

Worksheet S-3
Part I
Date/Time Prepared:
7/27/2016 9:29 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	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)	396	37	574			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	509	0	593			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	246			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	905	37	1,413			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)	905	37	1,413	0.00	122.92	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)	3,106	3,614	13,939	0.00	24.92	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	147.84	27.00
28.00 Observation Bed Days		0	200			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141333

Period:
From 03/01/2015
To 02/29/2016

Worksheet S-3
Part I
Date/Time Prepared:
7/27/2016 9:29 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	121	12	177	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	121		12	177	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RHC (CONSOLIDATED)	0.00						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days							33.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141333 Component CCN: 143483	Period: From 03/01/2015 To 02/29/2016	Worksheet S-8 Date/Time Prepared: 7/27/2016 9:29 am	
			Rural Health Clinic (RHC) I	Cost	
			1.00		
1.00	Clinic Address and Identification Street		238 S. CONGRESS		1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County		RUSHVILLE	IL62681	2.00
			1.00		
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0 3.00
			Grant Award	Date	
			1.00	2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)		0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)		0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)		0		6.00
7.00	Appalachian Regional Commission		0		7.00
8.00	Look-Alikes		0		8.00
9.00	OTHER (SPECIFY)		0		9.00
			1.00		
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N		0 10.00
		Sunday	Monday	Tuesday	
		from to	from to	from	
		1.00 2.00	3.00 4.00	5.00	
11.00	Facility hours of operations (1) Clinic		08:00	17:00	08:00 11.00
			1.00		
			2.00		
12.00	Have you received an approval for an exception to the productivity standard?		N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		Y	2	13.00
		Provider name	CCN number		
		1.00	2.00		
14.00	Provider name, CCN number		COMMUNITY MEDICAL CLINIC		143484 14.00
14.01			ELMER HUGH TAYLOR CLINIC		143483 14.01
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
				Total Visits	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)				
		County			
		4.00			
2.00	City, State, ZIP Code, County		SCHUYLER		2.00
		Tuesday	Wednesday	Thursday	
		to	from to	from to	
		6.00	7.00 8.00	9.00 10.00	
Facility hours of operations (1)					
11.00	Clinic		17:00	08:00	17:00 11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141333 Component CCN: 143483	Period: From 03/01/2015 To 02/29/2016	Worksheet S-8 Date/Time Prepared: 7/27/2016 9:29 am Cost
		Rural Health Clinic (RHC) I	

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 141333	Period: From 03/01/2015 To 02/29/2016	Worksheet S-10 Date/Time Prepared: 7/27/2016 9:29 am
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				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)		0.573086		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		1,314,009		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		1,664,714		5.00
6.00	Medicaid charges		5,703,753		6.00
7.00	Medicaid cost (line 1 times line 6)		3,268,741		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)		290,018		8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0		9.00
10.00	Stand-alone SCHIP charges		0		10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0		11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		290,018		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	25,810	17,116	42,926	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	14,791	9,809	24,600	21.00
22.00	Partial payment by patients approved for charity care	9,687	6,251	15,938	22.00
23.00	Cost of charity care (line 21 minus line 22)	5,104	3,558	8,662	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		998,462		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		146,730		27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		851,732		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		488,116		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		496,778		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		786,796		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141333

Period:
From 03/01/2015
To 02/29/2016

Worksheet A
Date/Time Prepared:
7/27/2016 9:29 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		384,247	384,247	11,536	395,783	1.00
1.01	00101		109,872	109,872	2,220	112,092	1.01
1.02	00102		20,271	20,271	972	21,243	1.02
2.00	00200		485,590	485,590	8,206	493,796	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	0	5,028,115	5,028,115	-48,292	4,979,823	4.00
5.02	00592	197,713	67,236	264,949	0	264,949	5.02
5.04	00591	338,895	193,156	532,051	0	532,051	5.04
5.05	00590	618,948	1,290,886	1,909,834	-26,720	1,883,114	5.05
6.00	00600	191,302	94,349	285,651	0	285,651	6.00
7.00	00700	60,706	164,380	225,086	0	225,086	7.00
7.01	00701	0	21,298	21,298	64,635	85,933	7.01
9.00	00900	268,872	33,132	302,004	0	302,004	9.00
10.00	01000	301,762	324,577	626,339	0	626,339	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	99,518	8,612	108,130	0	108,130	13.00
16.00	01600	350,583	66,234	416,817	0	416,817	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	777,408	80,500	857,908	0	857,908	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	132,806	159,708	292,514	0	292,514	50.00
53.00	05300	234,866	15,446	250,312	0	250,312	53.00
54.00	05400	436,785	594,711	1,031,496	45,508	1,077,004	54.00
60.00	06000	452,396	611,918	1,064,314	35,099	1,099,413	60.00
62.00	06200	0	57,041	57,041	0	57,041	62.00
65.00	06500	19,953	42,776	62,729	0	62,729	65.00
66.00	06600	326,687	104,907	431,594	-100,869	330,725	66.00
67.00	06700	122,156	0	122,156	67,525	189,681	67.00
68.00	06800	55,228	0	55,228	33,344	88,572	68.00
69.00	06900	101,117	142,418	243,535	0	243,535	69.00
71.00	07100	0	43,541	43,541	0	43,541	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	689,511	689,511	0	689,511	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	1,345,357	457,503	1,802,860	-120,242	1,682,618	88.00
90.00	09000	138,926	1,261,012	1,399,938	0	1,399,938	90.00
90.01	09001	532,565	98,212	630,777	23,292	654,069	90.01
90.02	09002	111,132	112,973	224,105	0	224,105	90.02
91.00	09100	505,065	1,864,555	2,369,620	0	2,369,620	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		7,720,746	14,628,687	22,349,433	-3,786	22,345,647	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	0	0	0	192.00
194.00	07950	207,747	147,023	354,770	3,786	358,556	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	17,145	44,152	61,297	0	61,297	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00		7,945,638	14,819,862	22,765,500	0	22,765,500	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141333

Period:
From 03/01/2015
To 02/29/2016

Worksheet A
Date/Time Prepared:
7/27/2016 9:29 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	0	395,783	1.00
1.01	00101	-33,662	78,430	1.01
1.02	00102	0	21,243	1.02
2.00	00200	-34,826	458,970	2.00
3.00	00300	0	0	3.00
4.00	00400	-2,083,620	2,896,203	4.00
5.02	00592	-11,698	253,251	5.02
5.04	00591	-69,207	462,844	5.04
5.05	00590	-90,031	1,793,083	5.05
6.00	00600	4,594	290,245	6.00
7.00	00700	-531	224,555	7.00
7.01	00701	0	85,933	7.01
9.00	00900	0	302,004	9.00
10.00	01000	-161,415	464,924	10.00
11.00	01100	0	0	11.00
13.00	01300	0	108,130	13.00
16.00	01600	-11,797	405,020	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	0	857,908	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	-96,227	196,287	50.00
53.00	05300	0	250,312	53.00
54.00	05400	0	1,077,004	54.00
60.00	06000	0	1,099,413	60.00
62.00	06200	0	57,041	62.00
65.00	06500	0	62,729	65.00
66.00	06600	0	330,725	66.00
67.00	06700	0	189,681	67.00
68.00	06800	0	88,572	68.00
69.00	06900	-29,460	214,075	69.00
71.00	07100	0	43,541	71.00
72.00	07200	0	0	72.00
73.00	07300	0	689,511	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	-18,983	1,663,635	88.00
90.00	09000	-479,638	920,300	90.00
90.01	09001	-387,455	266,614	90.01
90.02	09002	0	224,105	90.02
91.00	09100	-281,721	2,087,899	91.00
92.00	09200	0	0	92.00
SPECIAL PURPOSE COST CENTERS				
118.00		-3,785,677	18,559,970	118.00
NONREIMBURSABLE COST CENTERS				
192.00	19200	0	0	192.00
194.00	07950	0	358,556	194.00
194.01	07951	0	0	194.01
194.02	07952	0	61,297	194.02
194.03	07953	0	0	194.03
194.04	07954	0	0	194.04
200.00		-3,785,677	18,979,823	200.00

		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	22,934	1.00	
2.00	CULBERTSON GARDENS	194.00	0	3,786	2.00	
	TOTALS		0	26,720		
C - RHC PHYSICIAN EXPENSE						
1.00	RURAL HEALTH CLINIC	88.00	25,000	0	1.00	
	TOTALS		25,000	0		
D - RHC EXPENSES						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	45,508	0	1.00	
2.00	LABORATORY	60.00	35,099	0	2.00	
3.00	PLANT & HOUSEKEEPING-RHC	7.01	55,200	9,435	3.00	
	TOTALS		135,807	9,435		
E - THERAPY RECLASS						
1.00	OCCUPATIONAL THERAPY	67.00	45,694	21,831	1.00	
2.00	SPEECH PATHOLOGY	68.00	22,564	10,780	2.00	
	TOTALS		68,258	32,611		
F - PHYSICIAN BENEFITS						
1.00	RUSHVILLE FAMILY CLINIC	90.01	0	48,292	1.00	
	TOTALS		0	48,292		
500.00	Grand Total: Increases		229,065	117,058	500.00	

		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	26,720	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	26,720			
C - RHC PHYSICIAN EXPENSE							
1.00	RUSHVILLE FAMILY CLINIC	90.01	25,000	0	0		1.00
	TOTALS		25,000	0			
D - RHC EXPENSES							
1.00	RURAL HEALTH CLINIC	88.00	135,807	9,435	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		135,807	9,435			
E - THERAPY RECLASS							
1.00	PHYSICAL THERAPY	66.00	68,258	32,611	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		68,258	32,611			
F - PHYSICIAN BENEFITS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	48,292	0		1.00
	TOTALS		0	48,292			
500.00	Grand Total: Decreases		229,065	117,058			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141333

Period:
From 03/01/2015
To 02/29/2016

Worksheet A-7
Part I
Date/Time Prepared:
7/27/2016 9:29 am

	Beginning Balances	Acquisitions			Disposals and Retirements		
		Purchases	Donation	Total			
	1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	411,152	15,000	0	15,000	0	1.00
2.00	Land Improvements	993,433	8,255	0	8,255	5,168	2.00
3.00	Buildings and Fixtures	10,685,920	99,176	0	99,176	340,592	3.00
4.00	Building Improvements	59,000	1,338,198	0	1,338,198	467,609	4.00
5.00	Fixed Equipment	184,640	211,253	0	211,253	0	5.00
6.00	Movable Equipment	6,550,209	354,896	0	354,896	1,036,231	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	18,884,354	2,026,778	0	2,026,778	1,849,600	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	18,884,354	2,026,778	0	2,026,778	1,849,600	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	996,520	0				2.00
3.00	Buildings and Fixtures	10,444,504	0				3.00
4.00	Building Improvements	929,589	0				4.00
5.00	Fixed Equipment	395,893	0				5.00
6.00	Movable Equipment	5,868,874	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	19,061,532	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	19,061,532	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141333

Period:
From 03/01/2015
To 02/29/2016

Worksheet A-7
Part II
Date/Time Prepared:
7/27/2016 9:29 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	370,951	13,296	0	0	0	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	100,272	9,600	0	0	0	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	20,271	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	341,616	143,974	0	0	0	2.00
3.00	Total (sum of lines 1-2)	833,110	166,870	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	384,247				1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	0	109,872				1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	20,271				1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	485,590				2.00
3.00	Total (sum of lines 1-2)	0	999,980				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141333

Period:
From 03/01/2015
To 02/29/2016

Worksheet A-7
Part III
Date/Time Prepared:
7/27/2016 9:29 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	7,877,211	0	7,877,211	0.503043	11,536	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	1,515,647	0	1,515,647	0.096790	2,220	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	663,437	0	663,437	0.042367	972	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	5,602,837	0	5,602,837	0.357800	8,206	2.00
3.00	Total (sum of lines 1-2)	15,659,132	0	15,659,132	1.000000	22,934	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	11,536	370,951	13,296	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	0	0	2,220	66,610	9,600	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	0	972	20,271	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	8,206	306,790	143,974	2.00
3.00	Total (sum of lines 1-2)	0	0	22,934	764,622	166,870	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	11,536	0	0	395,783	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	0	2,220	0	0	78,430	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	972	0	0	21,243	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	8,206	0	0	458,970	2.00
3.00	Total (sum of lines 1-2)	0	22,934	0	0	954,426	3.00

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.	
			3.00	4.00	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01 Investment income - NEW CAP REL COSTS-RHCS BLDG/MME (chapter 2)			0NEW 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)			0NEW CAP REL COSTS-MED ARTS BLDG/MME	1.02	0	1.02
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)	B	-17,668	HOSPITAL ONLY ADMIN & GENERAL	5.04	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-2,084	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	-840	OTHER ADMIN. & GENERAL	5.05	0	7.00
8.00 Television and radio service (chapter 21)	A	-531	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	-1,251,269			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	-160,963	DIETARY	10.00	0	14.00
15.00 Rental of quarters to employees 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	-11,797	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines	B	-452	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		0RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL 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			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01 Depreciation - NEW CAP REL COSTS-RHCS BLDG/MME			0NEW CAP REL COSTS-RHCS BLDG/MME	1.01	0	26.01
26.02 Depreciation - NEW CAP REL COSTS-MED ARTS BLDG/MME			0NEW CAP REL COSTS-MED ARTS BLDG/MME	1.02	0	26.02
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141333

Period:
From 03/01/2015
To 02/29/2016

Worksheet A-8

Date/Time Prepared:
7/27/2016 9:29 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.	
			Cost Center		Line #		
			1.00	2.00	3.00		
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***			19.00	28.00
29.00 Physicians' assistant			0			0.00	0 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0OCCUPATIONAL THERAPY			67.00	30.00
30.99 Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS			30.00	30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH 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	-17,090	OTHER ADMIN. & GENERAL			5.05	0 33.00
33.01		0				0.00	0 33.01
33.02 MISCELLANEOUS INCOME	B	-4,180	OTHER ADMIN. & GENERAL			5.05	0 33.02
33.03 MARKETING SALARY EXPENSE	A	-17,357	HOSPITAL ONLY ADMIN & GENERAL			5.04	0 33.03
33.04 MARKETING BENEFITS EXPENSE	A	-6,456	EMPLOYEE BENEFITS DEPARTMENT			4.00	0 33.04
33.05 MARKETING OTHER EXPENSE	A	-65,802	HOSPITAL ONLY ADMIN & GENERAL			5.04	0 33.05
33.06 MARKETING OTHER EXPENSE	A	-9,998	OTHER ADMIN. & GENERAL			5.05	0 33.06
33.07 MARKETING OTHER EXPENSE	A	-18,909	RURAL HEALTH CLINIC			88.00	0 33.07
33.08 MARKETING OTHER EXPENSE	A	-2,123	CAP REL COSTS-MVBLE EQUIP			2.00	9 33.08
33.09 LOBBYING PORTION OF DUES	A	-7,453	OTHER ADMIN. & GENERAL			5.05	0 33.09
33.10 HEALTHLINK ADMINISTRATIVE FEES	A	31,620	HOSPITAL ONLY ADMIN & GENERAL			5.04	0 33.10
33.11 PART B PHYSICIAN BILLING SALARIES	A	-11,698	HOSPITAL BUSINESS OFFICE			5.02	0 33.11
33.12 PART B PHYSICIAN BILLING EMP BENEFIT	A	-4,351	EMPLOYEE BENEFITS DEPARTMENT			4.00	0 33.12
33.13 MARKETING OTHER EXPENSE	A	-3,551	RUSHVILLE FAMILY CLINIC			90.01	0 33.13
33.14 PATIENT COLLECTION FEES	B	-47,919	OTHER ADMIN. & GENERAL			5.05	0 33.14
33.15 SPECIAL ASSESSMENTS ASBESTOS COSTS A	A	4,594	MAINTENANCE & REPAIRS			6.00	0 33.15
33.16 PROPERTY TAXES	A	-467	OTHER ADMIN. & GENERAL			5.05	0 33.16
33.17 IMRF CONTRIBUTION	A	-2,072,813	EMPLOYEE BENEFITS DEPARTMENT			4.00	0 33.17
33.18 OTHER ADJUSTMENTS (SPECIFY (3)		0				0.00	0 33.18
33.19 OPC RENT - CLINIC	B	-19,755	CLINIC			90.00	0 33.19
33.20 OPC RENT - RHC	B	-33,662	NEW CAP REL COSTS-RHCS BLDG/MME			1.01	9 33.20
33.21 OTHER ADJUSTMENTS (SPECIFY (3)		0				0.00	0 33.21
33.22 OTHER ADJUSTMENTS (SPECIFY (3)		0				0.00	0 33.22
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,785,677					50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141333

Period:
From 03/01/2015
To 02/29/2016

Worksheet A-8-2

Date/Time Prepared:
7/27/2016 9:29 am

Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00 OPERATING ROOM	96,227	96,227	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	29,460	29,460	0	0	0	5.00
6.00	90.00 CLINIC	200,000	200,000	0	0	0	6.00
7.00	90.00 CLINIC	224,000	224,000	0	0	0	7.00
8.00	90.00 CLINIC	35,883	35,883	0	0	0	8.00
9.00	91.00 EMERGENCY	1,800,157	281,721	1,518,436	0	0	9.00
10.00	88.00 RURAL HEALTH CLINIC	74	74	0	0	0	10.00
11.00	90.01 RUSHVILLE FAMILY CLINIC	383,904	383,904	0	0	0	11.00
200.00		2,803,305	1,251,269	1,552,036		0	200.00
Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	50.00 OPERATING ROOM	0	0	0	0	0	1.00
2.00	54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00 LABORATORY	0	0	0	0	0	3.00
4.00	65.00 RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	69.00 ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	90.00 CLINIC	0	0	0	0	0	6.00
7.00	90.00 CLINIC	0	0	0	0	0	7.00
8.00	90.00 CLINIC	0	0	0	0	0	8.00
9.00	91.00 EMERGENCY	0	0	0	0	0	9.00
10.00	88.00 RURAL HEALTH CLINIC	0	0	0	0	0	10.00
11.00	90.01 RUSHVILLE FAMILY CLINIC	0	0	0	0	0	11.00
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	96,227		1.00
2.00	54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0		2.00
3.00	60.00 LABORATORY	0	0	0	0		3.00
4.00	65.00 RESPIRATORY THERAPY	0	0	0	0		4.00
5.00	69.00 ELECTROCARDIOLOGY	0	0	0	29,460		5.00
6.00	90.00 CLINIC	0	0	0	200,000		6.00
7.00	90.00 CLINIC	0	0	0	224,000		7.00
8.00	90.00 CLINIC	0	0	0	35,883		8.00
9.00	91.00 EMERGENCY	0	0	0	281,721		9.00
10.00	88.00 RURAL HEALTH CLINIC	0	0	0	74		10.00
11.00	90.01 RUSHVILLE FAMILY CLINIC	0	0	0	383,904		11.00
200.00		0	0	0	1,251,269		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141333		Period: From 03/01/2015 To 02/29/2016		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/27/2016 9:29 am	
				Physical Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					40	1.00
2.00	Line 1 multiplied by 15 hours per week					600	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	782.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.99	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.50	38.50	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					60,245	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					60,245	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)					60,245	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)					60,245	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141333				Period: From 03/01/2015 To 02/29/2016		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/27/2016 9:29 am		
						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	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	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	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	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	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE										
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.99	0.00	0.00	0.00	0.00	0.00	0.00	0.00	52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	0	0	0	53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	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	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	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)							60,245		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)							60,245		63.00
64.00	Total cost of outside supplier services (from your records)							47,733		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)							0		65.00
LINE 33 CALCULATION										
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others							0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27							0		100.02
LINE 34 CALCULATION										
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							0		101.01
101.02	Line 34 = sum of lines 27 and 31							0		101.02
LINE 35 CALCULATION										
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others							0		102.01
102.02	Line 35 = sum of lines 31 and 32							0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141333

Period:
From 03/01/2015
To 02/29/2016

Worksheet B
Part I
Date/Time Prepared:
7/27/2016 9:29 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
		BLDG & FIXT	NEW RHCS BLDG/MME	NEW MED ARTS BLDG/MME	MVBLE EQUIP	
		1.00	1.01	1.02	2.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT	395,783	395,783				1.00
1.01 00101 NEW CAP REL COSTS-RHCS BLDG/MME	78,430	0	78,430			1.01
1.02 00102 NEW CAP REL COSTS-MED ARTS BLDG/MME	21,243	0	0	21,243		1.02
2.00 00200 CAP REL COSTS-MVBLE EQUIP	458,970				458,970	2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	2,896,203	0	0	0	0	4.00
5.02 00592 HOSPITAL BUSINESS OFFICE	253,251	0	0	0	0	5.02
5.04 00591 HOSPITAL ONLY ADMIN & GENERAL	462,844	23,641	0	0	27,416	5.04
5.05 00590 OTHER ADMIN. & GENERAL	1,793,083	34,410	0	0	39,904	5.05
6.00 00600 MAINTENANCE & REPAIRS	290,245	38,496	0	0	44,642	6.00
7.00 00700 OPERATION OF PLANT	224,555	0	0	0	0	7.00
7.01 00701 PLANT & HOUSEKEEPING-RHC	85,933	0	0	0	0	7.01
9.00 00900 HOUSEKEEPING	302,004	15,633	0	0	18,129	9.00
10.00 01000 DIETARY	464,924	19,584	0	0	22,711	10.00
11.00 01100 CAFETERIA	0	6,691	0	0	7,759	11.00
13.00 01300 NURSING ADMINISTRATION	108,130	850	0	0	985	13.00
16.00 01600 MEDICAL RECORDS & LIBRARY	405,020	17,156	0	0	19,895	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	857,908	42,376	0	0	49,141	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	196,287	29,943	0	0	34,723	50.00
53.00 05300 ANESTHESIOLOGY	250,312	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,077,004	22,331	0	0	25,897	54.00
60.00 06000 LABORATORY	1,099,413	8,454	0	0	9,804	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	57,041	708	0	0	821	62.00
65.00 06500 RESPIRATORY THERAPY	62,729	5,353	0	0	6,207	65.00
66.00 06600 PHYSICAL THERAPY	330,725	12,872	0	0	14,927	66.00
67.00 06700 OCCUPATIONAL THERAPY	189,681	6,528	0	0	7,570	67.00
68.00 06800 SPEECH PATHOLOGY	88,572	3,307	0	0	3,834	68.00
69.00 06900 ELECTROCARDIOLOGY	214,075	765	0	0	887	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	43,541	10,982	0	0	12,735	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	689,511	4,893	0	0	5,674	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	1,663,635	0	78,430	0	0	88.00
90.00 09000 CLINIC	920,300	55,147	0	0	63,952	90.00
90.01 09001 RUSHVILLE FAMILY CLINIC	266,614	0	0	21,243	0	90.01
90.02 09002 GEROPSYCH	224,105	19,336	0	0	22,423	90.02
91.00 09100 EMERGENCY	2,087,899	16,327	0	0	18,934	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	18,559,970	395,783	78,430	21,243	458,970	118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 07950 CULBERTSON GARDENS	358,556	0	0	0	0	194.00
194.01 07951 MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02 07952 FOUNDATION	61,297	0	0	0	0	194.02
194.03 07953 OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04 07954 VACANT SPACE	0	0	0	0	0	194.04
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	18,979,823	395,783	78,430	21,243	458,970	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141333

Period:
From 03/01/2015
To 02/29/2016

Worksheet B
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Date/Time Prepared:
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Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	HOSPITAL BUSINESS OFFICE	Subtotal	HOSPITAL ONLY ADMIN & GENERAL	Subtotal	
			4.00	5.02	5A.02	5.04	5A.04	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,896,203					4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	71,181	324,432				5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	123,040	0	636,941	636,941		5.04
5.05	00590	OTHER ADMIN. & GENERAL	236,847	0	2,104,244	75,140	2,179,384	5.05
6.00	00600	MAINTENANCE & REPAIRS	73,204	0	446,587	15,947	462,534	6.00
7.00	00700	OPERATION OF PLANT	23,230	0	247,785	8,848	256,633	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	21,123	0	107,056	3,823	110,879	7.01
9.00	00900	HOUSEKEEPING	102,887	0	438,653	15,664	454,317	9.00
10.00	01000	DIETARY	115,473	0	622,692	22,236	644,928	10.00
11.00	01100	CAFETERIA	0	0	14,450	516	14,966	11.00
13.00	01300	NURSING ADMINISTRATION	38,082	0	148,047	5,287	153,334	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	134,154	0	576,225	20,576	596,801	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	297,484	16,361	1,263,270	45,110	1,308,380	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	50,820	8,646	320,419	11,442	331,861	50.00
53.00	05300	ANESTHESIOLOGY	89,874	3,535	343,721	12,274	355,995	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	184,555	86,315	1,396,102	49,853	1,445,955	54.00
60.00	06000	LABORATORY	186,545	68,240	1,372,456	49,009	1,421,465	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,587	60,157	2,148	62,305	62.00
65.00	06500	RESPIRATORY THERAPY	7,635	1,916	83,840	2,994	86,834	65.00
66.00	06600	PHYSICAL THERAPY	98,891	13,193	470,608	16,805	487,413	66.00
67.00	06700	OCCUPATIONAL THERAPY	64,230	4,864	272,873	9,744	282,617	67.00
68.00	06800	SPEECH PATHOLOGY	29,768	2,402	127,883	4,567	132,450	68.00
69.00	06900	ELECTROCARDIOLOGY	38,694	16,682	271,103	9,681	280,784	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,919	70,177	2,506	72,683	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	28,460	728,538	26,015	754,553	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	472,414	17,058	2,231,537	79,686	2,311,223	88.00
90.00	09000	CLINIC	53,162	25,418	1,117,979	39,922	1,157,901	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	61,057	4,345	353,259	12,615	365,874	90.01
90.02	09002	GEROPSYCH	42,526	268	308,658	11,022	319,680	90.02
91.00	09100	EMERGENCY	193,269	22,223	2,338,652	83,511	2,422,163	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,810,145	324,432	18,473,912	636,941	18,473,912	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	79,497	0	438,053	0	438,053	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	6,561	0	67,858	0	67,858	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments			0		0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,896,203	324,432	18,979,823	636,941	18,979,823	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141333

Period:
From 03/01/2015
To 02/29/2016

Worksheet B
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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	2,179,384				5.05
6.00	00600	MAINTENANCE & REPAIRS	60,001	522,535			6.00
7.00	00700	OPERATION OF PLANT	33,291	0	289,924		7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	14,383	0	0	125,262	7.01
9.00	00900	HOUSEKEEPING	58,935	27,299	15,147	0	555,698
10.00	01000	DIETARY	83,661	34,199	18,975	0	38,374
11.00	01100	CAFETERIA	1,941	11,684	6,483	0	13,110
13.00	01300	NURSING ADMINISTRATION	19,891	1,484	823	0	1,665
16.00	01600	MEDICAL RECORDS & LIBRARY	77,418	29,958	16,622	0	33,615
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	169,726	73,998	41,057	0	83,032
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	43,050	52,287	29,011	0	58,670
53.00	05300	ANESTHESIOLOGY	46,180	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	187,572	38,996	21,636	0	43,757
60.00	06000	LABORATORY	184,395	14,762	8,191	0	16,565
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	8,082	1,236	686	0	1,387
65.00	06500	RESPIRATORY THERAPY	11,264	9,347	5,186	0	10,488
66.00	06600	PHYSICAL THERAPY	63,228	22,478	12,471	0	25,222
67.00	06700	OCCUPATIONAL THERAPY	36,662	11,400	6,325	0	12,791
68.00	06800	SPEECH PATHOLOGY	17,182	5,774	3,204	0	6,479
69.00	06900	ELECTROCARDIOLOGY	36,424	1,335	741	0	1,498
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,429	19,176	10,640	0	21,518
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	97,882	8,543	4,740	0	9,587
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	299,816	0	0	125,262	0
90.00	09000	CLINIC	150,205	96,302	53,432	0	108,060
90.01	09001	RUSHVILLE FAMILY CLINIC	47,462	0	0	0	0
90.02	09002	GEROPSYCH	41,470	33,766	18,735	0	37,888
91.00	09100	EMERGENCY	314,206	28,511	15,819	0	31,992
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,113,756	522,535	289,924	125,262	555,698
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	CULBERTSON GARDENS	56,825	0	0	0	0
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0
194.02	07952	FOUNDATION	8,803	0	0	0	0
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0
194.04	07954	VACANT SPACE	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	2,179,384	522,535	289,924	125,262	555,698

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141333

Period:
From 03/01/2015
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	
		10.00	11.00	13.00	16.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
2.00	00200						2.00
4.00	00400						4.00
5.02	00592						5.02
5.04	00591						5.04
5.05	00590						5.05
6.00	00600						6.00
7.00	00700						7.00
7.01	00701						7.01
9.00	00900						9.00
10.00	01000	820,137					10.00
11.00	01100	392,647	440,831				11.00
13.00	01300	0	6,235	183,432			13.00
16.00	01600	0	57,303	0	811,717		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	94,700	102,295	90,937	81,825	2,045,950	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	13,939	12,389	20,972	562,179	50.00
53.00	05300	0	8,895	0	0	411,070	53.00
54.00	05400	0	52,816	0	38,506	1,829,238	54.00
60.00	06000	0	59,447	0	42,975	1,747,800	60.00
62.00	06200	0	0	0	0	73,696	62.00
65.00	06500	0	2,184	1,925	1,375	128,603	65.00
66.00	06600	0	35,859	0	12,033	658,704	66.00
67.00	06700	0	9,531	0	0	359,326	67.00
68.00	06800	0	4,328	0	0	169,417	68.00
69.00	06900	0	10,325	9,176	6,532	346,815	69.00
71.00	07100	0	0	0	0	133,446	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	875,305	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	369,588	3,105,889	88.00
90.00	09000	0	18,624	16,541	76,324	1,677,389	90.00
90.01	09001	0	0	0	0	413,336	90.01
90.02	09002	0	1,032	913	0	453,484	90.02
91.00	09100	0	58,018	51,551	161,587	3,083,847	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		487,347	440,831	183,432	811,717	18,075,494	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	0	0	0	192.00
194.00	07950	310,988	0	0	0	805,866	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	76,661	194.02
194.03	07953	21,802	0	0	0	21,802	194.03
194.04	07954	0	0	0	0	0	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		820,137	440,831	183,432	811,717	18,979,823	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 141333	Period: From 03/01/2015 To 02/29/2016	Worksheet B Part I Date/Time Prepared: 7/27/2016 9:29 am
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME		1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.02	00592	HOSPITAL BUSINESS OFFICE		5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL		5.04
5.05	00590	OTHER ADMIN. & GENERAL		5.05
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC		7.01
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,045,950
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	562,179
53.00	05300	ANESTHESIOLOGY	0	411,070
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,829,238
60.00	06000	LABORATORY	0	1,747,800
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	73,696
65.00	06500	RESPIRATORY THERAPY	0	128,603
66.00	06600	PHYSICAL THERAPY	0	658,704
67.00	06700	OCCUPATIONAL THERAPY	0	359,326
68.00	06800	SPEECH PATHOLOGY	0	169,417
69.00	06900	ELECTROCARDIOLOGY	0	346,815
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	133,446
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	875,305
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	3,105,889
90.00	09000	CLINIC	0	1,677,389
90.01	09001	RUSHVILLE FAMILY CLINIC	0	413,336
90.02	09002	GEROPSYCH	0	453,484
91.00	09100	EMERGENCY	0	3,083,847
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	18,075,494
NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0
194.00	07950	CULBERTSON GARDENS	0	805,866
194.01	07951	MEDICAL ARTS BUILDING	0	0
194.02	07952	FOUNDATION	0	76,661
194.03	07953	OUTPATIENT MEALS	0	21,802
194.04	07954	VACANT SPACE	0	0
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	18,979,823

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141333

Period:
From 03/01/2015
To 02/29/2016

Worksheet B
Part II
Date/Time Prepared:
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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	
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	4.00
5.02 00592	HOSPITAL BUSINESS OFFICE	0	0	0	0	5.02
5.04 00591	HOSPITAL ONLY ADMIN & GENERAL	0	23,641	0	27,416	5.04
5.05 00590	OTHER ADMIN. & GENERAL	0	34,410	0	39,904	5.05
6.00 00600	MAINTENANCE & REPAIRS	0	38,496	0	44,642	6.00
7.00 00700	OPERATION OF PLANT	0	0	0	0	7.00
7.01 00701	PLANT & HOUSEKEEPING-RHC	0	0	0	0	7.01
9.00 00900	HOUSEKEEPING	0	15,633	0	18,129	9.00
10.00 01000	DIETARY	0	19,584	0	22,711	10.00
11.00 01100	CAFETERIA	0	6,691	0	7,759	11.00
13.00 01300	NURSING ADMINISTRATION	0	850	0	985	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	17,156	0	19,895	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	42,376	0	49,141	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	29,943	0	34,723	50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	22,331	0	25,897	54.00
60.00 06000	LABORATORY	0	8,454	0	9,804	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	708	0	821	62.00
65.00 06500	RESPIRATORY THERAPY	0	5,353	0	6,207	65.00
66.00 06600	PHYSICAL THERAPY	0	12,872	0	14,927	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	6,528	0	7,570	67.00
68.00 06800	SPEECH PATHOLOGY	0	3,307	0	3,834	68.00
69.00 06900	ELECTROCARDIOLOGY	0	765	0	887	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	10,982	0	12,735	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	4,893	0	5,674	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	78,430	0	88.00
90.00 09000	CLINIC	0	55,147	0	63,952	90.00
90.01 09001	RUSHVILLE FAMILY CLINIC	0	0	0	21,243	90.01
90.02 09002	GEROPSYCH	0	19,336	0	22,423	90.02
91.00 09100	EMERGENCY	0	16,327	0	18,934	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	395,783	78,430	21,243	458,970
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		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	395,783	78,430	21,243	458,970

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141333	Period: From 03/01/2015 To 02/29/2016	Worksheet B Part II Date/Time Prepared: 7/27/2016 9:29 am			
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	51,057	0	0	51,057	5.04	
5.05 00590	OTHER ADMIN. & GENERAL	74,314	0	0	6,022	80,336	5.05
6.00 00600	MAINTENANCE & REPAIRS	83,138	0	0	1,278	2,212	6.00
7.00 00700	OPERATION OF PLANT	0	0	0	709	1,227	7.00
7.01 00701	PLANT & HOUSEKEEPING-RHC	0	0	0	306	530	7.01
9.00 00900	HOUSEKEEPING	33,762	0	0	1,255	2,173	9.00
10.00 01000	DIETARY	42,295	0	0	1,782	3,084	10.00
11.00 01100	CAFETERIA	14,450	0	0	41	72	11.00
13.00 01300	NURSING ADMINISTRATION	1,835	0	0	424	733	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	37,051	0	0	1,649	2,854	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	91,517	0	0	3,615	6,257	30.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	64,666	0	0	917	1,587	50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	984	1,702	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	48,228	0	0	3,996	6,915	54.00
60.00 06000	LABORATORY	18,258	0	0	3,928	6,797	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,529	0	0	172	298	62.00
65.00 06500	RESPIRATORY THERAPY	11,560	0	0	240	415	65.00
66.00 06600	PHYSICAL THERAPY	27,799	0	0	1,347	2,331	66.00
67.00 06700	OCCUPATIONAL THERAPY	14,098	0	0	781	1,351	67.00
68.00 06800	SPEECH PATHOLOGY	7,141	0	0	366	633	68.00
69.00 06900	ELECTROCARDIOLOGY	1,652	0	0	776	1,343	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	23,717	0	0	201	348	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	10,567	0	0	2,085	3,608	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	78,430	0	0	6,387	11,052	88.00
90.00 09000	CLINIC	119,099	0	0	3,200	5,537	90.00
90.01 09001	RUSHVILLE FAMILY CLINIC	21,243	0	0	1,011	1,750	90.01
90.02 09002	GEROPSYCH	41,759	0	0	883	1,529	90.02
91.00 09100	EMERGENCY	35,261	0	0	6,702	11,579	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	954,426	0	0	51,057	77,917	118.00
NONREIMBURSABLE COST CENTERS							
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 07950	CULBERTSON GARDENS	0	0	0	0	2,095	194.00
194.01 07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02 07952	FOUNDATION	0	0	0	0	324	194.02
194.03 07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04 07954	VACANT SPACE	0	0	0	0	0	194.04
200.00	Cross Foot Adjustments	0					200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	954,426	0	0	51,057	80,336	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141333		Period: From 03/01/2015 To 02/29/2016		Worksheet B Part II Date/Time Prepared: 7/27/2016 9:29 am	
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	86,628				6.00
7.00	00700	OPERATION OF PLANT	0	1,936			7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	836		7.01
9.00	00900	HOUSEKEEPING	4,526	101	0	41,817	9.00
10.00	01000	DIETARY	5,670	127	0	2,888	55,846
11.00	01100	CAFETERIA	1,937	43	0	987	26,737
13.00	01300	NURSING ADMINISTRATION	246	5	0	125	0
16.00	01600	MEDICAL RECORDS & LIBRARY	4,967	111	0	2,530	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,268	274	0	6,248	6,448
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,668	194	0	4,415	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,465	144	0	3,293	0
60.00	06000	LABORATORY	2,447	55	0	1,247	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	205	5	0	104	0
65.00	06500	RESPIRATORY THERAPY	1,550	35	0	789	0
66.00	06600	PHYSICAL THERAPY	3,726	83	0	1,898	0
67.00	06700	OCCUPATIONAL THERAPY	1,890	42	0	963	0
68.00	06800	SPEECH PATHOLOGY	957	21	0	488	0
69.00	06900	ELECTROCARDIOLOGY	221	5	0	113	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,179	71	0	1,619	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,416	32	0	721	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	836	0	0
90.00	09000	CLINIC	15,965	357	0	8,131	0
90.01	09001	RUSHVILLE FAMILY CLINIC	0	0	0	0	0
90.02	09002	GEROPSYCH	5,598	125	0	2,851	0
91.00	09100	EMERGENCY	4,727	106	0	2,407	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	86,628	1,936	836	41,817	33,185
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	CULBERTSON GARDENS	0	0	0	0	21,176
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0
194.02	07952	FOUNDATION	0	0	0	0	0
194.03	07953	OUTPATIENT MEALS	0	0	0	0	1,485
194.04	07954	VACANT SPACE	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	86,628	1,936	836	41,817	55,846

ALLOCATION OF CAPITAL RELATED COSTS		Provi der CCN: 141333		Period: From 03/01/2015 To 02/29/2016		Worksheet B Part II Date/Time Prepared: 7/27/2016 9:29 am			
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments			
		11.00	13.00	16.00	24.00	25.00			
GENERAL SERVICE COST CENTERS									
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00		
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME					1.01		
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME					1.02		
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00		
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00		
5.02	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	44,267					11.00		
13.00	01300		626	3,994			13.00		
16.00	01600	5,754		0	54,916		16.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	10,271	1,980	5,536	144,414		30.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	1,400	270	1,419	83,536	0	50.00		
53.00	05300	893	0	0	3,579	0	53.00		
54.00	05400	5,304	0	2,605	76,950	0	54.00		
60.00	06000	5,970	0	2,907	41,609	0	60.00		
62.00	06200	0	0	0	2,313	0	62.00		
65.00	06500	219	42	93	14,943	0	65.00		
66.00	06600	3,601	0	814	41,599	0	66.00		
67.00	06700	957	0	0	20,082	0	67.00		
68.00	06800	435	0	0	10,041	0	68.00		
69.00	06900	1,037	200	442	5,789	0	69.00		
71.00	07100	0	0	0	29,135	0	71.00		
72.00	07200	0	0	0	0	0	72.00		
73.00	07300	0	0	0	18,429	0	73.00		
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	0	0	25,004	121,709	0	88.00		
90.00	09000	1,870	360	5,164	159,683	0	90.00		
90.01	09001	0	0	0	24,004	0	90.01		
90.02	09002	104	20	0	52,869	0	90.02		
91.00	09100	5,826	1,122	10,932	78,662	0	91.00		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00		
SPECIAL PURPOSE COST CENTERS									
118.00		SUBTOTALS (SUM OF LINES 1-117)		44,267	3,994	54,916	929,346	0	118.00
NONREIMBURSABLE COST CENTERS									
192.00	19200	0	0	0	0	0	192.00		
194.00	07950	0	0	0	23,271	0	194.00		
194.01	07951	0	0	0	0	0	194.01		
194.02	07952	0	0	0	324	0	194.02		
194.03	07953	0	0	0	1,485	0	194.03		
194.04	07954	0	0	0	0	0	194.04		
200.00		Cross Foot Adjustments				0	200.00		
201.00		Negative Cost Centers				0	201.00		
202.00		44,267	3,994	54,916	954,426	0	202.00		
		TOTAL (sum lines 118-201)							

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141333	Period: From 03/01/2015 To 02/29/2016	Worksheet B Part II Date/Time Prepared: 7/27/2016 9:29 am
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME	1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	5.04
5.05	00590	OTHER ADMIN. & GENERAL	5.05
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	7.01
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
90.00	09000	CLINIC	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	90.01
90.02	09002	GEROPSYCH	90.02
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	CULBERTSON GARDENS	194.00
194.01	07951	MEDICAL ARTS BUILDING	194.01
194.02	07952	FOUNDATION	194.02
194.03	07953	OUTPATIENT MEALS	194.03
194.04	07954	VACANT SPACE	194.04
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141333

Period:
From 03/01/2015
To 02/29/2016

Worksheet B-1

Date/Time Prepared:
7/27/2016 9:29 am

Cost Center Description		CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)		
		BLDG & FIXT (SQUARE FEET)	NEW RHCS BLDG/MME (SQUARE FEET)	NEW MED ARTS BLDG/MME (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)			
		1.00	1.01	1.02	2.00			4.00
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	55,899					1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME	0	11,800				1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	0	9,400			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				55,899		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	7,568,579	4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	0	0	0	0	186,015	5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	3,339	0	0	3,339	321,538	5.04
5.05	00590	OTHER ADMIN. & GENERAL	4,860	0	0	4,860	618,948	5.05
6.00	00600	MAINTENANCE & REPAIRS	5,437	0	0	5,437	191,302	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	60,706	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	0	0	55,200	7.01
9.00	00900	HOUSEKEEPING	2,208	0	0	2,208	268,872	9.00
10.00	01000	DIETARY	2,766	0	0	2,766	301,762	10.00
11.00	01100	CAFETERIA	945	0	0	945	0	11.00
13.00	01300	NURSING ADMINISTRATION	120	0	0	120	99,518	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,423	0	0	2,423	350,583	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,985	0	0	5,985	777,408	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,229	0	0	4,229	132,806	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	234,866	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,154	0	0	3,154	482,293	54.00
60.00	06000	LABORATORY	1,194	0	0	1,194	487,495	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	19,953	65.00
66.00	06600	PHYSICAL THERAPY	1,818	0	0	1,818	258,430	66.00
67.00	06700	OCCUPATIONAL THERAPY	922	0	0	922	167,850	67.00
68.00	06800	SPEECH PATHOLOGY	467	0	0	467	77,792	68.00
69.00	06900	ELECTROCARDIOLOGY	108	0	0	108	101,117	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,551	0	0	1,551	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	691	0	0	691	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	11,800	0	0	1,234,550	88.00
90.00	09000	CLINIC	7,789	0	0	7,789	138,926	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	0	9,400	0	159,560	90.01
90.02	09002	GEROPSYCH	2,731	0	0	2,731	111,132	90.02
91.00	09100	EMERGENCY	2,306	0	0	2,306	505,065	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	55,899	11,800	9,400	55,899	7,343,687	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	207,747	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	17,145	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)	395,783	78,430	21,243	458,970	2,896,203	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.080323	6.646610	2.259894	8.210701	0.382661	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 141333	Period: From 03/01/2015 To 02/29/2016	Worksheet B-1 Date/Time Prepared: 7/27/2016 9:29 am			
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	31,540,638				5.02	
5.04 00591	HOSPITAL ONLY ADMIN & GENERAL	0	-636,941	17,836,971		5.04	
5.05 00590	OTHER ADMIN. & GENERAL	0	0	2,104,244	-2,179,384	16,800,439	5.05
6.00 00600	MAINTENANCE & REPAIRS	0	0	446,587	0	462,534	6.00
7.00 00700	OPERATION OF PLANT	0	0	247,785	0	256,633	7.00
7.01 00701	PLANT & HOUSEKEEPING-RHC	0	0	107,056	0	110,879	7.01
9.00 00900	HOUSEKEEPING	0	0	438,653	0	454,317	9.00
10.00 01000	DIETARY	0	0	622,692	0	644,928	10.00
11.00 01100	CAFETERIA	0	0	14,450	0	14,966	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	148,047	0	153,334	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	576,225	0	596,801	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	1,590,654	0	1,263,270	0	1,308,380	30.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	840,568	0	320,419	0	331,861	50.00
53.00 05300	ANESTHESIOLOGY	343,679	0	343,721	0	355,995	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	8,390,866	0	1,396,102	0	1,445,955	54.00
60.00 06000	LABORATORY	6,634,304	0	1,372,456	0	1,421,465	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	154,256	0	60,157	0	62,305	62.00
65.00 06500	RESPIRATORY THERAPY	186,236	0	83,840	0	86,834	65.00
66.00 06600	PHYSICAL THERAPY	1,282,573	0	470,608	0	487,413	66.00
67.00 06700	OCCUPATIONAL THERAPY	472,864	0	272,873	0	282,617	67.00
68.00 06800	SPEECH PATHOLOGY	233,525	0	127,883	0	132,450	68.00
69.00 06900	ELECTROCARDIOLOGY	1,621,864	0	271,103	0	280,784	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	283,825	0	70,177	0	72,683	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2,766,904	0	728,538	0	754,553	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	1,658,397	0	2,231,537	0	2,311,223	88.00
90.00 09000	CLINIC	2,471,148	0	1,117,979	0	1,157,901	90.00
90.01 09001	RUSHVILLE FAMILY CLINIC	422,398	0	353,259	0	365,874	90.01
90.02 09002	GEROPSYCH	26,021	0	308,658	0	319,680	90.02
91.00 09100	EMERGENCY	2,160,556	0	2,338,652	0	2,422,163	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	31,540,638	-636,941	17,836,971	-2,179,384	16,294,528	118.00
NONREIMBURSABLE COST CENTERS							
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 07950	CULBERTSON GARDENS	0	-438,053	0	0	438,053	194.00
194.01 07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02 07952	FOUNDATION	0	-67,858	0	0	67,858	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)	324,432		636,941		2,179,384	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.010286		0.035709		0.129722	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0		51,057		80,336	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000		0.002862		0.004782	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141333

Period:
From 03/01/2015
To 02/29/2016

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	PLANT & HOUSEKEEPING-RHC (SQUARE FEET)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)		
		6.00	7.00	7.01	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME					1.01	
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME					1.02	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.02	00592	HOSPITAL BUSINESS OFFICE					5.02	
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL					5.04	
5.05	00590	OTHER ADMIN. & GENERAL					5.05	
6.00	00600	MAINTENANCE & REPAIRS	42,263				6.00	
7.00	00700	OPERATION OF PLANT	0	42,263			7.00	
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	11,800		7.01	
9.00	00900	HOUSEKEEPING	2,208	2,208	0	40,055	9.00	
10.00	01000	DIETARY	2,766	2,766	0	2,766	40,626	10.00
11.00	01100	CAFETERIA	945	945	0	945	19,450	11.00
13.00	01300	NURSING ADMINISTRATION	120	120	0	120	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,423	2,423	0	2,423	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,985	5,985	0	5,985	4,691	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	11,800	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 1-117)	42,263	42,263	11,800	40,055	24,141	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	15,405	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	1,080	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)	522,535	289,924	125,262	555,698	820,137	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.363888	6.859996	10.615424	13.873374	20.187491	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	86,628	1,936	836	41,817	55,846	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.049736	0.045808	0.070847	1.043990	1.374637	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141333

Period:
From 03/01/2015
To 02/29/2016

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Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRS ING)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	16.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
1.01	00101				1.01
1.02	00102				1.02
2.00	00200				2.00
4.00	00400				4.00
5.02	00592				5.02
5.04	00591				5.04
5.05	00590				5.05
6.00	00600				6.00
7.00	00700				7.00
7.01	00701				7.01
9.00	00900				9.00
10.00	01000				10.00
11.00	01100	11,101			11.00
13.00	01300	157	63,088		13.00
16.00	01600	1,443	0	2,361	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	2,576	31,276	238	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	351	4,261	61	50.00
53.00	05300	224	0	0	53.00
54.00	05400	1,330	0	112	54.00
60.00	06000	1,497	0	125	60.00
62.00	06200	0	0	0	62.00
65.00	06500	55	662	4	65.00
66.00	06600	903	0	35	66.00
67.00	06700	240	0	0	67.00
68.00	06800	109	0	0	68.00
69.00	06900	260	3,156	19	69.00
71.00	07100	0	0	0	71.00
72.00	07200	0	0	0	72.00
73.00	07300	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	0	0	1,075	88.00
90.00	09000	469	5,689	222	90.00
90.01	09001	0	0	0	90.01
90.02	09002	26	314	0	90.02
91.00	09100	1,461	17,730	470	91.00
92.00	09200				92.00
SPECIAL PURPOSE COST CENTERS					
118.00		11,101	63,088	2,361	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	0	0	0	192.00
194.00	07950	0	0	0	194.00
194.01	07951	0	0	0	194.01
194.02	07952	0	0	0	194.02
194.03	07953	0	0	0	194.03
194.04	07954	0	0	0	194.04
200.00					200.00
201.00					201.00
202.00		440,831	183,432	811,717	202.00
203.00		39.710927	2.907558	343.802202	203.00
204.00		44,267	3,994	54,916	204.00
205.00		3.987659	0.063308	23.259636	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141333

Period:
From 03/01/2015
To 02/29/2016

Worksheet C
Part I
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		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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	2,045,950		2,045,950	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	562,179		562,179	0	0	50.00
53.00	05300 ANESTHESIOLOGY	411,070		411,070	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,829,238		1,829,238	0	0	54.00
60.00	06000 LABORATORY	1,747,800		1,747,800	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	73,696		73,696	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	128,603	0	128,603	0	0	65.00
66.00	06600 PHYSICAL THERAPY	658,704	0	658,704	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	359,326	0	359,326	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	169,417	0	169,417	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	346,815		346,815	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	133,446		133,446	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	875,305		875,305	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	3,105,889		3,105,889	0	0	88.00
90.00	09000 CLINIC	1,677,389		1,677,389	0	0	90.00
90.01	09001 RUSHVILLE FAMILY CLINIC	413,336		413,336	0	0	90.01
90.02	09002 GEROPSYCH	453,484		453,484	0	0	90.02
91.00	09100 EMERGENCY	3,083,847		3,083,847	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	294,492		294,492		0	92.00
200.00	Subtotal (see instructions)	18,369,986	0	18,369,986	0	0	200.00
201.00	Less Observation Beds	294,492		294,492		0	201.00
202.00	Total (see instructions)	18,075,494	0	18,075,494	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141333

Period:
From 03/01/2015
To 02/29/2016

Worksheet C
Part I
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		Title XVIII			Hospital	Cost		
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,364,683		1,364,683			30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	840,568	840,568	0.668808	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	343,679	343,679	1.196087	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	100,427	8,290,439	8,390,866	0.218003	0.000000	54.00
60.00	06000	LABORATORY	240,244	6,394,060	6,634,304	0.263449	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	18,507	135,749	154,256	0.477751	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	149	186,087	186,236	0.690538	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	107,130	1,175,443	1,282,573	0.513580	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	125,010	347,854	472,864	0.759893	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	20,757	212,768	233,525	0.725477	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	58,049	1,563,815	1,621,864	0.213837	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	204,487	79,338	283,825	0.470170	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	556,770	2,210,134	2,766,904	0.316348	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,658,397	1,658,397			88.00
90.00	09000	CLINIC	2,434	2,468,714	2,471,148	0.678789	0.000000	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	422,398	422,398	0.978546	0.000000	90.01
90.02	09002	GEROPSYCH	0	26,021	26,021	17.427616	0.000000	90.02
91.00	09100	EMERGENCY	6,899	2,153,657	2,160,556	1.427340	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	864	225,107	225,971	1.303229	0.000000	92.00
200.00		Subtotal (see instructions)	2,806,410	28,734,228	31,540,638			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,806,410	28,734,228	31,540,638			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141333

Period:
From 03/01/2015
To 02/29/2016

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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141333

Period:
From 03/01/2015
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		Title XIX		Hospital		Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	2,045,950		2,045,950	0	2,045,950	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	562,179		562,179	0	562,179	50.00
53.00	05300 ANESTHESIOLOGY	411,070		411,070	0	411,070	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,829,238		1,829,238	0	1,829,238	54.00
60.00	06000 LABORATORY	1,747,800		1,747,800	0	1,747,800	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	73,696		73,696	0	73,696	62.00
65.00	06500 RESPIRATORY THERAPY	128,603	0	128,603	0	128,603	65.00
66.00	06600 PHYSICAL THERAPY	658,704	0	658,704	0	658,704	66.00
67.00	06700 OCCUPATIONAL THERAPY	359,326	0	359,326	0	359,326	67.00
68.00	06800 SPEECH PATHOLOGY	169,417	0	169,417	0	169,417	68.00
69.00	06900 ELECTROCARDIOLOGY	346,815		346,815	0	346,815	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	133,446		133,446	0	133,446	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	875,305		875,305	0	875,305	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	3,105,889		3,105,889	0	3,105,889	88.00
90.00	09000 CLINIC	1,677,389		1,677,389	0	1,677,389	90.00
90.01	09001 RUSHVILLE FAMILY CLINIC	413,336		413,336	0	413,336	90.01
90.02	09002 GEROPSYCH	453,484		453,484	0	453,484	90.02
91.00	09100 EMERGENCY	3,083,847		3,083,847	0	3,083,847	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	294,492		294,492		294,492	92.00
200.00	Subtotal (see instructions)	18,369,986	0	18,369,986	0	18,369,986	200.00
201.00	Less Observation Beds	294,492		294,492		294,492	201.00
202.00	Total (see instructions)	18,075,494	0	18,075,494	0	18,075,494	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141333

Period:
From 03/01/2015
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		Title XIX			Hospital	Cost		
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,364,683		1,364,683			30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	840,568	840,568	0.668808	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	343,679	343,679	1.196087	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	100,427	8,290,439	8,390,866	0.218003	0.000000	54.00
60.00	06000	LABORATORY	240,244	6,394,060	6,634,304	0.263449	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	18,507	135,749	154,256	0.477751	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	149	186,087	186,236	0.690538	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	107,130	1,175,443	1,282,573	0.513580	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	125,010	347,854	472,864	0.759893	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	20,757	212,768	233,525	0.725477	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	58,049	1,563,815	1,621,864	0.213837	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	204,487	79,338	283,825	0.470170	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	556,770	2,210,134	2,766,904	0.316348	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,658,397	1,658,397	1.872826	0.000000	88.00
90.00	09000	CLINIC	2,434	2,468,714	2,471,148	0.678789	0.000000	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	422,398	422,398	0.978546	0.000000	90.01
90.02	09002	GEROPSYCH	0	26,021	26,021	17.427616	0.000000	90.02
91.00	09100	EMERGENCY	6,899	2,153,657	2,160,556	1.427340	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	864	225,107	225,971	1.303229	0.000000	92.00
200.00		Subtotal (see instructions)	2,806,410	28,734,228	31,540,638			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,806,410	28,734,228	31,540,638			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141333

Period:
From 03/01/2015
To 02/29/2016

Worksheet C
Part I
Date/Time Prepared:
7/27/2016 9:29 am

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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 141333	Period: From 03/01/2015 To 02/29/2016	Worksheet D Part II Date/Time Prepared: 7/27/2016 9:29 am
		Title XVIII	Hospital	Cost

Cost Center Description		Capital Related Cost (from Wkst. C, 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	83,536	840,568	0.099380	0	0	50.00
53.00	05300 ANESTHESIOLOGY	3,579	343,679	0.010414	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	76,950	8,390,866	0.009171	76,643	703	54.00
60.00	06000 LABORATORY	41,609	6,634,304	0.006272	151,809	952	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	2,313	154,256	0.014995	9,228	138	62.00
65.00	06500 RESPIRATORY THERAPY	14,943	186,236	0.080237	149	12	65.00
66.00	06600 PHYSICAL THERAPY	41,599	1,282,573	0.032434	9,790	318	66.00
67.00	06700 OCCUPATIONAL THERAPY	20,082	472,864	0.042469	10,160	431	67.00
68.00	06800 SPEECH PATHOLOGY	10,041	233,525	0.042998	3,339	144	68.00
69.00	06900 ELECTROCARDIOLOGY	5,789	1,621,864	0.003569	46,205	165	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	29,135	283,825	0.102651	109,149	11,204	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	18,429	2,766,904	0.006661	232,963	1,552	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	121,709	1,658,397	0.073390	0	0	88.00
90.00	09000 CLINIC	159,683	2,471,148	0.064619	36	2	90.00
90.01	09001 RUSHVILLE FAMILY CLINIC	24,004	422,398	0.056828	0	0	90.01
90.02	09002 GEROPSYCH	52,869	26,021	2.031782	0	0	90.02
91.00	09100 EMERGENCY	78,662	2,160,556	0.036408	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	20,787	225,971	0.091990	0	0	92.00
200.00	Total (lines 50-199)	805,719	30,175,955		649,471	15,621	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141333

Period:
From 03/01/2015
To 02/29/2016

Worksheet D
Part IV
Date/Time Prepared:
7/27/2016 9:29 am

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141333

Period:
From 03/01/2015
To 02/29/2016

Worksheet D
Part IV
Date/Time Prepared:
7/27/2016 9:29 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital			
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	840,568	0.000000	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	0	343,679	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,390,866	0.000000	0.000000	76,643	54.00
60.00	06000	LABORATORY	0	6,634,304	0.000000	0.000000	151,809	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	154,256	0.000000	0.000000	9,228	62.00
65.00	06500	RESPIRATORY THERAPY	0	186,236	0.000000	0.000000	149	65.00
66.00	06600	PHYSICAL THERAPY	0	1,282,573	0.000000	0.000000	9,790	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	472,864	0.000000	0.000000	10,160	67.00
68.00	06800	SPEECH PATHOLOGY	0	233,525	0.000000	0.000000	3,339	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,621,864	0.000000	0.000000	46,205	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	283,825	0.000000	0.000000	109,149	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,766,904	0.000000	0.000000	232,963	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,658,397	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	2,471,148	0.000000	0.000000	36	90.00
90.01	09001	RUSHVILLE FAMILY CLINIC	0	422,398	0.000000	0.000000	0	90.01
90.02	09002	GEROPSYCH	0	26,021	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	2,160,556	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	225,971	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	30,175,955			649,471	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141333	Period: From 03/01/2015 To 02/29/2016	Worksheet D Part IV Date/Time Prepared: 7/27/2016 9:29 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	Cost
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000 LABORATORY	0	0	0		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0		62.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000 CLINIC	0	0	0		90.00
90.01	09001 RUSHVILLE FAMILY CLINIC	0	0	0		90.01
90.02	09002 GEROPSYCH	0	0	0		90.02
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141333	Period: From 03/01/2015 To 02/29/2016	Worksheet D Part V Date/Time Prepared: 7/27/2016 9:29 am
		Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.668808	0	271,167	0	0	50.00
53.00	05300 ANESTHESIOLOGY	1.196087	0	108,454	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.218003	0	3,024,179	75	0	54.00
60.00	06000 LABORATORY	0.263449	0	2,653,113	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.477751	0	105,490	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.690538	0	55,482	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.513580	0	418,058	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.759893	0	34,178	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.725477	0	9,490	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.213837	0	749,665	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.470170	0	49,713	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	0.316348	0	1,434,072	25,988	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000					88.00
90.00	09000 CLINIC	0.678789	0	1,386,873	26,166	0	90.00
90.01	09001 RUSHVILLE FAMILY CLINIC	0.978546	0	146,950	5,201	0	90.01
90.02	09002 GEROPSYCH	17.427616	0	26,021	0	0	90.02
91.00	09100 EMERGENCY	1.427340	0	692,669	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.303229	0	136,919	0	0	92.00
200.00	Subtotal (see instructions)		0	11,302,493	57,430	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	11,302,493	57,430		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141333	Period: From 03/01/2015 To 02/29/2016	Worksheet D Part V Date/Time Prepared: 7/27/2016 9:29 am
		Title XVIII	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	181,359	0	50.00
53.00	05300 ANESTHESIOLOGY	129,720	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	659,280	16	54.00
60.00	06000 LABORATORY	698,960	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	50,398	0	62.00
65.00	06500 RESPIRATORY THERAPY	38,312	0	65.00
66.00	06600 PHYSICAL THERAPY	214,706	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	25,972	0	67.00
68.00	06800 SPEECH PATHOLOGY	6,885	0	68.00
69.00	06900 ELECTROCARDIOLOGY	160,306	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	23,374	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	453,666	8,221	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
90.00	09000 CLINIC	941,394	17,761	90.00
90.01	09001 RUSHVILLE FAMILY CLINIC	143,797	5,089	90.01
90.02	09002 GEROPSYCH	453,484	0	90.02
91.00	09100 EMERGENCY	988,674	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	178,437	0	92.00
200.00	Subtotal (see instructions)	5,348,724	31,087	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	5,348,724	31,087	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141333 Component CCN: 14Z333	Period: From 03/01/2015 To 02/29/2016	Worksheet D Part V Date/Time Prepared: 7/27/2016 9:29 am
	Title XVIII	Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.668808	0	0	0	0	50.00
53.00 05300 ANESTHESIOLOGY	1.196087	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.218003	0	0	0	0	54.00
60.00 06000 LABORATORY	0.263449	0	0	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.477751	0	0	0	0	62.00
65.00 06500 RESPIRATORY THERAPY	0.690538	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.513580	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.759893	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.725477	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.213837	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.470170	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	0.316348	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0.000000					88.00
90.00 09000 CLINIC	0.678789	0	0	0	0	90.00
90.01 09001 RUSHVILLE FAMILY CLINIC	0.978546	0	0	0	0	90.01
90.02 09002 GEROPSYCH	17.427616	0	0	0	0	90.02
91.00 09100 EMERGENCY	1.427340	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1.303229	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	201.00
202.00 Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141333 Component CCN: 14Z333	Period: From 03/01/2015 To 02/29/2016	Worksheet D Part V Date/Time Prepared: 7/27/2016 9:29 am
	Title XVIII	Swing Beds - SNF	Cost

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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141333	Period: From 03/01/2015 To 02/29/2016	Worksheet D-1 Date/Time Prepared: 7/27/2016 9:29 am
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,613 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			774 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)			574 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			472 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)			121 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			244 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)			2 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			396 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)			472 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)			37 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			134.54 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			134.54 20.00
21.00	Total general inpatient routine service cost (see instructions)			2,045,950 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)			32,828 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)			269 25.00
26.00	Total swing-bed cost (see instructions)			906,266 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,139,684 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)			1,139,684 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)			1,472.46 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			583,094 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)			583,094 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141333		Period: From 03/01/2015 To 02/29/2016		Worksheet D-1 Date/Time Prepared: 7/27/2016 9:29 am	
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)					211,305	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					794,399	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)					695,001	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					54,481	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					749,482	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)					200	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,472.46	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					294,492	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141333		Period: From 03/01/2015 To 02/29/2016		Worksheet D-1 Date/Time Prepared: 7/27/2016 9:29 am	
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	144,414	2,045,950	0.070585	294,492	20,787	90.00
91.00	Nursing School cost	0	2,045,950	0.000000	294,492	0	91.00
92.00	Allied health cost	0	2,045,950	0.000000	294,492	0	92.00
93.00	All other Medical Education	0	2,045,950	0.000000	294,492	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141333	Period: From 03/01/2015 To 02/29/2016	Worksheet D-3 Date/Time Prepared: 7/27/2016 9:29 am	
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		597,028		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.668808	0	0	50.00
53.00	05300 ANESTHESIOLOGY	1.196087	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.218003	76,643	16,708	54.00
60.00	06000 LABORATORY	0.263449	151,809	39,994	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.477751	9,228	4,409	62.00
65.00	06500 RESPIRATORY THERAPY	0.690538	149	103	65.00
66.00	06600 PHYSICAL THERAPY	0.513580	9,790	5,028	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.759893	10,160	7,721	67.00
68.00	06800 SPEECH PATHOLOGY	0.725477	3,339	2,422	68.00
69.00	06900 ELECTROCARDIOLOGY	0.213837	46,205	9,880	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.470170	109,149	51,319	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.316348	232,963	73,697	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.678789	36	24	90.00
90.01	09001 RUSHVILLE FAMILY CLINIC	0.978546	0	0	90.01
90.02	09002 GEROPSYCH	17.427616	0	0	90.02
91.00	09100 EMERGENCY	1.427340	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.303229	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		649,471	211,305	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)		649,471		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141333	Period: From 03/01/2015 To 02/29/2016	Worksheet D-3	
		Component CCN: 14Z333		Date/Time Prepared: 7/27/2016 9:29 am	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.668808	0	0	50.00
53.00	05300 ANESTHESIOLOGY	1.196087	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.218003	13,415	2,925	54.00
60.00	06000 LABORATORY	0.263449	63,131	16,632	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.477751	1,922	918	62.00
65.00	06500 RESPIRATORY THERAPY	0.690538	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.513580	74,050	38,031	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.759893	87,860	66,764	67.00
68.00	06800 SPEECH PATHOLOGY	0.725477	15,563	11,291	68.00
69.00	06900 ELECTROCARDIOLOGY	0.213837	468	100	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.470170	54,201	25,484	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.316348	235,204	74,406	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.678789	0	0	90.00
90.01	09001 RUSHVILLE FAMILY CLINIC	0.978546	0	0	90.01
90.02	09002 GEROPSYCH	17.427616	0	0	90.02
91.00	09100 EMERGENCY	1.427340	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.303229	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		545,814	236,551	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		545,814		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141333	Period: From 03/01/2015 To 02/29/2016	Worksheet E Part B Date/Time Prepared: 7/27/2016 9:29 am
		Title XVII	Hospital	Cost
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,379,811	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		5,379,811	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 charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		5,433,609	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		48,298	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,750,837	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)		3,634,474	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)		3,634,474	30.00
31.00	Primary payer payments		833	31.00
32.00	Subtotal (line 30 minus line 31)		3,633,641	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)		220,699	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		143,454	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		214,546	36.00
37.00	Subtotal (see instructions)		3,777,095	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,777,095	40.00
40.01	Sequestration adjustment (see instructions)		75,542	40.01
41.00	Interim payments		3,468,233	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		233,320	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141333

Period:
From 03/01/2015
To 02/29/2016

Worksheet E-1
Part I
Date/Time Prepared:
7/27/2016 9:29 am

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		736,150		3,468,233	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)		736,150		3,468,233		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		0		233,320		6.01
6.02	SETTLEMENT TO PROGRAM		45,839		0		6.02
7.00	Total Medicare program liability (see instructions)		690,311		3,701,553		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141333
Component CCN: 14Z333

Period:
From 03/01/2015
To 02/29/2016

Worksheet E-1
Part I
Date/Time Prepared:
7/27/2016 9:29 am

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		970,889		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)		970,889		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		9,154		0	6.02
7.00	Total Medicare program liability (see instructions)		961,735		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 141333

Period:
From 03/01/2015
To 02/29/2016

Worksheet E-1
Part II
Date/Time Prepared:
7/27/2016 9:29 am

		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			177 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			396 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			0 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			574 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			31,540,638 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			42,926 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			1 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			1 8.00
9.00	Sequestration adjustment amount (see instructions)			0 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			1 10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			1 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 141333	Period: From 03/01/2015 To 02/29/2016	Worksheet E-2
		Component CCN: 14Z333		Date/Time Prepared: 7/27/2016 9:29 am
		Title XVIII	Swing Beds - SNF	Cost
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	756,977	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)	238,917	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	509	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)	995,894	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	995,894	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)	995,894	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	14,532	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)	981,362	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	981,362	0	19.00
19.01	Sequestration adjustment (see instructions)	19,627	0	19.01
20.00	Interim payments	970,889	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)	-9,154	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141333	Period: From 03/01/2015 To 02/29/2016	Worksheet E-3 Part V Date/Time Prepared: 7/27/2016 9:29 am
		Title XVII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			794,399 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)			794,399 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			802,343 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)			802,343 19.00
20.00	Deductibles (exclude professional component)			101,220 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			701,123 22.00
23.00	Coinurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			701,123 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			5,040 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			3,276 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			5,040 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			704,399 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 29.50
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (see instructions)			704,399 30.00
30.01	Sequestration adjustment (see instructions)			14,088 30.01
31.00	Interim payments			736,150 31.00
32.00	Tentative settlement (for contractor use only)			0 32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)			-45,839 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 141333

Period:
From 03/01/2015
To 02/29/2016

Worksheet G

Date/Time Prepared:
7/27/2016 9:29 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	8,363,986	0	0	0	1.00
2.00	Temporary investments	165,075	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,904,096	0	0	0	4.00
5.00	Other receivable	711,102	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	449,145	0	0	0	7.00
8.00	Prepaid expenses	225,924	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	12,819,328	0	0	0	11.00
FIXED ASSETS						
12.00	Land	426,152	0	0	0	12.00
13.00	Land improvements	1,071,915	0	0	0	13.00
14.00	Accumulated depreciation	-684,324	0	0	0	14.00
15.00	Buildings	6,092,130	0	0	0	15.00
16.00	Accumulated depreciation	-3,670,371	0	0	0	16.00
17.00	Leasehold improvements	944,589	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	10,526,745	0	0	0	23.00
24.00	Accumulated depreciation	-7,437,353	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)	7,269,483	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	3,621,799	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	1,903,024	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,524,823	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	25,613,634	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	285,281	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,088,016	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	71,202	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	435,411	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,879,910	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	650,951	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	3,070,577	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,721,528	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	5,601,438	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	20,012,196				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)	20,012,196	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	25,613,634	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141333

Period:
From 03/01/2015
To 02/29/2016

Worksheet G-1

Date/Time Prepared:
7/27/2016 9:29 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		19,921,866		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-570,467				2.00
3.00	Total (sum of line 1 and line 2)		19,351,399		0		3.00
4.00	PRIOR PERIOD ADJUSTMENT	660,797		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)		660,797		0		10.00
11.00	Subtotal (line 3 plus line 10)		20,012,196		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)		20,012,196		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	PRIOR PERIOD ADJUSTMENT		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	ROUNDING		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 141333

Period:
From 03/01/2015
To 02/29/2016

Worksheet G-2
Parts I & II
Date/Time Prepared:
7/27/2016 9:29 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,323,657		1,323,657	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	283,513		283,513	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)	1,607,170		1,607,170	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)	1,607,170		1,607,170	17.00
18.00	Ancillary services	1,374,730	22,101,220	23,475,950	18.00
19.00	Outpatient services	10,873	7,595,625	7,606,498	19.00
20.00	RURAL HEALTH CLINIC	0	1,659,384	1,659,384	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	464,744	464,744	27.00
27.01	DIETARY	0	2,546	2,546	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,992,773	31,823,519	34,816,292	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		22,765,500		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		0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		22,765,500		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141333

Period:
From 03/01/2015
To 02/29/2016

Worksheet G-3

Date/Time Prepared:
7/27/2016 9:29 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	34,816,292	1.00
2.00	Less contractual allowances and discounts on patients' accounts	13,353,650	2.00
3.00	Net patient revenues (line 1 minus line 2)	21,462,642	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	22,765,500	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,302,858	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	257,980	6.00
7.00	Income from investments	82,638	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	54,965	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC INCOME	386,008	24.00
24.01	TAX REVENUE	594,197	24.01
24.02	EHR REIMBURSEMENT	105,998	24.02
25.00	Total other income (sum of lines 6-24)	1,481,786	25.00
26.00	Total (line 5 plus line 25)	178,928	26.00
27.00	BAD DEBTS	695,607	27.00
27.01	CHARITY CARE	53,788	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	749,395	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-570,467	29.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141333 Component CCN: 143483	Period: From 03/01/2015 To 02/29/2016	Worksheet M-1 Date/Time Prepared: 7/27/2016 9:29 am
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) I Reclassified	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	243,015	239,039	482,054	25,000	507,054	1.00
2.00	Physician Assistant	103,404	0	103,404	0	103,404	2.00
3.00	Nurse Practitioner	262,051	0	262,051	0	262,051	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	370,311	0	370,311	0	370,311	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	10,560	0	10,560	0	10,560	7.00
8.00	Laboratory Technician	80,607	0	80,607	-80,607	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)	1,069,948	239,039	1,308,987	-55,607	1,253,380	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	80,627	80,627	0	80,627	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	80,627	80,627	0	80,627	14.00
15.00	Medical Supplies	0	52,194	52,194	0	52,194	15.00
16.00	Transportation (Health Care Staff)	0	10,962	10,962	0	10,962	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	63,156	63,156	0	63,156	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,069,948	382,822	1,452,770	-55,607	1,397,163	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
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	275,409	74,681	350,090	-64,635	285,455	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	275,409	74,681	350,090	-64,635	285,455	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,345,357	457,503	1,802,860	-120,242	1,682,618	32.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141333	Period: From 03/01/2015 To 02/29/2016	Worksheet M-1
	Component CCN: 143483		Date/Time Prepared: 7/27/2016 9:29 am
		Rural Health Clinic (RHC) I	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00 Physician	-74	506,980	1.00
2.00 Physician Assistant	0	103,404	2.00
3.00 Nurse Practitioner	0	262,051	3.00
4.00 Visiting Nurse	0	0	4.00
5.00 Other Nurse	0	370,311	5.00
6.00 Clinical Psychologist	0	0	6.00
7.00 Clinical Social Worker	0	10,560	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)	-74	1,253,306	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	80,627	13.00
14.00 Subtotal (sum of lines 11 through 13)	0	80,627	14.00
15.00 Medical Supplies	0	52,194	15.00
16.00 Transportation (Health Care Staff)	0	10,962	16.00
17.00 Depreciation-Medical Equipment	0	0	17.00
18.00 Professional Liability Insurance	0	0	18.00
19.00 Other Health Care Costs	0	0	19.00
20.00 Allowable GME Costs	0	0	20.00
21.00 Subtotal (sum of lines 15 through 20)	0	63,156	21.00
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-74	1,397,089	22.00
COSTS OTHER THAN RHC/FOHC SERVICES			
23.00 Pharmacy	0	0	23.00
24.00 Dental	0	0	24.00
25.00 Optometry	0	0	25.00
26.00 All other nonreimbursable costs	0	0	26.00
27.00 Nonallowable GME costs	0	0	27.00
28.00 Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD			
29.00 Facility Costs	0	0	29.00
30.00 Administrative Costs	-18,909	266,546	30.00
31.00 Total Facility Overhead (sum of lines 29 and 30)	-18,909	266,546	31.00
32.00 Total facility costs (sum of lines 22, 28 and 31)	-18,983	1,663,635	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141333 Component CCN: 143483	Period: From 03/01/2015 To 02/29/2016	Worksheet M-2 Date/Time Prepared: 7/27/2016 9:29 am
			Rural Health Clinic (RHC) I	Cost

	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Posi tions						
1.00	Physician	1.59	6,012	4,200	6,678	1.00
2.00	Physician Assistant	0.88	2,789	2,100	1,848	2.00
3.00	Nurse Practitioner	2.65	4,922	2,100	5,565	3.00
4.00	Subtotal (sum of lines 1 through 3)	5.12	13,723		14,091	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	0.19	216		216	7.00
7.01	Medical Nutrition Therapist (FOHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FOHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	5.31	13,939		14,307	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES			
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)		1,397,089 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)		1,397,089 12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)		1.000000 13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)		266,546 14.00
15.00	Parent provider overhead allocated to facility (see instructions)		1,442,254 15.00
16.00	Total overhead (sum of lines 14 and 15)		1,708,800 16.00
17.00	Allowable GME overhead (see instructions)		0 17.00
18.00	Subtotal (see instructions)		1,708,800 18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)		1,708,800 19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)		3,105,889 20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141333	Period: From 03/01/2015 To 02/29/2016	Worksheet M-3
		Component CCN: 143483		Date/Time Prepared: 7/27/2016 9:29 am
		Title XVIII	Rural Health Clinic (RHC) I	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		3,105,889	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		20,163	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		3,085,726	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		14,307	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)		14,307	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		215.68	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	80.44	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	215.68	215.68	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	3,090	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	666,451	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	16	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	3,451	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	3,451	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		669,902	16.00
16.01	Total program charges (see instructions)(from contractor's records)		390,803	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		13,569	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		23,260	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.)		479,282	16.04
16.05	Total program cost (see instructions)		502,542	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		47,539	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		65,939	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		502,542	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		7,940	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		510,482	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		510,482	26.00
26.01	Sequestration adjustment (see instructions)		10,210	26.01
27.00	Interim payments		427,018	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)		73,254	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter 1, §115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 141333 Component CCN: 143483	Period: From 03/01/2015 To 02/29/2016	Worksheet M-4 Date/Time Prepared: 7/27/2016 9:29 am		
		Title XVIII	Rural Health Clinic (RHC) I	Cost		
				Pneumococcal	Influenza	
				1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)			1,253,306	1,253,306	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time			0.000156	0.001900	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)			196	2,381	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)			5,364	1,128	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)			5,560	3,509	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)			1,397,089	1,397,089	6.00
7.00	Total overhead (from Wkst. M-2, line 16)			1,708,800	1,708,800	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)			0.003980	0.002512	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)			6,801	4,293	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)			12,361	7,802	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)			25	304	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)			494.44	25.66	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries			9	136	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)			4,450	3,490	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)				20,163	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)				7,940	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141333	Period: From 03/01/2015 To 02/29/2016	Worksheet M-5
	Component CCN: 143483		Date/Time Prepared: 7/27/2016 9:29 am
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		427,018	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)		427,018	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		73,254	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		500,272	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00