

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 260025

Period: From 10/01/2013 To 09/30/2014

Worksheet S Parts I-III Date/Time Prepared: 2/27/2015 1:56 pm

**PART I - COST REPORT STATUS**

Provider use only

1.  Electronically filed cost report  
 2.  Manually submitted cost report  
 3.  If this is an amended report enter the number of times the provider resubmitted this cost report  
 4.  Medicare Utilization. Enter "F" for full or "L" for low.

Date: 2/27/2015 Time: 1:56 pm

Contractor use only

5.  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.  Initial Report for this Provider CCN  
 9.  Final Report for this Provider CCN

10. NPR Date:  
 11. Contractor's Vendor Code: 4  
 12.  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 HANNIBAL REGIONAL HOSPITAL ( 260025 ) for the cost reporting period beginning 10/01/2013 and ending 09/30/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) \_\_\_\_\_  
 Officer or Administrator of Provider(s)

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	-292,562	-329	-43,159	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	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		14,414		0	10.00
10.01 RURAL HEALTH CLINIC II	0		17,581		0	10.01
10.02 RURAL HEALTH CLINIC III	0		36,964		0	10.02
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00 CMHC I	0		0		0	12.00
200.00 Total	0	-292,562	68,630	-43,159	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: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet S-2 Part I Date/Time Prepared: 2/27/2015 1:54 pm
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1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 Zip Code: 63401		4.00 County: MARION		1.00
1.00	Street: HIGHWAY 36, 6000 HOSPITAL DRIVE	State: MO		Zip Code: 63401		County: MARION		2.00
2.00	City: HANNIBAL							

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
						V	XVIII	XIX		
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	HANNIBAL REGIONAL HOSPITAL	260025	99926	1	01/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									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	HANNIBAL REGIONAL - HHA	267282	99926		04/10/1990	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	HANNIBAL REG - SHELBI NA	268512	99926		06/11/1997	N	O	O	15.00
15.01	Hospital-Based Health Clinic - RHC II	HANNIBAL REG - LAGRANGE	263984	99926		04/03/1992	N	O	O	15.01
15.02	Hospital-Based Health Clinic - RHC III	HANNIBAL REG - MONROE CITY	268513	99926		06/11/1997	N	O	O	15.02
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)					10/01/2013	09/30/2014	20.00
21.00	Type of Control (see instructions)					2		21.00

Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)								22.01
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N		23.00

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
	1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,236	298	37	0	1,476	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet S-2 Part I Date/Time Prepared: 2/27/2015 1:54 pm		
		Urban/Rural S	Date of Geogr			
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2			26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	1			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.	10/01/2013	09/30/2014		36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N			39.00	
		V	XVIII	XIX		
		1.00	2.00	3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet S-2 Part I Date/Time Prepared: 2/27/2015 1:54 pm
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		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	
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ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings							
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)					N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	

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

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

65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet S-2 Part I Date/Time Prepared: 2/27/2015 1:54 pm		
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	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
<b>Inpatient Psychiatric Facility PPS</b>						
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. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	71.00
<b>Inpatient Rehabilitation Facility PPS</b>						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	76.00
					1.00	
<b>Long Term Care Hospital PPS</b>						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00
<b>TEFRA Providers</b>						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
				V	XIX	
				1.00	2.00	
<b>Title V and XIX Services</b>						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	95.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet S-2 Part I Date/Time Prepared: 2/27/2015 1:54 pm			
		V 1.00	XIX 2.00				
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. Rural Providers	0.00	0.00				97.00
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N					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)						106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)						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.	N					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.	N	N	N	N		109.00
		1.00	2.00	3.00	3.00		
<b>Miscellaneous Cost Reporting Information</b>							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.			N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.			Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1			118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00			
118.01	List amounts of malpractice premiums and paid losses:	153,489	45,000			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.			Y	Y		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.			Y			121.00
<b>Transplant Center Information</b>							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.			N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.						134.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet S-2 Part I Date/Time Prepared: 2/27/2015 1:54 pm			
		1.00	2.00				
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00	
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?	Y				144.00	
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N				145.00	
				1.00			
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N				147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N				148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N				149.00	
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
				1.00			
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	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5					0.00	166.00
				1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y				167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0				168.00	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.75				169.00	
				Beginning	Ending		
				1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2013		09/30/2014		170.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet S-2 Part II Date/Time Prepared: 2/27/2015 1:54 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		N		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A	12/10/2014
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		Y		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.		N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
			Part A		Part B
			Y/N	Date	Y/N
			1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		Y	01/21/2015	Y
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)		N		N
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
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
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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet S-2 Part II Date/Time Prepared: 2/27/2015 1:54 pm	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	0	1.00	2.00	3.00
		N		N	21.00
					1.00
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				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.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				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				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				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.				33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				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.				35.00
			Y/N	Date	
			1.00	2.00	
<b>Home Office Costs</b>					
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.				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.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
			1.00	2.00	
<b>Cost Report Preparer Contact Information</b>					
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.	JIM		MCKAKIN	41.00
42.00	Enter the employer/company name of the cost report preparer.	HANNIBAL REGIONAL HEALTHCARE SYSTEM			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	573-248-5431		JIM.MCKAKIN@HRHONLINE.ORG	43.00

		Part B		
		Date		
		4.00		
<b>PS&amp;R Data</b>				
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)	01/21/2015		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)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
<b>Cost Report Preparer Contact Information</b>				
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.	GROUP DIRECTOR - FISCAL SERVICES		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: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/27/2015 1:54 pm

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	
					Title V	
	1. 00	2. 00	3. 00	4. 00	5. 00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	83	30,295	0.00	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)		83	30,295	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	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					0	13.00
14.00 Total (see instructions)	43.00	91	33,215	0.00	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	101.00				0	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	99.00				0	25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.02 RURAL HEALTH CLINIC III	88.02				0	26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		91				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: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/27/2015 1:54 pm

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)	8,603	931	13,989			1.00
2.00 HMO and other (see instructions)	561	1,774				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	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	8,603	931	13,989			7.00
8.00 INTENSIVE CARE UNIT	1,452	201	2,198			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		127	1,377			13.00
14.00 Total (see instructions)	10,055	1,259	17,564	0.00	753.67	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	3,830	255	6,378	0.00	13.40	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	0	0	0	0.00	0.00	25.00
26.00 RURAL HEALTH CLINIC	1,219	202	4,723	0.00	8.82	26.00
26.01 RURAL HEALTH CLINIC II	1,237	670	4,876	0.00	6.79	26.01
26.02 RURAL HEALTH CLINIC III	1,346	163	4,136	0.00	7.48	26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	790.16	27.00
28.00 Observation Bed Days		0	1,437			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	14	178			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: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/27/2015 1:54 pm

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	2,323	281	4,444	1.00
2.00 HMO and other (see instructions)			210	0		2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	2,323	281	4,444	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	0.00					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	0.00					25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 RURAL HEALTH CLINIC II	0.00					26.01
26.02 RURAL HEALTH CLINIC III	0.00					26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet S-3 Part II Date/Time Prepared: 2/27/2015 1:54 pm			
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
<b>PART II - WAGE DATA</b>								
<b>SALARIES</b>								
1.00	Total salaries (see instructions)	200.00	50,454,464	0	50,454,464	1,643,531.00	30.70	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		395,297	0	395,297	1,726.00	229.02	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		5,806,149	0	5,806,149	35,881.00	161.82	5.00
6.00	Non-physician-Part B		965,824	0	965,824	40,224.00	24.01	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		10,489,179	-222,276	10,266,903	252,882.96	40.60	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>								
11.00	Contract labor: Direct Patient Care		971,724	0	971,724	12,210.25	79.58	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		344,976	0	344,976	2,133.00	161.73	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
<b>WAGE-RELATED COSTS</b>								
17.00	Wage-related costs (core) (see instructions)		14,646,284	0	14,646,284			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		2,821,258	0	2,821,258			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		19,256	0	19,256			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		400,302	0	400,302			23.00
24.00	Wage-related costs (RHC/FQHC)		448,754	0	448,754			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26.00	Employee Benefits Department	4.00	488,986	222,276	711,262	35,207.00	20.20	26.00
27.00	Administrative & General	5.00	9,464,888	0	9,464,888	316,314.00	29.92	27.00
28.00	Administrative & General under contract (see inst.)		1,439,470	0	1,439,470	7,126.00	202.00	28.00
29.00	Maintenance & Repairs	6.00	285,096	0	285,096	19,114.00	14.92	29.00
30.00	Operation of Plant	7.00	576,867	0	576,867	26,761.00	21.56	30.00
31.00	Laundry & Linen Service	8.00	31,136	0	31,136	3,018.00	10.32	31.00
32.00	Housekeeping	9.00	597,133	0	597,133	49,481.00	12.07	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	768,993	0	768,993	53,775.00	14.30	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	601,287	0	601,287	20,003.00	30.06	38.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet S-3  
Part II  
Date/Time Prepared:  
2/27/2015 1:54 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
39.00	Central Services and Supply	14.00	130,027	0	130,027	7,830.00	16.61	39.00
40.00	Pharmacy	15.00	1,515,939	0	1,515,939	37,075.00	40.89	40.00
41.00	Medical Records & Medical Records Library	16.00	726,176	0	726,176	36,407.00	19.95	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet S-3  
Part III  
Date/Time Prepared:  
2/27/2015 1:54 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Sal ari es (from Worksheet A-6)	Adj uste d Sal ari es (col . 2 ± col . 3)	Pai d Hours Rel ated to Sal ari es i n col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	45,121,961	0	45,121,961	1,574,552.00	28.66	1.00
2.00	Excluded area salaries (see instructions)	10,489,179	-222,276	10,266,903	252,882.96	40.60	2.00
3.00	Subtotal salaries (line 1 minus line 2)	34,632,782	222,276	34,855,058	1,321,669.04	26.37	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,316,700	0	1,316,700	14,343.25	91.80	4.00
5.00	Subtotal wage-related costs (see inst.)	14,665,540	0	14,665,540	0.00	42.08	5.00
6.00	Total (sum of lines 3 thru 5)	50,615,022	222,276	50,837,298	1,336,012.29	38.05	6.00
7.00	Total overhead cost (see instructions)	16,625,998	222,276	16,848,274	612,111.00	27.52	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet S-3 Part IV Date/Time Prepared: 2/27/2015 1:54 pm
			Amount Reported	
			1.00	
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions		2,220,471	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		2,384,505	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)		9,231,908	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		60,477	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		57,904	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		140,984	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		27,013	14.00
15.00	'Workers' Compensation Insurance		496,286	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
<b>TAXES</b>				
17.00	FICA-Employers Portion Only		3,147,830	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		69,087	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
<b>OTHER</b>				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		342,459	21.00
22.00	Day Care Cost and Allowances		36,003	22.00
23.00	Tuition Reimbursement		120,927	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		18,335,854	24.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet S-3  
Part V  
Date/Time Prepared:  
2/27/2015 1:54 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	971,724	18,251,886	1.00
2.00	Hospital	971,724	14,598,380	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	398,469	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	446,699	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
15.00	Hospital-Based Health Clinic FOHC	0	0	15.00
16.00	Hospital-Based-CMHC	0	0	16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	2,808,338	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 260025 Component CCN: 267282		Period: From 10/01/2013 To 09/30/2014		Worksheet S-4 Date/Time Prepared: 2/27/2015 1:54 pm	
				Home Health Agency I		PPS	
				1.00			
0.00	County	MARION				0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
<b>HOME HEALTH AGENCY STATISTICAL DATA</b>							
1.00	Home Health Aide Hours	0	3,242	0	689	3,931	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	302.00	39.00	196.00	537.00	2.00
		Number of Employees (Full Time Equivalent)					
		Enter the number of hours in your normal work week			Staff	Contract	Total
		0			1.00	2.00	3.00
<b>HOME HEALTH AGENCY - NUMBER OF EMPLOYEES</b>							
3.00	Administrator and Assistant Administrator(s)	0.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			3.02	0.00	3.02	4.00
5.00	Other Administrative Personnel			0.31	0.00	0.31	5.00
6.00	Direct Nursing Service			5.79	0.00	5.79	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			2.03	0.00	2.03	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.08	0.00	0.08	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.07	0.00	0.07	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.03	0.00	0.03	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.89	0.00	1.89	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
<b>HOME HEALTH AGENCY CBSA CODES</b>							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99926			20.00
20.01				99914			20.01
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
<b>PPS ACTIVITY DATA</b>							
21.00	Skilled Nursing Visits	1,917	0	116	71	2,104	21.00
22.00	Skilled Nursing Visit Charges	249,547	0	12,905	9,135	271,587	22.00
23.00	Physical Therapy Visits	1,222	0	26	27	1,275	23.00
24.00	Physical Therapy Visit Charges	178,096	0	2,790	4,030	184,916	24.00
25.00	Occupational Therapy Visits	44	0	0	3	47	25.00
26.00	Occupational Therapy Visit Charges	6,510	0	0	465	6,975	26.00
27.00	Speech Pathology Visits	49	0	1	0	50	27.00
28.00	Speech Pathology Visit Charges	7,595	0	155	0	7,750	28.00
29.00	Medical Social Service Visits	8	0	1	0	9	29.00
30.00	Medical Social Service Visit Charges	1,240	0	155	0	1,395	30.00
31.00	Home Health Aide Visits	329	0	1	15	345	31.00
32.00	Home Health Aide Visit Charges	23,030	0	70	1,050	24,150	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,569	0	145	116	3,830	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	466,018	0	16,075	14,680	496,773	35.00
36.00	Total Number of Episodes (standard/non outlier)	271		35	9	315	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	38,201	0	1,606	1,614	41,421	38.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 260025 Component CCN: 268512	Period: From 10/01/2013 To 09/30/2014	Worksheet S-8 Date/Time Prepared: 2/27/2015 1:54 pm	
			Rural Health Clinic (RHC) I	Cost	
1.00					
Clinic Address and Identification					
1.00	Street	400 S. CENTER STREET			1.00
		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	SHELBI NA		MO63468	2.00
1.00					
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0
					3.00
Grant Award					
Date					
1.00					
2.00					
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)				0
					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)				0
					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				0
					6.00
7.00	Appalachian Regional Commission				0
					7.00
8.00	Look-Alikes				0
					8.00
9.00	OTHER (SPECIFY)				0
					9.00
1.00					
2.00					
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N
					0
10.00					
Sunday					
Monday					
Tuesday					
		from	to	from	to
		1.00	2.00	3.00	4.00
5.00					
Facility hours of operations (1)					
11.00	Clinic	08:00		17:00	08:00
					11.00
1.00					
2.00					
12.00	Have you received an approval for an exception to the productivity standard?				N
					12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N
					0
13.00					
Provider name					
CCN number					
1.00					
2.00					
14.00	Provider name, CCN number				
					14.00
Y/N					
V					
XVIII					
XIX					
Total Visits					
		1.00	2.00	3.00	4.00
		5.00			
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				0
					0
15.00					
County					
4.00					
2.00	City, State, Zip Code, County				SHELBY
					2.00
Tuesday					
Wednesday					
Thursday					
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00			
Facility hours of operations (1)					
11.00	Clinic	17:00	08:00	17:00	08:00
					17:00
11.00					

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 260025 Component CCN: 268512	Period: From 10/01/2013 To 09/30/2014	Worksheet S-8 Date/Time Prepared: 2/27/2015 1:54 pm Cost
		Rural Health Clinic (RHC) I	

	Friday		Saturday			
	from	to	from	to		
	11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) Clinic					
	08:00	17:00	08:00	12:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 260025 Component CCN: 263984		Period: From 10/01/2013 To 09/30/2014		Worksheet S-8 Date/Time Prepared: 2/27/2015 1:54 pm		
				Rural Health Clinic (RHC) II		Cost		
						1.00		
1.00	Clinic Address and Identification Street			1802 ELM STREET		1.00		
		City		State		Zip Code		
		1.00		2.00		3.00		
2.00	City, State, Zip Code, County		CANTON		MO63435		2.00	
						1.00		
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0		
				Grant Award		Date		
				1.00		2.00		
		Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS Act)			0		4.00		
5.00	Migrant Health Center (Section 329(d), PHS Act)			0		5.00		
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0		6.00		
7.00	Appalachian Regional Commission			0		7.00		
8.00	Look-Alikes			0		8.00		
9.00	OTHER (SPECIFY)			0		9.00		
				1.00		2.00		
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0		
		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		
						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.			N		0		
		Provider name		CCN number				
		1.00		2.00				
14.00	Provider name, CCN number					14.00		
		Y/N		V		Total Visits		
		1.00		2.00		3.00 4.00 5.00		
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			0		0		
						0		
2.00	City, State, Zip Code, County			LEWIS		2.00		
		Tuesday		Wednesday		Thursday		
		to		from to		from to		
		6.00		7.00 8.00		9.00 10.00		
11.00	Facility hours of operations (1) Clinic			17:00 08:00		17:00 08:00		
						17:00		

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 260025 Component CCN: 263984	Period: From 10/01/2013 To 09/30/2014	Worksheet S-8 Date/Time Prepared: 2/27/2015 1:54 pm Cost
		Rural Health Clinic (RHC) II	

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

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 260025 Component CCN: 268513	Period: From 10/01/2013 To 09/30/2014	Worksheet S-8 Date/Time Prepared: 2/27/2015 1:54 pm	
			Rural Health Clinic (RHC) III	Cost	
1.00					
Clinic Address and Identification					
1.00	Street	821 BUSINESS HWYS 24 & 36		1.00	
		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	MONROE CITY		MO63456	
2.00					
3.00					
FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban					
0					
3.00					
Grant Award					
Date					
1.00					
2.00					
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00	
7.00	Appalachian Regional Commission	0		7.00	
8.00	Look-Alikes	0		8.00	
9.00	OTHER (SPECIFY)	0		9.00	
1.00					
2.00					
10.00	Does this facility operate as other than an RHC or FOHC? 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
		1.00	2.00	3.00	4.00
5.00					
Facility hours of operations (1)					
11.00	Clinic	08:00		17:00	
08:00					
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.	N		0	
13.00					
Provider name					
CCN number					
1.00					
2.00					
14.00	Provider name, CCN number				
14.00					
Y/N					
V					
XVIII					
XIX					
Total Visits					
1.00					
2.00					
3.00					
4.00					
5.00					
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	0		0	
0					
15.00					
County					
4.00					
2.00	City, State, Zip Code, County	MONROE			
2.00					
Tuesday					
Wednesday					
Thursday					
		to	from	to	to
		6.00	7.00	8.00	9.00
10.00					
Facility hours of operations (1)					
11.00	Clinic	17:00		08:00	
08:00					
17:00					
08:00					
17:00					
11.00					

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 260025 Component CCN: 268513	Period: From 10/01/2013 To 09/30/2014	Worksheet S-8 Date/Time Prepared: 2/27/2015 1:54 pm Cost
		Rural Health Clinic (RHC) III	

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet S-10 Date/Time Prepared: 2/27/2015 1:54 pm
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			1.00		
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.319721	1.00	
<b>Medicaid (see instructions for each line)</b>					
2.00	Net revenue from Medicaid		7,162,078	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		3,270,302	5.00	
6.00	Medicaid charges		29,603,252	6.00	
7.00	Medicaid cost (line 1 times line 6)		9,464,781	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00	
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>					
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	
<b>Other state or local government indigent care program (see instructions for each line)</b>					
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	
<b>Uncompensated care (see instructions for each line)</b>					
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)		0	19.00	
			Uninsured patients	Insured patients	
			1.00	2.00	
			Total (col. 1 + col. 2)		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	8,013,696	1,495,767	9,509,463	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	2,562,147	478,228	3,040,375	21.00
22.00	Partial payment by patients approved for charity care	80,234	40,551	120,785	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,481,913	437,677	2,919,590	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)		8,305,154	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		483,135	27.00	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		7,822,019	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		2,500,864	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		5,420,454	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		5,420,454	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet A  
Date/Time Prepared:  
2/27/2015 1:54 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		2,648,208	2,648,208	693,969	3,342,177	1.00
2.00	00200		5,934,004	5,934,004	-1,857,816	4,076,188	2.00
4.00	00400		11,074,564	11,563,550	258,279	11,821,829	4.00
5.00	00500	488,986	9,229,945	18,694,833	177,448	18,872,281	5.00
6.00	00600	9,464,888	285,096	52,929	338,025	0	6.00
7.00	00700	576,867	1,563,718	2,140,585	0	2,140,585	7.00
8.00	00800	31,136	275,865	307,001	0	307,001	8.00
9.00	00900	597,133	200,637	797,770	0	797,770	9.00
10.00	01000	768,993	740,068	1,509,061	0	1,509,061	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	601,287	93,527	694,814	0	694,814	13.00
14.00	01400	130,027	153,093	283,120	-11,363	271,757	14.00
15.00	01500	1,515,939	610,984	2,126,923	0	2,126,923	15.00
16.00	01600	726,176	471,946	1,198,122	0	1,198,122	16.00
19.00	01900	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	5,159,456	2,163,511	7,322,967	62,858	7,385,825	30.00
31.00	03100	1,606,190	543,761	2,149,951	22,835	2,172,786	31.00
43.00	04300	309,773	138,892	448,665	5,971	454,636	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	1,045,798	914,481	1,960,279	0	1,960,279	50.00
51.00	05100	875,988	151,673	1,027,661	0	1,027,661	51.00
52.00	05200	842,591	218,761	1,061,352	5,392	1,066,744	52.00
53.00	05300	2,644,064	439,081	3,083,145	220,573	3,303,718	53.00
54.00	05400	1,112,310	631,121	1,743,431	310,521	2,053,952	54.00
56.00	03450	105,329	86,330	191,659	0	191,659	56.00
57.00	05700	216,718	203,388	420,106	107,894	528,000	57.00
58.00	05800	88,960	142,584	231,544	0	231,544	58.00
60.00	06000	1,796,869	2,171,147	3,968,016	106,987	4,075,003	60.00
62.00	06200	78,807	495,319	574,126	0	574,126	62.00
65.00	06500	737,014	235,863	972,877	26,748	999,625	65.00
66.00	06600	351,460	648,891	1,000,351	0	1,000,351	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	148,264	39,203	187,467	0	187,467	68.00
69.00	06900	1,033,165	858,450	1,891,615	0	1,891,615	69.00
70.00	07000	158,956	30,668	189,624	0	189,624	70.00
71.00	07100	0	9,005,472	9,005,472	-1,346,816	7,658,656	71.00
72.00	07200	0	571,346	571,346	1,346,816	1,918,162	72.00
73.00	07300	0	2,984,151	2,984,151	0	2,984,151	73.00
76.00	03020	770,572	672,011	1,442,583	99,878	1,542,461	76.00
76.01	03021	22,095	10,419	32,514	0	32,514	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	522,942	284,897	807,839	0	807,839	88.00
88.01	08801	477,190	208,682	685,872	28,105	713,977	88.01
88.02	08802	520,906	204,017	724,923	0	724,923	88.02
89.00	08900	0	0	0	0	0	89.00
91.00	09100	4,024,137	2,515,674	6,539,811	0	6,539,811	91.00
91.01	09101	0	0	0	0	0	91.01
91.02	09102	129,203	18,316	147,519	0	147,519	91.02
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	09900	0	0	0	0	0	99.00
101.00	10100	831,832	239,578	1,071,410	0	1,071,410	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	0	0	0	0	0	113.00
114.00	11400	0	0	0	0	0	114.00
118.00		40,797,117	59,877,175	100,674,292	258,279	100,932,571	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	7,534,518	2,039,554	9,574,072	0	9,574,072	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	888,586	377,052	1,265,638	-258,279	1,007,359	194.01
194.02	07952	7,382	41,070	48,452	0	48,452	194.02
194.03	07953	417,634	70,366	488,000	0	488,000	194.03
194.04	07954	165,951	72,808	238,759	0	238,759	194.04
194.05	07955	32,319	20,449	52,768	0	52,768	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	610,957	205,775	816,732	0	816,732	194.07
200.00		50,454,464	62,704,249	113,158,713	0	113,158,713	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet A  
Date/Time Prepared:  
2/27/2015 1:54 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-415,699	2,926,478	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-5,058	4,071,130	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,873,474	13,695,303	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,389,240	24,261,521	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	338,025	6.00
7.00	00700	OPERATION OF PLANT	-8,196	2,132,389	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	307,001	8.00
9.00	00900	HOUSEKEEPING	0	797,770	9.00
10.00	01000	DIETARY	-563,888	945,173	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	694,814	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	271,757	14.00
15.00	01500	PHARMACY	0	2,126,923	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-48,883	1,149,239	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-503,599	6,882,226	30.00
31.00	03100	INTENSIVE CARE UNIT	-4,759	2,168,027	31.00
43.00	04300	NURSERY	-962	453,674	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-39,092	1,921,187	50.00
51.00	05100	RECOVERY ROOM	0	1,027,661	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-1,922	1,064,822	52.00
53.00	05300	ANESTHESIOLOGY	-2,579,444	724,274	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,053,952	54.00
56.00	03450	RADIOISOTOPE	0	191,659	56.00
57.00	05700	CT SCAN	0	528,000	57.00
58.00	05800	MRI	0	231,544	58.00
60.00	06000	LABORATORY	-510,093	3,564,910	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	574,126	62.00
65.00	06500	RESPIRATORY THERAPY	0	999,625	65.00
66.00	06600	PHYSICAL THERAPY	-139,866	860,485	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	-110,289	77,178	68.00
69.00	06900	ELECTROCARDIOLOGY	-318,248	1,573,367	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-15,483	174,141	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,658,656	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,918,162	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,984,151	73.00
76.00	03020	CANCER CENTER	-32,726	1,509,735	76.00
76.01	03021	DIABETES CENTER	0	32,514	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	-2,024	805,815	88.00
88.01	08801	RURAL HEALTH CLINIC II	-312	713,665	88.01
88.02	08802	RURAL HEALTH CLINIC III	-25	724,898	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	09100	EMERGENCY	-3,782,751	2,757,060	91.00
91.01	09101	OUTPATIENT PSYCH	0	0	91.01
91.02	09102	WOUND CARE	0	147,519	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.00	09900	CMHC	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	1,071,410	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	114.00
118.00	11800	SUBTOTALS (SUM OF LINES 1-117)	-1,820,605	99,111,966	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	9,574,072	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	RENTAL	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	1,007,359	194.01
194.02	07952	HWY 61 BUILDING	0	48,452	194.02
194.03	07953	MEDICAL BUILDING	0	488,000	194.03
194.04	07954	PHYSICIAN OFFICES PITTSFIELD	0	238,759	194.04
194.05	07955	PHYSICIAN OFFICES MEXICO	0	52,768	194.05
194.06	07956	MENTAL HEALTH	0	0	194.06
194.07	07957	BOWLING GREEN/LOUISIANA CLINIC	0	816,732	194.07
200.00		TOTAL (SUM OF LINES 118-199)	-1,820,605	111,338,108	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - ADMISSION KITS</b>					
1.00		0.00	0	0	1.00
2.00	NURSERY	43.00	0	5,971	2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	0	5,392	3.00
	0		0	11,363	
<b>B - INTEREST EXP ON BONDS</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	693,969	1.00
	0		0	693,969	
<b>C - CAPITAL LEASE EXP</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,029,018	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	56,808	2.00
3.00	INTENSIVE CARE UNIT	31.00	0	20,637	3.00
4.00	ANESTHESIOLOGY	53.00	0	199,344	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	280,635	5.00
7.00	CT SCAN	57.00	0	97,510	7.00
8.00	LABORATORY	60.00	0	96,690	8.00
9.00	RESPIRATORY THERAPY	65.00	0	24,174	9.00
10.00	CANCER CENTER	76.00	0	90,265	10.00
11.00	RURAL HEALTH CLINIC II	88.01	0	25,400	11.00
	0		0	1,920,481	
<b>D - PROPERTY INSURANCE</b>					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	62,665	1.00
	0		0	62,665	
<b>E - IMPLANTS</b>					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,346,816	1.00
	0		0	1,346,816	
<b>F - CAP LEASE INTEREST</b>					
1.00	ADULTS & PEDIATRICS	30.00	0	6,050	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	2,198	2.00
3.00	ANESTHESIOLOGY	53.00	0	21,229	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	29,886	4.00
6.00	CT SCAN	57.00	0	10,384	6.00
7.00	LABORATORY	60.00	0	10,297	7.00
8.00	RESPIRATORY THERAPY	65.00	0	2,574	8.00
9.00	CANCER CENTER	76.00	0	9,613	9.00
10.00	RURAL HEALTH CLINIC II	88.01	0	2,705	10.00
	0		0	94,936	
<b>G - CHILDREN'S CENTER</b>					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	222,276	36,003	1.00
	0		222,276	36,003	
500.00	Grand Total: Increases		222,276	4,166,233	500.00

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
<b>A - ADMISSION KITS</b>							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	11,363	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		0	11,363			
<b>B - INTEREST EXP ON BONDS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	693,969	11		1.00
	0		0	693,969			
<b>C - CAPITAL LEASE EXP</b>							
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,920,481	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
	0		0	1,920,481			
<b>D - PROPERTY INSURANCE</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	62,665	9		1.00
	0		0	62,665			
<b>E - IMPLANTS</b>							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,346,816	0		1.00
	0		0	1,346,816			
<b>F - CAP LEASE INTEREST</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	94,936	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
	0		0	94,936			
<b>G - CHILDREN'S CENTER</b>							
1.00	CHILD DEVELOPMENT CENTER	194.01	222,276	36,003	0		1.00
	0		222,276	36,003			
500.00	Grand Total: Decreases		222,276	4,166,233			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet A-7  
Part I  
Date/Time Prepared:  
2/27/2015 1:54 pm

		Acquisitions			Disposals and Retirements		
		Beginning Balances	Purchases	Donation			Total
		1.00	2.00	3.00			4.00
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	2,693,370	0	0	0	1.00	
2.00	Land Improvements	7,112,763	253,660	0	253,660	2.00	
3.00	Buildings and Fixtures	42,883,675	1,376,165	0	1,376,165	3.00	
4.00	Building Improvements	18,479,557	146,067	0	146,067	4.00	
5.00	Fixed Equipment	124,221	197,360	0	197,360	5.00	
6.00	Movable Equipment	61,863,650	2,972,030	0	2,972,030	6.00	
7.00	HIT designated Assets	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	133,157,236	4,945,282	0	4,945,282	8.00	
9.00	Reconciling Items	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	133,157,236	4,945,282	0	4,945,282	10.00	
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	2,693,370	0			1.00	
2.00	Land Improvements	7,113,729	0			2.00	
3.00	Buildings and Fixtures	44,043,753	0			3.00	
4.00	Building Improvements	18,614,031	0			4.00	
5.00	Fixed Equipment	321,581	0			5.00	
6.00	Movable Equipment	64,287,103	0			6.00	
7.00	HIT designated Assets	0	0			7.00	
8.00	Subtotal (sum of lines 1-7)	137,073,567	0			8.00	
9.00	Reconciling Items	0	0			9.00	
10.00	Total (line 8 minus line 9)	137,073,567	0			10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet A-7  
Part II  
Date/Time Prepared:  
2/27/2015 1:54 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	2,648,208	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,934,004	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	8,582,212	0	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	2,648,208				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,934,004				2.00
3.00	Total (sum of lines 1-2)	0	8,582,212				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet A-7  
Part III  
Date/Time Prepared:  
2/27/2015 1:54 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	72,464,883	0	72,464,883	0.573898	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	64,608,684	10,805,666	53,803,018	0.426102	0	2.00
3.00	Total (sum of lines 1-2)	137,073,567	10,805,666	126,267,901	1.000000	0	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	0	2,648,208	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	4,076,188	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	6,724,396	0	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	278,270	0	0	0	2,926,478	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-5,058	0	0	0	4,071,130	2.00
3.00	Total (sum of lines 1-2)	273,212	0	0	0	6,997,608	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	2.00	3.00	4.00	5.00			
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)	B	-168,587		CAP REL COSTS-BLDG & FIXT	1.00	11	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00	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)		0			0.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-8,618		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	-7,777,030				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	-563,888		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	-48,883		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		0			0.00	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			ORESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3			OPHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)				OUTILIZATION REVIEW-SNF	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3			OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)				OADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3			OSPEECH PATHOLOGY	68.00		31.00

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		
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00
33.00 MISC INCOME	B	-11,046	ADMINISTRATIVE & GENERAL	5.00		0	33.00
34.00 RECRUITMENT FEES	A	-36,907	ADMINISTRATIVE & GENERAL	5.00		0	34.00
35.00 STAFF DEVELOPMENT	B	-18,962	ADMINISTRATIVE & GENERAL	5.00		0	35.00
36.00 NON ALLOWED ADVERTISING COSTS	A	-1,298,866	ADMINISTRATIVE & GENERAL	5.00		0	36.00
37.00 NURSERY PHOTOS	B	-962	NURSERY	43.00		0	37.00
38.00 ULTRAFAST LAB TEST	B	-813	LABORATORY	60.00		0	38.00
39.00 MEDICAID/FRA	A	7,384,964	ADMINISTRATIVE & GENERAL	5.00		0	39.00
40.00 LOBBYING EXPENSE	A	-21,765	ADMINISTRATIVE & GENERAL	5.00		0	40.00
41.00 ALCOHOLIC BEVERAGE EXPENSE	A	-1,035	ADMINISTRATIVE & GENERAL	5.00		0	41.00
42.00 EEG CONTRACT SERVICE	B	-15,483	ELECTROENCEPHALOGRAPHY	70.00		0	42.00
43.00 P/T CONTRACT SERVICE	B	-139,866	PHYSICAL THERAPY	66.00		0	43.00
44.00 EMPLOYED PHYSICIAN BENEFITS	A	-854,192	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	44.00
45.00 DEVELOPMENT SALARIES	A	-253,258	ADMINISTRATIVE & GENERAL	5.00		0	45.00
45.01 DEVELOPMENT EXPENSE	A	-157,483	ADMINISTRATIVE & GENERAL	5.00		0	45.01
45.02 SPEECH CONTRACT SERVICE	B	-110,289	SPEECH PATHOLOGY	68.00		0	45.02
45.03 OTHER - MISC	B	-46,200	ADMINISTRATIVE & GENERAL	5.00		0	45.03
45.04		0		0.00		0	45.04
45.05 MISC REVENUE	B	-1,922	DELIVERY ROOM & LABOR ROOM	52.00		0	45.05
45.06 BUILDING RENTAL INCOME	B	-247,112	CAP REL COSTS-BLDG & FIXT	1.00		11	45.06
45.07 PLANT OPERATIONS OTHER REV	B	422	OPERATION OF PLANT	7.00		0	45.07
45.08 CONTRIBUTIONS	A	-20,971	ADMINISTRATIVE & GENERAL	5.00		0	45.08
45.09 ADVERTISING EMPLOYEE BENEFITS	A	-67,147	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	45.09
45.10 FOUNDATION EMPLOYEE BENEFITS	A	-55,589	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	45.10
45.11 RHC-MONROE CIT OTHER REV	B	-25	RURAL HEALTH CLINIC III	88.02		0	45.11
45.12 EMERGENCY OTHER REV	B	-3,019	EMERGENCY	91.00		0	45.12
45.13 DEFINED BENEFIT PENSION PLAN	A	2,850,402	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	45.13
45.14 COMMUNICATIONS OTHER REVENUE	B	-46,224	ADMINISTRATIVE & GENERAL	5.00		0	45.14
45.15 GENERAL AND ADMINISTRATIVE OTHER REV	B	-26,580	ADMINISTRATIVE & GENERAL	5.00		0	45.15
45.16 RHC OTHER REVENUE	B	-2,024	RURAL HEALTH CLINIC	88.00		0	45.16
45.17 RHC -LAGRANGE OTHER REVENUE	B	-312	RURAL HEALTH CLINIC II	88.01		0	45.17
45.18 MISC REVENUE	B	-7,500	LABORATORY	60.00		0	45.18
45.19 MISC REVENUE	B	-7,500	ADULTS & PEDIATRICS	30.00		0	45.19
45.20 MISC REVENUE	B	-4,196	ELECTROCARDIOLOGY	69.00		0	45.20
45.21 MISC REVENUE	B	-4,759	INTENSIVE CARE UNIT	31.00		0	45.21
45.22 PATIENT PHONE	A	-22,322	ADMINISTRATIVE & GENERAL	5.00		0	45.22
45.23 PATIENT PHONE	A	-5,058	CAP REL COSTS-MVBLE EQUIP	2.00		11	45.23
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,820,605					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: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet A-8-2

Date/Time Prepared:  
2/27/2015 1:54 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	122,763	-9,737	132,500	159,800	1,154	1.00
2.00	30.00	ADULTS & PEDIATRICS	496,099	496,099	0	0	0	2.00
3.00	50.00	OPERATING ROOM	61,251	0	61,251	182,900	252	3.00
4.00	53.00	ANESTHESIOLOGY	2,612,300	2,524,029	88,271	167,500	408	4.00
5.00	60.00	LABORATORY	584,080	392,107	191,973	208,000	823	5.00
6.00	76.00	CANCER CENTER	60,000	0	60,000	159,800	355	6.00
7.00	91.00	EMERGENCY	3,846,341	3,640,063	206,278	159,800	867	7.00
8.00	69.00	ELECTROCARDIOLOGY	314,052	314,052	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			8,096,886	7,356,613	740,273		3,859	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	5.00	ADMINISTRATIVE & GENERAL	88,658	4,433	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	22,159	1,108	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	32,856	1,643	0	0	0	4.00
5.00	60.00	LABORATORY	82,300	4,115	0	0	0	5.00
6.00	76.00	CANCER CENTER	27,274	1,364	0	0	0	6.00
7.00	91.00	EMERGENCY	66,609	3,330	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			319,856	15,993	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	5.00	ADMINISTRATIVE & GENERAL	0	88,658	43,842	34,105		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	496,099		2.00
3.00	50.00	OPERATING ROOM	0	22,159	39,092	39,092		3.00
4.00	53.00	ANESTHESIOLOGY	0	32,856	55,415	2,579,444		4.00
5.00	60.00	LABORATORY	0	82,300	109,673	501,780		5.00
6.00	76.00	CANCER CENTER	0	27,274	32,726	32,726		6.00
7.00	91.00	EMERGENCY	0	66,609	139,669	3,779,732		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	314,052		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	319,856	420,417	7,777,030		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet B  
Part I  
Date/Time Prepared:  
2/27/2015 1:54 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,926,478	2,926,478			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	4,071,130		4,071,130		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	13,695,303	0	11,539	13,706,842	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	24,261,521	592,566	1,172,517	2,864,054	5.00
6.00 00600	MAINTENANCE & REPAIRS	338,025	0	0	88,548	6.00
7.00 00700	OPERATION OF PLANT	2,132,389	119,715	94,319	179,169	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	307,001	15,147	0	9,670	8.00
9.00 00900	HOUSEKEEPING	797,770	15,828	0	185,463	9.00
10.00 01000	DIETARY	945,173	50,633	6,526	238,841	10.00
11.00 01100	CAFETERIA	0	32,048	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	694,814	3,472	11,416	186,753	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	271,757	23,215	0	40,385	14.00
15.00 01500	PHARMACY	2,126,923	28,576	225,019	470,834	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,149,239	24,882	0	225,542	16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	6,882,226	598,779	0	1,448,387	30.00
31.00 03100	INTENSIVE CARE UNIT	2,168,027	99,053	0	498,865	31.00
43.00 04300	NURSERY	453,674	0	0	96,212	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	1,921,187	155,422	268,866	324,813	50.00
51.00 05100	RECOVERY ROOM	1,027,661	118,489	0	272,072	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,064,822	0	0	261,699	52.00
53.00 05300	ANESTHESIOLOGY	724,274	6,382	0	37,282	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,053,952	212,777	1,201,998	345,471	54.00
56.00 03450	RADIOISOTOPE	191,659	21,121	7,108	32,714	56.00
57.00 05700	CT SCAN	528,000	9,735	0	67,310	57.00
58.00 05800	MRI	231,544	14,364	72,532	27,630	58.00
60.00 06000	LABORATORY	3,564,910	78,851	679,333	558,088	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	574,126	2,298	0	24,477	62.00
65.00 06500	RESPIRATORY THERAPY	999,625	10,688	1,729	228,908	65.00
66.00 06600	PHYSICAL THERAPY	860,485	39,128	8,962	109,160	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	77,178	0	0	46,049	68.00
69.00 06900	ELECTROCARDIOLOGY	1,573,367	131,935	81,294	320,890	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	174,141	2,638	0	49,370	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,658,656	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	1,918,162	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2,984,151	0	0	0	73.00
76.00 03020	CANCER CENTER	1,509,735	0	0	239,331	76.00
76.01 03021	DIABETES CENTER	32,514	0	0	6,862	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	805,815	0	0	124,872	88.00
88.01 08801	RURAL HEALTH CLINIC II	713,665	0	105,100	86,525	88.01
88.02 08802	RURAL HEALTH CLINIC III	724,898	0	0	88,577	88.02
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00 09100	EMERGENCY	2,757,060	499,742	3,634	693,101	91.00
91.01 09101	OUTPATIENT PSYCH	0	0	0	0	91.01
91.02 09102	WOUND CARE	147,519	0	0	40,129	91.02
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
93.00 04040	FAMILY PRACTICE	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00 09900	CMHC	0	0	0	0	99.00
101.00 10100	HOME HEALTH AGENCY	1,071,410	0	0	258,358	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
114.00 11400	UTILIZATION REVIEW-SNF	0	0	0	0	114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	99,111,966	2,907,484	3,951,892	10,776,411	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	9,574,072	18,994	119,238	2,340,138	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	RENTAL	0	0	0	0	194.00
194.01 07951	CHILD DEVELOPMENT CENTER	1,007,359	0	0	206,949	194.01
194.02 07952	HWY 61 BUILDING	48,452	0	0	2,293	194.02
194.03 07953	MEDICAL BUILDING	488,000	0	0	129,713	194.03
194.04 07954	PHYSICIAN OFFICES PITTSFIELD	238,759	0	0	51,543	194.04
194.05 07955	PHYSICIAN OFFICES MEXICO	52,768	0	0	10,038	194.05

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet B  
Part I  
Date/Time Prepared:  
2/27/2015 1:54 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
194.06 07956 MENTAL HEALTH	0	0	0	0	0	194.06
194.07 07957 BOWLING GREEN/LOUISIANA CLINIC	816,732	0	0	189,757	1,006,489	194.07
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	111,338,108	2,926,478	4,071,130	13,706,842	111,338,108	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 260025		Period: From 10/01/2013 To 09/30/2014		Worksheet B Part I Date/Time Prepared: 2/27/2015 1:54 pm	
Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	28,890,658					5.00
6.00	00600	MAINTENANCE & REPAIRS	149,477	576,050				6.00
7.00	00700	OPERATION OF PLANT	885,000	26,506	3,437,098			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	116,273	1,897		11,866	461,854	8.00
9.00	00900	HOUSEKEEPING	350,084	1,983		12,400	0	1,363,528
10.00	01000	DIETARY	434,923	6,342		39,666	0	31,900
11.00	01100	CAFETERIA	11,230	4,014		25,106	0	20,191
13.00	01300	NURSING ADMINISTRATION	314,129	435		2,720	0	2,187
14.00	01400	CENTRAL SERVICES & SUPPLY	117,513	2,908		18,186	0	14,626
15.00	01500	PHARMACY	999,151	3,579		22,386	0	18,004
16.00	01600	MEDICAL RECORDS & LIBRARY	490,460	3,117		19,493	0	15,677
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	3,128,975	75,000	469,083	186,369	377,248	30.00
31.00	03100	INTENSIVE CARE UNIT	969,223	12,407	77,598	28,660	62,406	31.00
43.00	04300	NURSERY	192,687	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	935,704	19,467	121,757	74,229	97,920	50.00
51.00	05100	RECOVERY ROOM	496,963	14,841	92,825	15,438	74,652	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	464,830	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	269,095	799	5,000	0	4,021	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,336,545	29,497	184,489	33,596	134,056	54.00
56.00	03450	RADIOISOTOPE	88,515	2,646	16,546	0	13,307	56.00
57.00	05700	CT SCAN	212,016	1,219	7,626	0	6,133	57.00
58.00	05800	MRI	121,267	1,799	11,253	0	9,050	58.00
60.00	06000	LABORATORY	1,710,430	12,590	78,745	0	49,679	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	210,564	288	1,800	0	1,448	62.00
65.00	06500	RESPIRATORY THERAPY	434,845	4,136	25,866	0	6,734	65.00
66.00	06600	PHYSICAL THERAPY	356,628	8,380	52,412	1,061	24,652	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	43,180	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	738,490	16,525	103,358	14,065	83,123	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	79,246	330	2,067	2,258	1,662	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,683,693	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	672,149	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,045,685	0	0	0	0	73.00
76.00	03020	CANCER CENTER	612,895	37,945	237,328	6,712	0	76.00
76.01	03021	DIABETES CENTER	13,798	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	326,125	6,822	42,666	214	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	317,225	15,975	99,918	139	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	285,052	12,230	76,492	324	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	1,385,371	62,595	391,498	95,865	314,852	91.00
91.01	09101	OUTPATIENT PSYCH	0	0	0	0	0	91.01
91.02	09102	WOUND CARE	65,754	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	465,968	7,781	48,666	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,531,158	394,053	2,298,816	458,930	1,363,528	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,223,333	90,215	564,242	10	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	RENTAL	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	425,509	33,045	206,675	0	0	194.01
194.02	07952	HWY 61 BUILDING	17,782	11,902	74,438	0	0	194.02
194.03	07953	MEDICAL BUILDING	216,455	0	0	0	0	194.03
194.04	07954	PHYSICIAN OFFICES PITTSFIELD	101,726	3,769	23,573	251	0	194.04
194.05	07955	PHYSICIAN OFFICES MEXICO	22,008	11,085	69,332	0	0	194.05
194.06	07956	MENTAL HEALTH	0	9,629	60,225	0	0	194.06
194.07	07957	BOWLING GREEN/LOUISIANA CLINIC	352,687	22,352	139,797	2,663	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	28,890,658	576,050	3,437,098	461,854	1,363,528	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet B  
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2/27/2015 1:54 pm

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,754,004					10.00
11.00	01100	CAFETERIA	1,211,554	1,304,143				11.00
13.00	01300	NURSING ADMINISTRATION	0	28,142	1,244,068			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,000	0	499,590		14.00
15.00	01500	PHARMACY	0	52,131	0	0	3,946,603	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	51,194	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	468,790	295,261	822,126	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	73,660	83,520	243,982	0	0	31.00
43.00	04300	NURSERY	0	16,529	48,243	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	60,819	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	46,046	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	38,703	113,066	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	29,254	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	52,423	0	0	0	54.00
56.00	03450	RADIOISOTOPE	0	4,447	0	0	0	56.00
57.00	05700	CT SCAN	0	10,268	0	0	0	57.00
58.00	05800	MRI	0	4,242	0	0	0	58.00
60.00	06000	LABORATORY	0	93,642	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	4,008	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	38,966	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	17,084	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	7,079	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	49,439	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	8,279	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	411,863	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	87,727	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,946,603	73.00
76.00	03020	CANCER CENTER	0	20,653	0	0	0	76.00
76.01	03021	DIABETES CENTER	0	1,521	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	137,991	0	0	0	91.00
91.01	09101	OUTPATIENT PSYCH	0	0	0	0	0	91.01
91.02	09102	WOUND CARE	0	5,705	16,651	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	527	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,754,004	1,168,873	1,244,068	499,590	3,946,603	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	135,270	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	RENTAL	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	0	0	0	0	194.01
194.02	07952	HWY 61 BUILDING	0	0	0	0	0	194.02
194.03	07953	MEDICAL BUILDING	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0	0	194.04
194.05	07955	PHYSICIAN OFFICES MEXICO	0	0	0	0	0	194.05
194.06	07956	MENTAL HEALTH	0	0	0	0	0	194.06
194.07	07957	BOWLING GREEN/LOUISIANA CLINIC	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet B  
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2/27/2015 1:54 pm

Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	10.00	11.00	13.00	14.00	15.00	
202.00   TOTAL (sum lines 118-201)	1,754,004	1,304,143	1,244,068	499,590	3,946,603	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet B  
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Cost Center Description			MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	19.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
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
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,979,604					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		0				19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	1,326,351	0	16,078,595	0	16,078,595	30.00
31.00	03100	INTENSIVE CARE UNIT	257,344	0	4,574,745	0	4,574,745	31.00
43.00	04300	NURSERY	98,993	0	906,338	0	906,338	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	3,980,184	0	3,980,184	50.00
51.00	05100	RECOVERY ROOM	0	0	2,158,987	0	2,158,987	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,943,120	0	1,943,120	52.00
53.00	05300	ANESTHESIOLOGY	0	0	1,076,107	0	1,076,107	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	5,584,804	0	5,584,804	54.00
56.00	03450	RADIOISOTOPE	0	0	378,063	0	378,063	56.00
57.00	05700	CT SCAN	0	0	842,307	0	842,307	57.00
58.00	05800	MRI	0	0	493,681	0	493,681	58.00
60.00	06000	LABORATORY	0	0	6,826,268	0	6,826,268	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	819,009	0	819,009	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,751,497	0	1,751,497	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,477,952	0	1,477,952	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	173,486	0	173,486	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	3,112,486	0	3,112,486	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	319,991	0	319,991	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	10,754,212	0	10,754,212	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,678,038	0	2,678,038	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	7,976,439	0	7,976,439	73.00
76.00	03020	CANCER CENTER	0	0	2,664,599	0	2,664,599	76.00
76.01	03021	DIABETES CENTER	0	0	54,695	0	54,695	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	1,306,514	0	1,306,514	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	1,338,547	0	1,338,547	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	1,187,573	0	1,187,573	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	296,916	0	6,638,625	0	6,638,625	91.00
91.01	09101	OUTPATIENT PSYCH	0	0	0	0	0	91.01
91.02	09102	WOUND CARE	0	0	275,758	0	275,758	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	1,852,710	0	1,852,710	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,979,604	0	89,225,330	0	89,225,330	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	17,065,512	0	17,065,512	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	RENTAL	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	0	1,879,537	0	1,879,537	194.01
194.02	07952	HWY 61 BUILDING	0	0	154,867	0	154,867	194.02
194.03	07953	MEDICAL BUILDING	0	0	834,168	0	834,168	194.03
194.04	07954	PHYSICIAN OFFICES PITTSFIELD	0	0	419,621	0	419,621	194.04
194.05	07955	PHYSICIAN OFFICES MEXICO	0	0	165,231	0	165,231	194.05
194.06	07956	MENTAL HEALTH	0	0	69,854	0	69,854	194.06
194.07	07957	BOWLING GREEN/LOUISIANA CLINIC	0	0	1,523,988	0	1,523,988	194.07

COST ALLOCATION - GENERAL SERVICE COSTS

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To 09/30/2014

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2/27/2015 1:54 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	19.00	24.00	25.00	26.00	
200.00	Cross Foot Adjustments		0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,979,604	0	111,338,108	0	111,338,108	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet B Part II Date/Time Prepared: 2/27/2015 1:54 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,155	0	11,539	12,694	12,694 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	58,121	592,566	1,172,517	1,823,204	2,641 5.00
6.00 00600	MAINTENANCE & REPAIRS	1,199	0	0	1,199	82 6.00
7.00 00700	OPERATION OF PLANT	8,991	119,715	94,319	223,025	166 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	840	15,147	0	15,987	9 8.00
9.00 00900	HOUSEKEEPING	4,417	15,828	0	20,245	172 9.00
10.00 01000	DIETARY	2,030	50,633	6,526	59,189	221 10.00
11.00 01100	CAFETERIA	0	32,048	0	32,048	0 11.00
13.00 01300	NURSING ADMINISTRATION	415	3,472	11,416	15,303	173 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	679	23,215	0	23,894	37 14.00
15.00 01500	PHARMACY	3,131	28,576	225,019	256,726	437 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,444	24,882	0	26,326	209 16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	46,480	598,779	0	645,259	1,343 30.00
31.00 03100	INTENSIVE CARE UNIT	12,038	99,053	0	111,091	463 31.00
43.00 04300	NURSERY	2,348	0	0	2,348	89 43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	111,891	155,422	268,866	536,179	301 50.00
51.00 05100	RECOVERY ROOM	1,183	118,489	0	119,672	252 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,324	0	0	1,324	243 52.00
53.00 05300	ANESTHESIOLOGY	1,147	6,382	0	7,529	35 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,977	212,777	1,201,998	1,417,752	320 54.00
56.00 03450	RADIOISOTOPE	156	21,121	7,108	28,385	30 56.00
57.00 05700	CT SCAN	0	9,735	0	9,735	62 57.00
58.00 05800	MRI	0	14,364	72,532	86,896	26 58.00
60.00 06000	LABORATORY	6,353	78,851	679,333	764,537	517 60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	2,298	0	2,298	23 62.00
65.00 06500	RESPIRATORY THERAPY	27,550	10,688	1,729	39,967	212 65.00
66.00 06600	PHYSICAL THERAPY	496	39,128	8,962	48,586	101 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00 06800	SPEECH PATHOLOGY	411	0	0	411	43 68.00
69.00 06900	ELECTROCARDIOLOGY	3,226	131,935	81,294	216,455	298 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	548	2,638	0	3,186	46 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00 03020	CANCER CENTER	5,878	0	0	5,878	222 76.00
76.01 03021	DIABETES CENTER	35	0	0	35	6 76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	72,941	0	0	72,941	116 88.00
88.01 08801	RURAL HEALTH CLINIC II	1,865	0	105,100	106,965	80 88.01
88.02 08802	RURAL HEALTH CLINIC III	2,935	0	0	2,935	82 88.02
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
91.00 09100	EMERGENCY	5,195	499,742	3,634	508,571	643 91.00
91.01 09101	OUTPATIENT PSYCH	0	0	0	0	0 91.01
91.02 09102	WOUND CARE	0	0	0	0	37 91.02
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00
93.00 04040	FAMILY PRACTICE	0	0	0	0	0 93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00 09900	CMHC	0	0	0	0	0 99.00
101.00 10100	HOME HEALTH AGENCY	3,606	0	0	3,606	240 101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
114.00 11400	UTILIZATION REVIEW-SNF					114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	393,005	2,907,484	3,951,892	7,252,381	9,977 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	64,128	18,994	119,238	202,360	2,170 192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
194.00 07950	RENTAL	16,800	0	0	16,800	0 194.00
194.01 07951	CHILD DEVELOPMENT CENTER	1,604	0	0	1,604	192 194.01
194.02 07952	HWY 61 BUILDING	0	0	0	0	2 194.02
194.03 07953	MEDICAL BUILDING	364	0	0	364	120 194.03
194.04 07954	PHYSICIAN OFFICES PITTSFIELD	700	0	0	700	48 194.04
194.05 07955	PHYSICIAN OFFICES MEXICO	8,093	0	0	8,093	9 194.05
194.06 07956	MENTAL HEALTH	0	0	0	0	0 194.06

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2015 1:54 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
194.07 07957 BOWLING GREEN/LOUISIANA CLINIC	41,598	0	0	41,598	176	194.07
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0	0	0		0 201.00
202.00 TOTAL (sum lines 118-201)	526,292	2,926,478	4,071,130	7,523,900	12,694	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet B Part II Date/Time Prepared: 2/27/2015 1:54 pm				
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.00	6.00	7.00	8.00	9.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00		
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00		
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00		
5.00	00500	ADMINISTRATIVE & GENERAL	1,825,845			5.00		
6.00	00600	MAINTENANCE & REPAIRS	9,447	10,728		6.00		
7.00	00700	OPERATION OF PLANT	55,932	494	279,617	7.00		
8.00	00800	LAUNDRY & LINEN SERVICE	7,348	35	965	24,344	8.00	
9.00	00900	HOUSEKEEPING	22,125	37	1,009	0	43,588	9.00
10.00	01000	DIETARY	27,487	118	3,227	0	1,020	10.00
11.00	01100	CAFETERIA	710	75	2,042	0	645	11.00
13.00	01300	NURSING ADMINISTRATION	19,853	8	221	0	70	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,427	54	1,480	0	468	14.00
15.00	01500	PHARMACY	63,146	67	1,821	0	576	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	30,997	58	1,586	0	501	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	197,750	1,397	38,161	9,823	12,061	30.00
31.00	03100	INTENSIVE CARE UNIT	61,255	231	6,313	1,511	1,995	31.00
43.00	04300	NURSERY	12,178	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	59,136	363	9,905	3,913	3,130	50.00
51.00	05100	RECOVERY ROOM	31,408	276	7,552	814	2,386	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,377	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	17,007	15	407	0	129	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	84,469	549	15,009	1,771	4,285	54.00
56.00	03450	RADIOISOTOPE	5,594	49	1,346	0	425	56.00
57.00	05700	CT SCAN	13,399	23	620	0	196	57.00
58.00	05800	MRI	7,664	34	915	0	289	58.00
60.00	06000	LABORATORY	108,099	234	6,406	0	1,588	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	13,308	5	146	0	46	62.00
65.00	06500	RESPIRATORY THERAPY	27,482	77	2,104	0	215	65.00
66.00	06600	PHYSICAL THERAPY	22,539	156	4,264	56	788	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,729	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	46,672	308	8,408	741	2,657	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,008	6	168	119	53	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	169,609	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42,480	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	66,087	0	0	0	0	73.00
76.00	03020	CANCER CENTER	38,735	707	19,307	354	0	76.00
76.01	03021	DIABETES CENTER	872	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	20,611	127	3,471	11	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	20,049	298	8,129	7	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	18,015	228	6,223	17	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	87,555	1,166	31,849	5,053	10,065	91.00
91.01	09101	OUTPATIENT PSYCH	0	0	0	0	0	91.01
91.02	09102	WOUND CARE	4,156	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	29,449	145	3,959	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,487,164	7,340	187,013	24,190	43,588	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	266,875	1,680	45,904	1	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	RENTAL	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	26,892	615	16,814	0	0	194.01
194.02	07952	HWY 61 BUILDING	1,124	222	6,056	0	0	194.02
194.03	07953	MEDICAL BUILDING	13,680	0	0	0	0	194.03
194.04	07954	PHYSICIAN OFFICES PITTSFIELD	6,429	70	1,918	13	0	194.04
194.05	07955	PHYSICIAN OFFICES MEXICO	1,391	206	5,640	0	0	194.05
194.06	07956	MENTAL HEALTH	0	179	4,899	0	0	194.06
194.07	07957	BOWLING GREEN/LOUISIANA CLINIC	22,290	416	11,373	140	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,825,845	10,728	279,617	24,344	43,588	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet B Part II Date/Time Prepared: 2/27/2015 1:54 pm		
Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY
		10.00	11.00	13.00	14.00	15.00
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
6.00	00600					6.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000	91,262				10.00
11.00	01100	63,038	98,558			11.00
13.00	01300	0	2,127	37,755		13.00
14.00	01400	0	831	0	34,191	14.00
15.00	01500	0	3,940	0	0	326,713
16.00	01600	0	3,869	0	0	0
19.00	01900	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	24,391	22,312	24,951	0	0
31.00	03100	3,833	6,312	7,404	0	0
43.00	04300	0	1,249	1,464	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	0	4,596	0	0	0
51.00	05100	0	3,480	0	0	0
52.00	05200	0	2,925	3,431	0	0
53.00	05300	0	2,211	0	0	0
54.00	05400	0	3,962	0	0	0
56.00	03450	0	336	0	0	0
57.00	05700	0	776	0	0	0
58.00	05800	0	321	0	0	0
60.00	06000	0	7,077	0	0	0
62.00	06200	0	303	0	0	0
65.00	06500	0	2,945	0	0	0
66.00	06600	0	1,291	0	0	0
67.00	06700	0	0	0	0	0
68.00	06800	0	535	0	0	0
69.00	06900	0	3,736	0	0	0
70.00	07000	0	626	0	0	0
71.00	07100	0	0	0	28,187	0
72.00	07200	0	0	0	6,004	0
73.00	07300	0	0	0	0	326,713
76.00	03020	0	1,561	0	0	0
76.01	03021	0	115	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	0	0	0	0	0
88.01	08801	0	0	0	0	0
88.02	08802	0	0	0	0	0
89.00	08900	0	0	0	0	0
91.00	09100	0	10,428	0	0	0
91.01	09101	0	0	0	0	0
91.02	09102	0	431	505	0	0
92.00	09200	0	0	0	0	0
93.00	04040	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00	09900	0	0	0	0	0
101.00	10100	0	40	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300					113.00
114.00	11400					114.00
118.00		91,262	88,335	37,755	34,191	326,713
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	0	0	0	0	0
192.00	19200	0	10,223	0	0	0
193.00	19300	0	0	0	0	0
194.00	07950	0	0	0	0	0
194.01	07951	0	0	0	0	0
194.02	07952	0	0	0	0	0
194.03	07953	0	0	0	0	0
194.04	07954	0	0	0	0	0
194.05	07955	0	0	0	0	0
194.06	07956	0	0	0	0	0
194.07	07957	0	0	0	0	0
200.00						200.00
201.00						201.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 260025			Period: From 10/01/2013 To 09/30/2014		Worksheet B Part II Date/Time Prepared: 2/27/2015 1:54 pm	
Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY		
		10.00	11.00	13.00	14.00	15.00		
202.00	TOTAL (sum lines 118-201)	91,262	98,558	37,755	34,191	326,713	202.00	

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 260025		Period: From 10/01/2013 To 09/30/2014		Worksheet B Part II Date/Time Prepared: 2/27/2015 1:54 pm	
Cost Center Description		MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	19.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
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
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	63,546				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0			19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	42,576		1,020,024	0	1,020,024
31.00	03100	INTENSIVE CARE UNIT	8,261		208,669	0	208,669
43.00	04300	NURSERY	3,178		20,506	0	20,506
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0		617,523	0	617,523
51.00	05100	RECOVERY ROOM	0		165,840	0	165,840
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		37,300	0	37,300
53.00	05300	ANESTHESIOLOGY	0		27,333	0	27,333
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		1,528,117	0	1,528,117
56.00	03450	RADIOISOTOPE	0		36,165	0	36,165
57.00	05700	CT SCAN	0		24,811	0	24,811
58.00	05800	MRI	0		96,145	0	96,145
60.00	06000	LABORATORY	0		888,458	0	888,458
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0		16,129	0	16,129
65.00	06500	RESPIRATORY THERAPY	0		73,002	0	73,002
66.00	06600	PHYSICAL THERAPY	0		77,781	0	77,781
67.00	06700	OCCUPATIONAL THERAPY	0		0	0	0
68.00	06800	SPEECH PATHOLOGY	0		3,718	0	3,718
69.00	06900	ELECTROCARDIOLOGY	0		279,275	0	279,275
70.00	07000	ELECTROENCEPHALOGRAPHY	0		9,212	0	9,212
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		197,796	0	197,796
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		48,484	0	48,484
73.00	07300	DRUGS CHARGED TO PATIENTS	0		392,800	0	392,800
76.00	03020	CANCER CENTER	0		66,764	0	66,764
76.01	03021	DIABETES CENTER	0		1,028	0	1,028
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0		97,277	0	97,277
88.01	08801	RURAL HEALTH CLINIC II	0		135,528	0	135,528
88.02	08802	RURAL HEALTH CLINIC III	0		27,500	0	27,500
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0
91.00	09100	EMERGENCY	9,531		664,861	0	664,861
91.01	09101	OUTPATIENT PSYCH	0		0	0	0
91.02	09102	WOUND CARE	0		5,129	0	5,129
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0	0	0
93.00	04040	FAMILY PRACTICE	0		0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	09900	CMHC	0		0	0	0
101.00	10100	HOME HEALTH AGENCY	0		37,439	0	37,439
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	63,546	0	6,804,614	0	6,804,614
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		529,213	0	529,213
193.00	19300	NONPAID WORKERS	0		0	0	193.00
194.00	07950	RENTAL	0		16,800	0	16,800
194.01	07951	CHILD DEVELOPMENT CENTER	0		46,117	0	46,117
194.02	07952	HWY 61 BUILDING	0		7,404	0	7,404
194.03	07953	MEDICAL BUILDING	0		14,164	0	14,164
194.04	07954	PHYSICIAN OFFICES PITTSFIELD	0		9,178	0	9,178
194.05	07955	PHYSICIAN OFFICES MEXICO	0		15,339	0	15,339
194.06	07956	MENTAL HEALTH	0		5,078	0	5,078
194.07	07957	BOWLING GREEN/LOUISIANA CLINIC	0		75,993	0	75,993

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2015 1:54 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	19.00	24.00	25.00	26.00	
200.00	Cross Foot Adjustments		0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	63,546	0	7,523,900	0	7,523,900	202.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet B-1 Date/Time Prepared: 2/27/2015 1:54 pm
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	171,949				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		3,532,249			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	10,012	44,131,773		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	34,817	1,017,315	9,221,367	-28,890,658	82,447,450
6.00 00600	MAINTENANCE & REPAIRS	0	0	285,096	0	426,573
7.00 00700	OPERATION OF PLANT	7,034	81,834	576,867	0	2,525,592
8.00 00800	LAUNDRY & LINEN SERVICE	890	0	31,136	0	331,818
9.00 00900	HOUSEKEEPING	930	0	597,133	0	999,061
10.00 01000	DIETARY	2,975	5,662	768,993	0	1,241,173
11.00 01100	CAFETERIA	1,883	0	0	0	32,048
13.00 01300	NURSING ADMINISTRATION	204	9,905	601,287	0	896,455
14.00 01400	CENTRAL SERVICES & SUPPLY	1,364	0	130,027	0	335,357
15.00 01500	PHARMACY	1,679	195,234	1,515,939	0	2,851,352
16.00 01600	MEDICAL RECORDS & LIBRARY	1,462	0	726,176	0	1,399,663
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	35,182	0	4,663,357	0	8,929,392
31.00 03100	INTENSIVE CARE UNIT	5,820	0	1,606,190	0	2,765,945
43.00 04300	NURSERY	0	0	309,773	0	549,886
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	9,132	233,277	1,045,798	0	2,670,288
51.00 05100	RECOVERY ROOM	6,962	0	875,988	0	1,418,222
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	842,591	0	1,326,521
53.00 05300	ANESTHESIOLOGY	375	0	120,035	0	767,938
54.00 05400	RADIOLOGY-DIAGNOSTIC	12,502	1,042,895	1,112,310	0	3,814,198
56.00 03450	RADIOISOTOPE	1,241	6,167	105,329	0	252,602
57.00 05700	CT SCAN	572	0	216,718	0	605,045
58.00 05800	MRI	844	62,931	88,960	0	346,070
60.00 06000	LABORATORY	4,633	589,412	1,796,869	0	4,881,182
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	135	0	78,807	0	600,901
65.00 06500	RESPIRATORY THERAPY	628	1,500	737,014	0	1,240,950
66.00 06600	PHYSICAL THERAPY	2,299	7,776	351,460	0	1,017,735
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 06800	SPEECH PATHOLOGY	0	0	148,264	0	123,227
69.00 06900	ELECTROCARDIOLOGY	7,752	70,533	1,033,165	0	2,107,486
70.00 07000	ELECTROENCEPHALOGRAPHY	155	0	158,956	0	226,149
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	7,658,656
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,918,162
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,984,151
76.00 03020	CANCER CENTER	0	0	770,572	0	1,749,066
76.01 03021	DIABETES CENTER	0	0	22,095	0	39,376
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	402,048	0	930,687
88.01 08801	RURAL HEALTH CLINIC II	0	91,188	278,585	0	905,290
88.02 08802	RURAL HEALTH CLINIC III	0	0	285,191	0	813,475
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
91.00 09100	EMERGENCY	29,363	3,153	2,231,571	0	3,953,537
91.01 09101	OUTPATIENT PSYCH	0	0	0	0	0
91.02 09102	WOUND CARE	0	0	129,203	0	187,648
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
93.00 04040	FAMILY PRACTICE	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00 09900	CMHC	0	0	0	0	0
101.00 10100	HOME HEALTH AGENCY	0	0	831,832	0	1,329,768
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
114.00 11400	UTILIZATION REVIEW-SNF					114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	170,833	3,428,794	34,696,702	-28,890,658	67,152,645
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	1,116	103,455	7,534,518	0	12,052,442
193.00 19300	NONPAID WORKERS	0	0	0	0	0
194.00 07950	RENTAL	0	0	0	0	0
194.01 07951	CHILD DEVELOPMENT CENTER	0	0	666,310	0	1,214,308
194.02 07952	HWY 61 BUILDING	0	0	7,382	0	50,745
194.03 07953	MEDICAL BUILDING	0	0	417,634	0	617,713
194.04 07954	PHYSICIAN OFFICES PITTSFIELD	0	0	165,951	0	290,302
194.05 07955	PHYSICIAN OFFICES MEXICO	0	0	32,319	0	62,806

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet B-1  
Date/Time Prepared:  
2/27/2015 1:54 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
194.06 07956 MENTAL HEALTH	0	0	0	0	0	0	194.06
194.07 07957 BOWLING GREEN/LOUISIANA CLINIC	0	0	610,957	0	1,006,489	0	194.07
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)	2,926,478	4,071,130	13,706,842		28,890,658		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	17.019453	1.152560	0.310589		0.350413		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			12,694		1,825,845		204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.000288		0.022146		205.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 260025		Period: From 10/01/2013 To 09/30/2014		Worksheet B-1	
Date/Time Prepared: 2/27/2015 1:54 pm							
Cost Center	Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	270,222					6.00
7.00	00700	12,434	257,788				7.00
8.00	00800	890	890	499,595			8.00
9.00	00900	930	930	0	127,162		9.00
10.00	01000	2,975	2,975	0	2,975	247,646	10.00
11.00	01100	1,883	1,883	0	1,883	171,058	11.00
13.00	01300	204	204	0	204	0	13.00
14.00	01400	1,364	1,364	0	1,364	0	14.00
15.00	01500	1,679	1,679	0	1,679	0	15.00
16.00	01600	1,462	1,462	0	1,462	0	16.00
19.00	01900	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	35,182	35,182	201,598	35,182	66,188	30.00
31.00	03100	5,820	5,820	31,002	5,820	10,400	31.00
43.00	04300	0	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	9,132	9,132	80,295	9,132	0	50.00
51.00	05100	6,962	6,962	16,699	6,962	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	375	375	0	375	0	53.00
54.00	05400	13,837	13,837	36,341	12,502	0	54.00
56.00	03450	1,241	1,241	0	1,241	0	56.00
57.00	05700	572	572	0	572	0	57.00
58.00	05800	844	844	0	844	0	58.00
60.00	06000	5,906	5,906	0	4,633	0	60.00
62.00	06200	135	135	0	135	0	62.00
65.00	06500	1,940	1,940	0	628	0	65.00
66.00	06600	3,931	3,931	1,148	2,299	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	7,752	7,752	15,214	7,752	0	69.00
70.00	07000	155	155	2,443	155	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03020	17,800	17,800	7,260	0	0	76.00
76.01	03021	0	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	3,200	3,200	231	0	0	88.00
88.01	08801	7,494	7,494	150	0	0	88.01
88.02	08802	5,737	5,737	351	0	0	88.02
89.00	08900	0	0	0	0	0	89.00
91.00	09100	29,363	29,363	103,699	29,363	0	91.00
91.01	09101	0	0	0	0	0	91.01
91.02	09102	0	0	0	0	0	91.02
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	09900	0	0	0	0	0	99.00
101.00	10100	3,650	3,650	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
114.00	11400						114.00
118.00		184,849	172,415	496,431	127,162	247,646	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	42,319	42,319	11	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	15,501	15,501	0	0	0	194.01
194.02	07952	5,583	5,583	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	1,768	1,768	272	0	0	194.04
194.05	07955	5,200	5,200	0	0	0	194.05
194.06	07956	4,517	4,517	0	0	0	194.06
194.07	07957	10,485	10,485	2,881	0	0	194.07
200.00							200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet B-1

Date/Time Prepared:  
2/27/2015 1:54 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	576,050	3,437,098	461,854	1,363,528	1,754,004	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	2.131766	13.333041	0.924457	10.722763	7.082707	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	10,728	279,617	24,344	43,588	91,262	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.039701	1.084678	0.048727	0.342775	0.368518	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet B-1

Date/Time Prepared:  
2/27/2015 1:54 pm

Cost Center Description			CAFETERIA (FTES)	NURSING ADMINISTRATIVE (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	44,580					11.00
13.00	01300	NURSING ADMINISTRATION	962	302,825				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	376	0	10,923,634			14.00
15.00	01500	PHARMACY	1,782	0	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,750	0	0	0	32,016	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	10,093	200,118	0	0	21,451	30.00
31.00	03100	INTENSIVE CARE UNIT	2,855	59,389	0	0	4,162	31.00
43.00	04300	NURSERY	565	11,743	0	0	1,601	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	2,079	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	1,574	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,323	27,522	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,792	0	0	0	0	54.00
56.00	03450	RADIOISOTOPE	152	0	0	0	0	56.00
57.00	05700	CT SCAN	351	0	0	0	0	57.00
58.00	05800	MRI	145	0	0	0	0	58.00
60.00	06000	LABORATORY	3,201	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	137	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,332	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	584	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	242	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,690	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	283	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	9,005,472	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,918,162	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	0	73.00
76.00	03020	CANCER CENTER	706	0	0	0	0	76.00
76.01	03021	DIABETES CENTER	52	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	4,717	0	0	0	4,802	91.00
91.01	09101	OUTPATIENT PSYCH	0	0	0	0	0	91.01
91.02	09102	WOUND CARE	195	4,053	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	18	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	39,956	302,825	10,923,634	100	32,016	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,624	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	RENTAL	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	0	0	0	0	194.01
194.02	07952	HWY 61 BUILDING	0	0	0	0	0	194.02
194.03	07953	MEDICAL BUILDING	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0	0	194.04
194.05	07955	PHYSICIAN OFFICES MEXICO	0	0	0	0	0	194.05
194.06	07956	MENTAL HEALTH	0	0	0	0	0	194.06
194.07	07957	BOWLING GREEN/LOUISIANA CLINIC	0	0	0	0	0	194.07

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet B-1  
Date/Time Prepared:  
2/27/2015 1:54 pm

Cost Center Description		CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
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)	1,304,143	1,244,068	499,590	3,946,603	1,979,604	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	29.253993	4.108208	0.045735	39,466.030000	61.831709	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	98,558	37,755	34,191	326,713	63,546	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	2.210812	0.124676	0.003130	3,267.130000	1.984820	205.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet B-1 Date/Time Prepared: 2/27/2015 1:54 pm
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Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
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
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
43.00	04300	NURSERY	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	03450	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
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
76.00	03020	CANCER CENTER	76.00
76.01	03021	DIABETES CENTER	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00	08800	RURAL HEALTH CLINIC	88.00
88.01	08801	RURAL HEALTH CLINIC II	88.01
88.02	08802	RURAL HEALTH CLINIC III	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	89.00
91.00	09100	EMERGENCY	91.00
91.01	09101	OUTPATIENT PSYCH	91.01
91.02	09102	WOUND CARE	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.00	04040	FAMILY PRACTICE	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
99.00	09900	CMHC	99.00
101.00	10100	HOME HEALTH AGENCY	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00	11300	INTEREST EXPENSE	113.00
114.00	11400	UTILIZATION REVIEW-SNF	114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
194.00	07950	RENTAL	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	194.01
194.02	07952	HWY 61 BUILDING	194.02
194.03	07953	MEDICAL BUILDING	194.03
194.04	07954	PHYSICIAN OFFICES PITTSFIELD	194.04
194.05	07955	PHYSICIAN OFFICES MEXICO	194.05
194.06	07956	MENTAL HEALTH	194.06
194.07	07957	BOWLING GREEN/LOUISIANA CLINIC	194.07
200.00		Cross Foot Adjustments	200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet B-1  
Date/Time Prepared:  
2/27/2015 1:54 pm

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
201.00	Negative Cost Centers		201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	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

Provider CCN: 260025

Period:  
 From 10/01/2013  
 To 09/30/2014

Worksheet B-2  
 Date/Time Prepared:  
 2/27/2015 1:54 pm

	Description	Worksheet		Amount	
		Part	Line No.		
	1.00	2.00	3.00	4.00	
1.00	ADJ FOR EPO COSTS IN RENAL DIALYSIS		1 74.00	0	1.00
2.00	ADJ FOR EPO COSTS IN HOME PROGRAM		1 94.00	0	2.00
3.00	ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1 74.00	0	3.00
4.00	ADJ FOR ARANESP COSTS IN HOME PROGRAM		1 94.00	0	4.00
5.00	ADJ FOR ESA COSTS IN RENAL DIALYSIS		1 74.00	0	5.00
6.00	ADJ FOR ESA COSTS IN HOME PROGRAM		1 94.00	0	6.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2015 1:54 pm

		Title XVIII		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	16,078,595		16,078,595	0	16,078,595	30.00
31.00	03100 INTENSIVE CARE UNIT	4,574,745		4,574,745	0	4,574,745	31.00
43.00	04300 NURSERY	906,338		906,338	0	906,338	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	3,980,184		3,980,184	39,092	4,019,276	50.00
51.00	05100 RECOVERY ROOM	2,158,987		2,158,987	0	2,158,987	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,943,120		1,943,120	0	1,943,120	52.00
53.00	05300 ANESTHESIOLOGY	1,076,107		1,076,107	55,415	1,131,522	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,584,804		5,584,804	0	5,584,804	54.00
56.00	03450 RADIOISOTOPE	378,063		378,063	0	378,063	56.00
57.00	05700 CT SCAN	842,307		842,307	0	842,307	57.00
58.00	05800 MRI	493,681		493,681	0	493,681	58.00
60.00	06000 LABORATORY	6,826,268		6,826,268	109,673	6,935,941	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	819,009		819,009	0	819,009	62.00
65.00	06500 RESPIRATORY THERAPY	1,751,497	0	1,751,497	0	1,751,497	65.00
66.00	06600 PHYSICAL THERAPY	1,477,952	0	1,477,952	0	1,477,952	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	173,486	0	173,486	0	173,486	68.00
69.00	06900 ELECTROCARDIOLOGY	3,112,486		3,112,486	0	3,112,486	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	319,991		319,991	0	319,991	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10,754,212		10,754,212	0	10,754,212	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2,678,038		2,678,038	0	2,678,038	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7,976,439		7,976,439	0	7,976,439	73.00
76.00	03020 CANCER CENTER	2,664,599		2,664,599	32,726	2,697,325	76.00
76.01	03021 DIABETES CENTER	54,695		54,695	0	54,695	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	1,306,514		1,306,514	0	1,306,514	88.00
88.01	08801 RURAL HEALTH CLINIC II	1,338,547		1,338,547	0	1,338,547	88.01
88.02	08802 RURAL HEALTH CLINIC III	1,187,573		1,187,573	0	1,187,573	88.02
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
91.00	09100 EMERGENCY	6,638,625		6,638,625	139,669	6,778,294	91.00
91.01	09101 OUTPATIENT PSYCH	0		0	0	0	91.01
91.02	09102 WOUND CARE	275,758		275,758	0	275,758	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,497,785		1,497,785	0	1,497,785	92.00
93.00	04040 FAMILY PRACTICE	0		0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	09900 CMHC	0		0	0	0	99.00
101.00	10100 HOME HEALTH AGENCY	1,852,710		1,852,710	0	1,852,710	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
114.00	11400 UTILIZATION REVIEW-SNF						114.00
200.00	Subtotal (see instructions)	90,723,115	0	90,723,115	376,575	91,099,690	200.00
201.00	Less Observation Beds	1,497,785		1,497,785		1,497,785	201.00
202.00	Total (see instructions)	89,225,330	0	89,225,330	376,575	89,601,905	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2015 1:54 pm

		Title XVII			Hospital	PPS	
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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	5,854,573		5,854,573		30.00
31.00	03100	INTENSIVE CARE UNIT	1,877,659		1,877,659		31.00
43.00	04300	NURSERY	375,169		375,169		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	7,978,520	12,580,739	20,559,259	0.193596	50.00
51.00	05100	RECOVERY ROOM	1,385,969	2,379,949	3,765,918	0.573296	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	943,958	156	944,114	2.058141	52.00
53.00	05300	ANESTHESIOLOGY	3,001,052	2,589,956	5,591,008	0.192471	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,765,640	6,175,103	8,940,743	0.624647	54.00
56.00	03450	RADIOISOTOPE	444,461	2,158,382	2,602,843	0.145250	56.00
57.00	05700	CT SCAN	3,587,325	11,589,006	15,176,331	0.055501	57.00
58.00	05800	MRI	708,159	3,993,144	4,701,303	0.105009	58.00
60.00	06000	LABORATORY	11,300,061	22,072,010	33,372,071	0.204550	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	742,507	463,548	1,206,055	0.679081	62.00
65.00	06500	RESPIRATORY THERAPY	570,476	210,825	781,301	2.241770	65.00
66.00	06600	PHYSICAL THERAPY	915,652	448,650	1,364,302	1.083303	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	55,813	61,041	116,854	1.484639	68.00
69.00	06900	ELECTROCARDIOLOGY	3,806,938	8,665,320	12,472,258	0.249553	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	26,678	695,282	721,960	0.443225	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	59,904,022	29,869,444	89,773,466	0.119793	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	460,220	4,538,498	4,998,718	0.535745	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,045,358	20,225,144	49,270,502	0.161891	73.00
76.00	03020	CANCER CENTER	74,822	6,885,405	6,960,227	0.382832	76.00
76.01	03021	DIABETES CENTER	0	9,857	9,857	5.548849	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	763,840	763,840		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	822,771	822,771		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,120,232	1,120,232		88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	404,662	2,222,191	2,626,853	2.527216	91.00
91.01	09101	OUTPATIENT PSYCH	0	0	0	0.000000	91.01
91.02	09102	WOUND CARE	0	49,878	49,878	5.528650	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	242,190	1,058,460	1,300,650	1.151567	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0.000000	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	09900	CMHC	0	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	0	952,154	952,154		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
200.00		Subtotal (see instructions)	136,471,884	142,600,985	279,072,869		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	136,471,884	142,600,985	279,072,869		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2015 1:54 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.195497			50.00
51.00	05100 RECOVERY ROOM	0.573296			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2.058141			52.00
53.00	05300 ANESTHESIOLOGY	0.202382			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.624647			54.00
56.00	03450 RADIOISOTOPE	0.145250			56.00
57.00	05700 CT SCAN	0.055501			57.00
58.00	05800 MRI	0.105009			58.00
60.00	06000 LABORATORY	0.207837			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.679081			62.00
65.00	06500 RESPIRATORY THERAPY	2.241770			65.00
66.00	06600 PHYSICAL THERAPY	1.083303			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	1.484639			68.00
69.00	06900 ELECTROCARDIOLOGY	0.249553			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.443225			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.119793			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.535745			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.161891			73.00
76.00	03020 CANCER CENTER	0.387534			76.00
76.01	03021 DIABETES CENTER	5.548849			76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC				88.00
88.01	08801 RURAL HEALTH CLINIC II				88.01
88.02	08802 RURAL HEALTH CLINIC III				88.02
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER				89.00
91.00	09100 EMERGENCY	2.580386			91.00
91.01	09101 OUTPATIENT PSYCH	0.000000			91.01
91.02	09102 WOUND CARE	5.528650			91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.151567			92.00
93.00	04040 FAMILY PRACTICE	0.000000			93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.00	09900 CMHC				99.00
101.00	10100 HOME HEALTH AGENCY				101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300 INTEREST EXPENSE				113.00
114.00	11400 UTILIZATION REVIEW-SNF				114.00
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: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2015 1:54 pm

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		16,078,595	0	16,078,595	30.00
31.00	03100 INTENSIVE CARE UNIT		4,574,745	0	4,574,745	31.00
43.00	04300 NURSERY		906,338	0	906,338	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		3,980,184	39,092	4,019,276	50.00
51.00	05100 RECOVERY ROOM		2,158,987	0	2,158,987	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		1,943,120	0	1,943,120	52.00
53.00	05300 ANESTHESIOLOGY		1,076,107	55,415	1,131,522	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		5,584,804	0	5,584,804	54.00
56.00	03450 RADIOISOTOPE		378,063	0	378,063	56.00
57.00	05700 CT SCAN		842,307	0	842,307	57.00
58.00	05800 MRI		493,681	0	493,681	58.00
60.00	06000 LABORATORY		6,826,268	109,673	6,935,941	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		819,009	0	819,009	62.00
65.00	06500 RESPIRATORY THERAPY	0	1,751,497	0	1,751,497	65.00
66.00	06600 PHYSICAL THERAPY	0	1,477,952	0	1,477,952	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	173,486	0	173,486	68.00
69.00	06900 ELECTROCARDIOLOGY		3,112,486	0	3,112,486	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		319,991	0	319,991	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		10,754,212	0	10,754,212	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		2,678,038	0	2,678,038	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		7,976,439	0	7,976,439	73.00
76.00	03020 CANCER CENTER		2,664,599	32,726	2,697,325	76.00
76.01	03021 DIABETES CENTER		54,695	0	54,695	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC		1,306,514	0	1,306,514	88.00
88.01	08801 RURAL HEALTH CLINIC II		1,338,547	0	1,338,547	88.01
88.02	08802 RURAL HEALTH CLINIC III		1,187,573	0	1,187,573	88.02
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
91.00	09100 EMERGENCY		6,638,625	139,669	6,778,294	91.00
91.01	09101 OUTPATIENT PSYCH		0	0	0	91.01
91.02	09102 WOUND CARE		275,758	0	275,758	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		1,497,785	0	1,497,785	92.00
93.00	04040 FAMILY PRACTICE		0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00	09900 CMHC		0	0	0	99.00
101.00	10100 HOME HEALTH AGENCY		1,852,710	0	1,852,710	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
114.00	11400 UTILIZATION REVIEW-SNF					114.00
200.00	Subtotal (see instructions)		90,723,115	376,575	91,099,690	200.00
201.00	Less Observation Beds		1,497,785	0	1,497,785	201.00
202.00	Total (see instructions)		89,225,330	376,575	89,601,905	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 260025		Period: From 10/01/2013 To 09/30/2014		Worksheet C Part I Date/Time Prepared: 2/27/2015 1:54 pm	
			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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	5,854,573		5,854,573			30.00
31.00	03100	INTENSIVE CARE UNIT	1,877,659		1,877,659			31.00
43.00	04300	NURSERY	375,169		375,169			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	7,978,520	12,580,739	20,559,259	0.193596	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,385,969	2,379,949	3,765,918	0.573296	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	943,958	156	944,114	2.058141	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	3,001,052	2,589,956	5,591,008	0.192471	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,765,640	6,175,103	8,940,743	0.624647	0.000000	54.00
56.00	03450	RADIOISOTOPE	444,461	2,158,382	2,602,843	0.145250	0.000000	56.00
57.00	05700	CT SCAN	3,587,325	11,589,006	15,176,331	0.055501	0.000000	57.00
58.00	05800	MRI	708,159	3,993,144	4,701,303	0.105009	0.000000	58.00
60.00	06000	LABORATORY	11,300,061	22,072,010	33,372,071	0.204550	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	742,507	463,548	1,206,055	0.679081	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	570,476	210,825	781,301	2.241770	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	915,652	448,650	1,364,302	1.083303	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	55,813	61,041	116,854	1.484639	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	3,806,938	8,665,320	12,472,258	0.249553	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	26,678	695,282	721,960	0.443225	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	59,904,022	29,869,444	89,773,466	0.119793	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	460,220	4,538,498	4,998,718	0.535745	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,045,358	20,225,144	49,270,502	0.161891	0.000000	73.00
76.00	03020	CANCER CENTER	74,822	6,885,405	6,960,227	0.382832	0.000000	76.00
76.01	03021	DIABETES CENTER	0	9,857	9,857	5.548849	0.000000	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	763,840	763,840	1.710455	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	822,771	822,771	1.626877	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,120,232	1,120,232	1.060113	0.000000	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
91.00	09100	EMERGENCY	404,662	2,222,191	2,626,853	2.527216	0.000000	91.00
91.01	09101	OUTPATIENT PSYCH	0	0	0	0.000000	0.000000	91.01
91.02	09102	WOUND CARE	0	49,878	49,878	5.528650	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	242,190	1,058,460	1,300,650	1.151567	0.000000	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0.000000	0.000000	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.00	09900	CMHC	0	0	0			99.00
101.00	10100	HOME HEALTH AGENCY	0	952,154	952,154			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
200.00		Subtotal (see instructions)	136,471,884	142,600,985	279,072,869			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	136,471,884	142,600,985	279,072,869			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet C Part I Date/Time Prepared: 2/27/2015 1:54 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
	<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	03450 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
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
76.00	03020 CANCER CENTER	0.000000		76.00
76.01	03021 DIABETES CENTER	0.000000		76.01
	<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000		88.02
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
91.00	09100 EMERGENCY	0.000000		91.00
91.01	09101 OUTPATIENT PSYCH	0.000000		91.01
91.02	09102 WOUND CARE	0.000000		91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04040 FAMILY PRACTICE	0.000000		93.00
	<b>OTHER REIMBURSABLE COST CENTERS</b>			
99.00	09900 CMHC			99.00
101.00	10100 HOME HEALTH AGENCY			101.00
	<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00	11300 INTEREST EXPENSE			113.00
114.00	11400 UTILIZATION REVIEW-SNF			114.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 260025		Period: From 10/01/2013 To 09/30/2014		Worksheet D Part I Date/Time Prepared: 2/27/2015 1:54 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
Title XVII		Hospital		PPS			
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,020,024	0	1,020,024	15,426	66.12	30.00
31.00	INTENSIVE CARE UNIT	208,669		208,669	2,198	94.94	31.00
43.00	NURSERY	20,506		20,506	1,377	14.89	43.00
200.00	Total (Lines 30-199)	1,249,199		1,249,199	19,001		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	8,603	568,830				30.00
31.00	INTENSIVE CARE UNIT	1,452	137,853				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (Lines 30-199)	10,055	706,683				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part II Date/Time Prepared: 2/27/2015 1:54 pm
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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	617,523	20,559,259	0.030036	5,962,361	179,085	50.00
51.00	05100 RECOVERY ROOM	165,840	3,765,918	0.044037	704,644	31,030	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	37,300	944,114	0.039508	2,692	106	52.00
53.00	05300 ANESTHESIOLOGY	27,333	5,591,008	0.004889	1,696,829	8,296	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,528,117	8,940,743	0.170916	1,791,446	306,187	54.00
56.00	03450 RADIOISOTOPE	36,165	2,602,843	0.013894	349,060	4,850	56.00
57.00	05700 CT SCAN	24,811	15,176,331	0.001635	2,361,707	3,861	57.00
58.00	05800 MRI	96,145	4,701,303	0.020451	451,171	9,227	58.00
60.00	06000 LABORATORY	888,458	33,372,071	0.026623	7,511,547	199,980	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	16,129	1,206,055	0.013373	378,788	5,066	62.00
65.00	06500 RESPIRATORY THERAPY	73,002	781,301	0.093436	351,168	32,812	65.00
66.00	06600 PHYSICAL THERAPY	77,781	1,364,302	0.057012	703,360	40,100	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	3,718	116,854	0.031817	15,803	503	68.00
69.00	06900 ELECTROCARDIOLOGY	279,275	12,472,258	0.022392	1,974,065	44,203	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	9,212	721,960	0.012760	16,636	212	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	197,796	89,773,466	0.002203	30,200,301	66,531	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	48,484	4,998,718	0.009699	238,105	2,309	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	392,800	49,270,502	0.007972	14,905,990	118,831	73.00
76.00	03020 CANCER CENTER	66,764	6,960,227	0.009592	74,822	718	76.00
76.01	03021 DIABETES CENTER	1,028	9,857	0.104291	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	97,277	763,840	0.127353	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	135,528	822,771	0.164721	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	27,500	1,120,232	0.024548	0	0	88.02
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100 EMERGENCY	664,861	2,626,853	0.253102	341,820	86,515	91.00
91.01	09101 OUTPATIENT PSYCH	0	0	0.000000	0	0	91.01
91.02	09102 WOUND CARE	5,129	49,878	0.102831	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	95,019	1,300,650	0.073055	201,480	14,719	92.00
93.00	04040 FAMILY PRACTICE	0	0	0.000000	0	0	93.00
200.00	Total (lines 50-199)	5,612,995	270,013,314		70,233,795	1,155,141	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 260025		Period: From 10/01/2013 To 09/30/2014		Worksheet D Part III Date/Time Prepared: 2/27/2015 1:54 pm	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see instructions)	PPS Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,426	0.00	8,603	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,198	0.00	1,452	0		31.00
43.00	04300	NURSERY	1,377	0.00	0	0		43.00
200.00		Total (lines 30-199)	19,001		10,055	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet D  
Part IV  
Date/Time Prepared:  
2/27/2015 1:54 pm

Cost Center Description		Title XVIII				Hospital		PPS	
		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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
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
56.00	03450	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	0	58.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
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
76.00	03020	CANCER CENTER	0	0	0	0	0	0	76.00
76.01	03021	DIABETES CENTER	0	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	0	88.02
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
91.01	09101	OUTPATIENT PSYCH	0	0	0	0	0	0	91.01
91.02	09102	WOUND CARE	0	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	0	93.00
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: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet D  
Part IV  
Date/Time Prepared:  
2/27/2015 1:54 pm

Cost Center Description			Title XVIII			Hospital		PPS	
			Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
			6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	0	20,559,259	0.000000	0.000000	5,962,361	50.00	
51.00	05100	RECOVERY ROOM	0	3,765,918	0.000000	0.000000	704,644	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	944,114	0.000000	0.000000	2,692	52.00	
53.00	05300	ANESTHESIOLOGY	0	5,591,008	0.000000	0.000000	1,696,829	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,940,743	0.000000	0.000000	1,791,446	54.00	
56.00	03450	RADIOISOTOPE	0	2,602,843	0.000000	0.000000	349,060	56.00	
57.00	05700	CT SCAN	0	15,176,331	0.000000	0.000000	2,361,707	57.00	
58.00	05800	MRI	0	4,701,303	0.000000	0.000000	451,171	58.00	
60.00	06000	LABORATORY	0	33,372,071	0.000000	0.000000	7,511,547	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,206,055	0.000000	0.000000	378,788	62.00	
65.00	06500	RESPIRATORY THERAPY	0	781,301	0.000000	0.000000	351,168	65.00	
66.00	06600	PHYSICAL THERAPY	0	1,364,302	0.000000	0.000000	703,360	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	116,854	0.000000	0.000000	15,803	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	12,472,258	0.000000	0.000000	1,974,065	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	721,960	0.000000	0.000000	16,636	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	89,773,466	0.000000	0.000000	30,200,301	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,998,718	0.000000	0.000000	238,105	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	49,270,502	0.000000	0.000000	14,905,990	73.00	
76.00	03020	CANCER CENTER	0	6,960,227	0.000000	0.000000	74,822	76.00	
76.01	03021	DIABETES CENTER	0	9,857	0.000000	0.000000	0	76.01	
<b>OUTPATIENT SERVICE COST CENTERS</b>									
88.00	08800	RURAL HEALTH CLINIC	0	763,840	0.000000	0.000000	0	88.00	
88.01	08801	RURAL HEALTH CLINIC II	0	822,771	0.000000	0.000000	0	88.01	
88.02	08802	RURAL HEALTH CLINIC III	0	1,120,232	0.000000	0.000000	0	88.02	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00	
91.00	09100	EMERGENCY	0	2,626,853	0.000000	0.000000	341,820	91.00	
91.01	09101	OUTPATIENT PSYCH	0	0	0.000000	0.000000	0	91.01	
91.02	09102	WOUND CARE	0	49,878	0.000000	0.000000	0	91.02	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,300,650	0.000000	0.000000	201,480	92.00	
93.00	04040	FAMILY PRACTICE	0	0	0.000000	0.000000	0	93.00	
200.00		Total (lines 50-199)	0	270,013,314			70,233,795	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared: 2/27/2015 1:54 pm
Title XVIII		Hospital	PPS

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)	
ANCILLARY SERVICE COST CENTERS		11.00	12.00	13.00	
50.00	05000 OPERATING ROOM	0	3,849,479	0	50.00
51.00	05100 RECOVERY ROOM	0	1,132,226	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	156	0	52.00
53.00	05300 ANESTHESIOLOGY	0	754,491	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	1,809,408	0	54.00
56.00	03450 RADIOISOTOPE	0	935,658	0	56.00
57.00	05700 CT SCAN	0	3,544,504	0	57.00
58.00	05800 MRI	0	1,369,716	0	58.00
60.00	06000 LABORATORY	0	4,023,744	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	154,158	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	77,943	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	3,681,423	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	247,401	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	10,651,172	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	2,643,575	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6,732,282	0	73.00
76.00	03020 CANCER CENTER	0	3,245,870	0	76.00
76.01	03021 DIABETES CENTER	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0	0	0	88.02
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00	09100 EMERGENCY	0	536,604	0	91.00
91.01	09101 OUTPATIENT PSYCH	0	0	0	91.01
91.02	09102 WOUND CARE	0	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	673,440	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0	93.00
200.00	Total (lines 50-199)	0	46,063,250	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part V Date/Time Prepared: 2/27/2015 1:54 pm
		Title XVIII	Hospital	PPS

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		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.193596	3,849,479	0	745,244	50.00	
51.00	05100 RECOVERY ROOM	0.573296	1,132,226	0	649,101	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	2.058141	156	0	321	52.00	
53.00	05300 ANESTHESIOLOGY	0.192471	754,491	0	145,218	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.624647	1,809,408	0	1,130,241	54.00	
56.00	03450 RADIO SOTOPE	0.145250	935,658	0	135,904	56.00	
57.00	05700 CT SCAN	0.055501	3,544,504	0	196,724	57.00	
58.00	05800 MRI	0.105009	1,369,716	0	143,833	58.00	
60.00	06000 LABORATORY	0.204550	4,023,744	0	823,057	60.00	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.679081	154,158	0	104,686	62.00	
65.00	06500 RESPIRATORY THERAPY	2.241770	77,943	0	174,730	65.00	
66.00	06600 PHYSICAL THERAPY	1.083303	0	0	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00	
68.00	06800 SPEECH PATHOLOGY	1.484639	0	0	0	68.00	
69.00	06900 ELECTROCARDIOLOGY	0.249553	3,681,423	0	918,710	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	0.443225	247,401	0	109,654	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.119793	10,651,172	0	1,275,936	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.535745	2,643,575	0	1,416,282	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.161891	6,732,282	0	7,635	1,089,896	73.00
76.00	03020 CANCER CENTER	0.382832	3,245,870	0	0	1,242,623	76.00
76.01	03021 DIABETES CENTER	5.548849	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0.000000			0	88.00	
88.01	08801 RURAL HEALTH CLINIC II	0.000000			0	88.01	
88.02	08802 RURAL HEALTH CLINIC III	0.000000			0	88.02	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000			0	89.00	
91.00	09100 EMERGENCY	2.527216	536,604	0	1,356,114	91.00	
91.01	09101 OUTPATIENT PSYCH	0.000000	0	0	0	91.01	
91.02	09102 WOUND CARE	5.528650	0	0	0	91.02	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.151567	673,440	0	775,511	92.00	
93.00	04040 FAMILY PRACTICE	0.000000	0	0	0	93.00	
200.00	Subtotal (see instructions)		46,063,250	0	7,635	12,433,785	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		46,063,250	0	7,635	12,433,785	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part V Date/Time Prepared: 2/27/2015 1:54 pm
		Title XVIII	Hospital	PPS

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		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000	OPERATING ROOM	0	0	50.00
51.00 05100	RECOVERY ROOM	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00 03450	RADIOISOTOPE	0	0	56.00
57.00 05700	CT SCAN	0	0	57.00
58.00 05800	MRI	0	0	58.00
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
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
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	1,236	73.00
76.00 03020	CANCER CENTER	0	0	76.00
76.01 03021	DIABETES CENTER	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00 08800	RURAL HEALTH CLINIC	0	0	88.00
88.01 08801	RURAL HEALTH CLINIC II	0	0	88.01
88.02 08802	RURAL HEALTH CLINIC III	0	0	88.02
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00 09100	EMERGENCY	0	0	91.00
91.01 09101	OUTPATIENT PSYCH	0	0	91.01
91.02 09102	WOUND CARE	0	0	91.02
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
93.00 04040	FAMILY PRACTICE	0	0	93.00
200.00	Subtotal (see instructions)	0	1,236	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	1,236	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet D-1 Date/Time Prepared: 2/27/2015 1:54 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		15,426	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		15,426	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)		13,989	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	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)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		8,603	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)		0	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)		0	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
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		16,078,595	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)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		16,078,595	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		16,078,595	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,042.30	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		8,966,907	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)		8,966,907	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 260025		Period: From 10/01/2013 To 09/30/2014		Worksheet D-1	
		Title XVIII		Hospital		PPS	
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)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	4,574,745	2,198	2,081.32	1,452	3,022,077	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)					14,459,320	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					26,448,304	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)					706,683	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,155,141	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,861,824	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					24,586,480	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)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,437	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,042.30	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,497,785	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 260025		Period: From 10/01/2013 To 09/30/2014		Worksheet D-1 Date/Time Prepared: 2/27/2015 1:54 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,020,024	16,078,595	0.063440	1,497,785	95,019	90.00
91.00	Nursing School cost	0	16,078,595	0.000000	1,497,785	0	91.00
92.00	Allied health cost	0	16,078,595	0.000000	1,497,785	0	92.00
93.00	All other Medical Education	0	16,078,595	0.000000	1,497,785	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet D-3 Date/Time Prepared: 2/27/2015 1:54 pm
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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		3,934,724		30.00
31.00	03100 INTENSIVE CARE UNIT		1,273,076		31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.195497	5,962,361	1,165,624	50.00
51.00	05100 RECOVERY ROOM	0.573296	704,644	403,970	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2.058141	2,692	5,541	52.00
53.00	05300 ANESTHESIOLOGY	0.202382	1,696,829	343,408	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.624647	1,791,446	1,119,021	54.00
56.00	03450 RADIOISOTOPE	0.145250	349,060	50,701	56.00
57.00	05700 CT SCAN	0.055501	2,361,707	131,077	57.00
58.00	05800 MRI	0.105009	451,171	47,377	58.00
60.00	06000 LABORATORY	0.207837	7,511,547	1,561,177	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.679081	378,788	257,228	62.00
65.00	06500 RESPIRATORY THERAPY	2.241770	351,168	787,238	65.00
66.00	06600 PHYSICAL THERAPY	1.083303	703,360	761,952	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	1.484639	15,803	23,462	68.00
69.00	06900 ELECTROCARDIOLOGY	0.249553	1,974,065	492,634	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.443225	16,636	7,373	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.119793	30,200,301	3,617,785	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.535745	238,105	127,564	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.161891	14,905,990	2,413,146	73.00
76.00	03020 CANCER CENTER	0.387534	74,822	28,996	76.00
76.01	03021 DIABETES CENTER	5.548849	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000		0	88.02
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	09100 EMERGENCY	2.580386	341,820	882,028	91.00
91.01	09101 OUTPATIENT PSYCH	0.000000	0	0	91.01
91.02	09102 WOUND CARE	5.528650	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.151567	201,480	232,018	92.00
93.00	04040 FAMILY PRACTICE	0.000000	0	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		70,233,795	14,459,320	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)		70,233,795		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet E Part A Date/Time Prepared: 2/27/2015 1:54 pm	
		Title XVIII	Hospital	PPS	
		0	before 1/1	on/after 1/1	2.00
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER PPS</b>					
1.00	DRG Amounts Other than Outlier Payments		16,896,062		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013 (see instructions)		0		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		0		1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI (see instructions)		0		1.03
2.00	Outlier payments for discharges. (see instructions)		522,165		2.00
2.01	Outlier reconciliation amount		0		2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0		2.02
3.00	Managed Care Simulated Payments		77,195		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		87.06		4.00
<b>Indirect Medical Education Adjustment</b>					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)		0		28.00
29.00	Total IME payment ( sum of lines 22 and 28)		0		29.00
<b>Disproportionate Share Adjustment</b>					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.41		30.00
31.00	Percentage of Medicaid patient days (see instructions)		17.17		31.00
32.00	Sum of lines 30 and 31		22.58		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet E Part A Date/Time Prepared: 2/27/2015 1:54 pm	
		Title XVIII	Hospital		PPS
		0	before 1/1	on/after 1/1	2.00
33.00	Allowable disproportionate share percentage (see instructions)		7.84	1.01	33.00
34.00	Disproportionate share adjustment (see instructions)		331,163		34.00
			Prior to October 1	On/After October 1	
		0	1.00	1.01	2.00
<b>Uncompensated Care Adjustment</b>					
35.00	Total uncompensated care amount (see instructions)		0		35.00
35.01	Factor 3 (see instructions)		0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,069,780		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		18,819,170		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		22,922,072		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		22,922,072		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		1,390,373		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		8,172		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Worksheet D, Part IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		24,320,617		59.00
60.00	Primary payer payments		26,347		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		24,294,270		61.00
62.00	Deductibles billed to program beneficiaries		2,108,512		62.00
63.00	Coinurance billed to program beneficiaries		62,744		63.00
64.00	Allowable bad debts (see instructions)		567,560		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		368,914		65.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet E  
Part A  
Date/Time Prepared:  
2/27/2015 1:54 pm

		Title XVIII	Hospital	PPS		
		0	Prior to October 1 1.00	1.01	On/After October 1 2.00	
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		477,515			66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		22,491,928			67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0			68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0			69.00
70.00	OTHER ADJUSTMENTS		-754			70.00
70.50	RURAL DEMONSTRATION PROJECT		0			70.50
70.92	Bundled Model 1 discount amount		0			70.92
70.93	HVBP incentive payment (see instructions)		-8,051			70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		0			70.94
70.95	Recovery of accelerated depreciation		0			70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0			70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0			70.97
70.98	Low Volume Payment-3		0			70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		22,483,123			71.00
71.01	Sequestration adjustment (see instructions)		449,662			71.01
72.00	Interim payments		22,326,023			72.00
73.00	Tentative settlement (for contractor use only)		0			73.00
74.00	Balance due provider (Program) line 71 minus lines 71.01, 72 and 73		-292,562			74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0			75.00
<b>TO BE COMPLETED BY CONTRACTOR</b>						
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0			90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0			91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0			92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0			93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00			94.00
95.00	Time value of money for operating expenses (see instructions)		0			95.00
96.00	Time value of money for capital related expenses (see instructions)		0			96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet E Part B Date/Time Prepared: 2/27/2015 1:54 pm
		Title XVII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		1,236	1.00
2.00	Medical and other services reimbursed under OPPI (see instructions)		12,433,785	2.00
3.00	PPS payments		8,491,569	3.00
4.00	Outlier payment (see instructions)		391,039	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.882	5.00
6.00	Line 2 times line 5		10,966,598	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		81.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		1,236	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		7,635	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		7,635	14.00
<b>Customary charges</b>				
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)		7,635	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		6,399	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)		1,236	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)		8,882,608	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		1,782,115	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		7,101,729	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		7,101,729	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		7,101,729	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		175,724	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		114,221	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		107,369	36.00
37.00	Subtotal (see instructions)		7,215,950	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		7,215,950	40.00
40.01	Sequestration adjustment (see instructions)		144,319	40.01
41.00	Interim payments		7,071,960	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-329	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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: 260025		Period: From 10/01/2013 To 09/30/2014		Worksheet E-1 Part I Date/Time Prepared: 2/27/2015 1:54 pm	
		Title XVIII		Hospital		PPS	
		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		22,326,023		7,071,960	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)		22,326,023		7,071,960	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		292,562		329	6.02	
7.00	Total Medicare program liability (see instructions)		22,033,461		7,071,631	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: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet E-1  
Part II  
Date/Time Prepared:  
2/27/2015 1:54 pm

		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			4,444 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			10,055 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6 line 2			561 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			16,187 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			279,072,869 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			9,509,463 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			1,354,096 8.00
9.00	Sequestration adjustment amount (see instructions)			27,082 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			1,327,014 10.00
<b>INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			1,370,173 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)			-43,159 32.00

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

Provider CCN: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet G

Date/Time Prepared:  
2/27/2015 1:54 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	18,774,069	0	0	0	1.00
2.00	Temporary investments	1,521,316	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	13,780,703	0	0	0	4.00
5.00	Other receivable	1,128,047	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,376,402	0	0	0	7.00
8.00	Prepaid expenses	881,968	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)	38,462,505	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	2,693,370	0	0	0	12.00
13.00	Land improvements	7,113,729	0	0	0	13.00
14.00	Accumulated depreciation	-5,096,149	0	0	0	14.00
15.00	Buildings	44,043,753	0	0	0	15.00
16.00	Accumulated depreciation	-25,800,047	0	0	0	16.00
17.00	Leasehold improvements	18,614,031	0	0	0	17.00
18.00	Accumulated depreciation	-9,227,635	0	0	0	18.00
19.00	Fixed equipment	321,581	0	0	0	19.00
20.00	Accumulated depreciation	-104,737	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	64,287,103	0	0	0	23.00
24.00	Accumulated depreciation	-49,809,395	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)	47,035,604	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	43,053,485	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	7,593,474	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	50,646,959	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	136,145,068	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	5,391,981	0	0	0	37.00
38.00	Salaries, wages, and fees payable	7,654,663	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	56,317	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	7,691,849	0	0	0	43.00
44.00	Other current liabilities	4,445,314	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	25,240,124	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	12,487,527	0	0	0	46.00
47.00	Notes payable	1,343,508	0	0	0	47.00
48.00	Unsecured loans	4,354,680	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	18,185,715	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	43,425,839	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	92,719,229				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)	92,719,229	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	136,145,068	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet G-1

Date/Time Prepared:  
2/27/2015 1:54 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		86,211,500		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		5,814,905				2.00
3.00	Total (sum of line 1 and line 2)		92,026,405		0		3.00
4.00	PRIOR PERIOD ADJ	692,824		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)		692,824		0		10.00
11.00	Subtotal (line 3 plus line 10)		92,719,229		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		92,719,229		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 ADJ		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
2/27/2015 1:54 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	6,229,742		6,229,742	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	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)	6,229,742		6,229,742	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	1,877,659		1,877,659	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)	1,877,659		1,877,659	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8,107,401		8,107,401	17.00
18.00	Ancillary services	127,075,931	135,611,459	262,687,390	18.00
19.00	Outpatient services	1,673,572	2,945,509	4,619,081	19.00
20.00	RURAL HEALTH CLINIC	0	763,840	763,840	20.00
20.01	RURAL HEALTH CLINIC II	0	822,771	822,771	20.01
20.02	RURAL HEALTH CLINIC III	0	1,120,232	1,120,232	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		952,154	952,154	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC		0	0	24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN REVENUE	3,155,835	5,541,814	8,697,649	27.00
27.01	PHYSICIAN REVENUE - NRCC	0	11,248,122	11,248,122	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	140,012,739	159,005,901	299,018,640	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		113,158,713		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		113,158,713		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 260025

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet G-3

Date/Time Prepared:  
2/27/2015 1:54 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	299,018,640	1.00
2.00	Less contractual allowances and discounts on patients' accounts	177,418,600	2.00
3.00	Net patient revenues (line 1 minus line 2)	121,600,040	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	113,158,713	4.00
5.00	Net income from service to patients (line 3 minus line 4)	8,441,327	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	604,340	6.00
7.00	Income from investments	179,153	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	563,888	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	RENTAL INCOME	338,356	24.00
24.01	NON OPERATING INCOME	384,843	24.01
24.02	OTHER REVENUE	3,608,152	24.02
25.00	Total other income (sum of lines 6-24)	5,678,732	25.00
26.00	Total (line 5 plus line 25)	14,120,059	26.00
27.00	BAD DEBTS	8,305,154	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	8,305,154	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,814,905	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 260025

Period: From 10/01/2013

Worksheet H

HHA CCN: 267282

To 09/30/2014

Date/Time Prepared: 2/27/2015 1:54 pm

Home Health Agency I

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	218,868	25,946	0	0	102,261	347,075	5.00
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	362,899	43,020	0	0	17,988	423,907	6.00
7.00	Physical Therapy	173,434	20,560	0	0	0	193,994	7.00
8.00	Occupational Therapy	6,376	756	0	0	3,649	10,781	8.00
9.00	Speech Pathology	6,203	735	0	0	539	7,477	9.00
10.00	Medical Social Services	1,235	146	0	0	0	1,381	10.00
11.00	Home Health Aide	62,816	7,446	0	0	0	70,262	11.00
12.00	Supplies (see instructions)	0	0	0	0	16,311	16,311	12.00
13.00	Drugs	0	0	0	0	222	222	13.00
14.00	DME	0	0	0	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	831,831	98,609	0	0	140,970	1,071,410	24.00
		Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	347,075	0	347,075			5.00
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	0	423,907	0	423,907			6.00
7.00	Physical Therapy	0	193,994	0	193,994			7.00
8.00	Occupational Therapy	0	10,781	0	10,781			8.00
9.00	Speech Pathology	0	7,477	0	7,477			9.00
10.00	Medical Social Services	0	1,381	0	1,381			10.00
11.00	Home Health Aide	0	70,262	0	70,262			11.00
12.00	Supplies (see instructions)	0	16,311	0	16,311			12.00
13.00	Drugs	0	222	0	222			13.00
14.00	DME	0	0	0	0			14.00
<b>HHA NONREIMBURSABLE SERVICES</b>								
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	0	1,071,410	0	1,071,410			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 260025 HHA CCN: 267282	Period: From 10/01/2013 To 09/30/2014	Worksheet H-1 Part I Date/Time Prepared: 2/27/2015 1:54 pm
			Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)		
		Bldgs & Fixtures	Movable Equipment					
		0	1.00					2.00
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00	
2.00	Capital Related - Movable Equipment	0		0		0	2.00	
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00	
4.00	Transportation	0	0	0	0	0	4.00	
5.00	Administrative and General	347,075	0	0	0	347,075	5.00	
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	423,907	0	0	0	423,907	6.00	
7.00	Physical Therapy	193,994	0	0	0	193,994	7.00	
8.00	Occupational Therapy	10,781	0	0	0	10,781	8.00	
9.00	Speech Pathology	7,477	0	0	0	7,477	9.00	
10.00	Medical Social Services	1,381	0	0	0	1,381	10.00	
11.00	Home Health Aide	70,262	0	0	0	70,262	11.00	
12.00	Supplies (see instructions)	16,311	0	0	0	16,311	12.00	
13.00	Drugs	222	0	0	0	222	13.00	
14.00	DME	0	0	0	0	0	14.00	
<b>HHA NONREIMBURSABLE SERVICES</b>								
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	23.00	
24.00	Total (sum of lines 1-23)	1,071,410	0	0	0	1,071,410	24.00	
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	Capital Related - Bldg. & Fixtures						1.00	
2.00	Capital Related - Movable Equipment						2.00	
3.00	Plant Operation & Maintenance						3.00	
4.00	Transportation						4.00	
5.00	Administrative and General	347,075					5.00	
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	203,120	627,027				6.00	
7.00	Physical Therapy	92,955	286,949				7.00	
8.00	Occupational Therapy	5,166	15,947				8.00	
9.00	Speech Pathology	3,583	11,060				9.00	
10.00	Medical Social Services	662	2,043				10.00	
11.00	Home Health Aide	33,667	103,929				11.00	
12.00	Supplies (see instructions)	7,816	24,127				12.00	
13.00	Drugs	106	328				13.00	
14.00	DME	0	0				14.00	
<b>HHA NONREIMBURSABLE SERVICES</b>								
15.00	Home Dialysis Aide Services	0	0				15.00	
16.00	Respiratory Therapy	0	0				16.00	
17.00	Private Duty Nursing	0	0				17.00	
18.00	Clinic	0	0				18.00	
19.00	Health Promotion Activities	0	0				19.00	
20.00	Day Care Program	0	0				20.00	
21.00	Home Delivered Meals Program	0	0				21.00	
22.00	Homemaker Service	0	0				22.00	
23.00	All Others (specify)	0	0				23.00	
24.00	Total (sum of lines 1-23)		1,071,410				24.00	

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 260025

Period:

Worksheet H-1

HHA CCN: 267282

From 10/01/2013  
To 09/30/2014

Part II  
Date/Time Prepared:  
2/27/2015 1:54 pm

Home Health  
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	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-347,075	724,335
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	0	0	0	0	0	423,907
7.00	Physical Therapy	0	0	0	0	0	193,994
8.00	Occupational Therapy	0	0	0	0	0	10,781
9.00	Speech Pathology	0	0	0	0	0	7,477
10.00	Medical Social Services	0	0	0	0	0	1,381
11.00	Home Health Aide	0	0	0	0	0	70,262
12.00	Supplies (see instructions)	0	0	0	0	0	16,311
13.00	Drugs	0	0	0	0	0	222
14.00	DME	0	0	0	0	0	0
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-347,075	724,335
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		347,075
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.479164

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 260025

Period: From 10/01/2013

Worksheet H-2

HHA CCN: 267282

To 09/30/2014

Part I  
Date/Time Prepared: 2/27/2015 1:54 pm

Home Health Agency I

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Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDG & FIXT	MVBLE EQUIP				
		0	1.00				
1.00 Administrative and General	0	0	0	67,978	67,978	23,820	1.00
2.00 Skilled Nursing Care	627,027	0	0	112,712	739,739	259,215	2.00
3.00 Physical Therapy	286,949	0	0	53,867	340,816	119,426	3.00
4.00 Occupational Therapy	15,947	0	0	1,980	17,927	6,282	4.00
5.00 Speech Pathology	11,060	0	0	1,927	12,987	4,551	5.00
6.00 Medical Social Services	2,043	0	0	384	2,427	850	6.00
7.00 Home Health Aide	103,929	0	0	19,510	123,439	43,255	7.00
8.00 Supplies (see instructions)	24,127	0	0	0	24,127	8,454	8.00
9.00 Drugs	328	0	0	0	328	115	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	1,071,410	0	0	258,358	1,329,768	465,968	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
	6.00	7.00	8.00	9.00	10.00	11.00	
1.00 Administrative and General	7,781	48,666	0	0	0	527	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	7,781	48,666	0	0	0	527	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 260025

Period: From 10/01/2013

Worksheet H-2

HHA CCN: 267282

To 09/30/2014

Part I  
Date/Time Prepared:  
2/27/2015 1:54 pm

Home Health Agency I

PPS

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
		13.00	14.00	15.00	16.00	19.00	24.00	
1.00	Administrative and General	0	0	0	0	0	148,772	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	998,954	2.00
3.00	Physical Therapy	0	0	0	0	0	460,242	3.00
4.00	Occupational Therapy	0	0	0	0	0	24,209	4.00
5.00	Speech Pathology	0	0	0	0	0	17,538	5.00
6.00	Medical Social Services	0	0	0	0	0	3,277	6.00
7.00	Home Health Aide	0	0	0	0	0	166,694	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	32,581	8.00
9.00	Drugs	0	0	0	0	0	443	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	1,852,710	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1.00	Administrative and General	0	148,772					1.00
2.00	Skilled Nursing Care	0	998,954	87,219	1,086,173			2.00
3.00	Physical Therapy	0	460,242	40,184	500,426			3.00
4.00	Occupational Therapy	0	24,209	2,114	26,323			4.00
5.00	Speech Pathology	0	17,538	1,531	19,069			5.00
6.00	Medical Social Services	0	3,277	286	3,563			6.00
7.00	Home Health Aide	0	166,694	14,554	181,248			7.00
8.00	Supplies (see instructions)	0	32,581	2,845	35,426			8.00
9.00	Drugs	0	443	39	482			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
20.00	Total (sum of lines 1-19) (2)	0	1,852,710	148,772	1,852,710			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.087311				21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 260025 HHA CCN: 267282	Period: From 10/01/2013 To 09/30/2014	Worksheet H-2 Part II Date/Time Prepared: 2/27/2015 1:54 pm
		Home Health Agency I	PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00					
1.00 Administrative and General	0	0	218,868	0	67,978	3,650	1.00
2.00 Skilled Nursing Care	0	0	362,900	0	739,739	0	2.00
3.00 Physical Therapy	0	0	173,434	0	340,816	0	3.00
4.00 Occupational Therapy	0	0	6,376	0	17,927	0	4.00
5.00 Speech Pathology	0	0	6,203	0	12,987	0	5.00
6.00 Medical Social Services	0	0	1,235	0	2,427	0	6.00
7.00 Home Health Aide	0	0	62,816	0	123,439	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	24,127	0	8.00
9.00 Drugs	0	0	0	0	328	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	0	831,832		1,329,768	3,650	20.00
21.00 Total cost to be allocated	0	0	258,358		465,968	7,781	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.310589		0.350413	2.131781	22.00
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRSING)	
	7.00	8.00	9.00	10.00	11.00	13.00	
1.00 Administrative and General	3,650	0	0	0	18	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	3,650	0	0	0	18	0	20.00
21.00 Total cost to be allocated	48,666	0	0	0	527	0	21.00
22.00 Unit cost multiplier	13.333151	0.000000	0.000000	0.000000	29.277778	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 260025 HHA CCN: 267282	Period: From 10/01/2013 To 09/30/2014	Worksheet H-2 Part II Date/Time Prepared: 2/27/2015 1:54 pm
		Home Health Agency I	PPS

Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
	14.00	15.00	16.00	19.00		
1.00 Administrative and General	0	0	0	0		1.00
2.00 Skilled Nursing Care	0	0	0	0		2.00
3.00 Physical Therapy	0	0	0	0		3.00
4.00 Occupational Therapy	0	0	0	0		4.00
5.00 Speech Pathology	0	0	0	0		5.00
6.00 Medical Social Services	0	0	0	0		6.00
7.00 Home Health Aide	0	0	0	0		7.00
8.00 Supplies (see instructions)	0	0	0	0		8.00
9.00 Drugs	0	0	0	0		9.00
10.00 DME	0	0	0	0		10.00
11.00 Home Dialysis Aide Services	0	0	0	0		11.00
12.00 Respiratory Therapy	0	0	0	0		12.00
13.00 Private Duty Nursing	0	0	0	0		13.00
14.00 Clinic	0	0	0	0		14.00
15.00 Health Promotion Activities	0	0	0	0		15.00
16.00 Day Care Program	0	0	0	0		16.00
17.00 Home Delivered Meals Program	0	0	0	0		17.00
18.00 Homemaker Service	0	0	0	0		18.00
19.00 All Others (specify)	0	0	0	0		19.00
20.00 Total (sum of lines 1-19)	0	0	0	0		20.00
21.00 Total cost to be allocated	0	0	0	0		21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet H-3 Part I Date/Time Prepared: 2/27/2015 1:54 pm
		HHA CCN: 267282	Title XVII I	Home Health Agency I PPS

Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (col. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	1,086,173		1,086,173	3,665	296.36	1.00
2.00	Physical Therapy	3.00	500,426	0	500,426	2,013	248.60	2.00
3.00	Occupational Therapy	4.00	26,323	0	26,323	74	355.72	3.00
4.00	Speech Pathology	5.00	19,069	0	19,069	72	264.85	4.00
5.00	Medical Social Services	6.00	3,563		3,563	12	296.92	5.00
6.00	Home Health Aide	7.00	181,248		181,248	542	334.41	6.00
7.00	Total (sum of lines 1-6)		1,816,802	0	1,816,802	6,378		7.00

Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits		Ratio (col. 3 ÷ col. 4)	
			Part A	Part B		
				Not Subject to Deductibles & Coinsurance		Subject to Deductibles
	0	1.00	2.00	3.00	4.00	5.00

Limitation Cost Computation							
8.00	Skilled Nursing Care		99926	81	1,615		8.00
8.01	Skilled Nursing Care		99914	18	390		8.01
9.00	Physical Therapy		99926	19	939		9.00
9.01	Physical Therapy		99914	4	313		9.01
10.00	Occupational Therapy		99926	0	45		10.00
10.01	Occupational Therapy		99914	0	2		10.01
11.00	Speech Pathology		99926	0	44		11.00
11.01	Speech Pathology		99914	0	6		11.01
12.00	Medical Social Services		99926	0	8		12.00
12.01	Medical Social Services		99914	0	1		12.01
13.00	Home Health Aide		99926	7	321		13.00
13.01	Home Health Aide		99914	0	17		13.01
14.00	Total (sum of lines 8-13)			129	3,701		14.00

Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (col. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	35,426	0	35,426	66,383	0.533661	15.00
16.00	Cost of Drugs	9.00	482	0	482	0	0.000000	16.00

Cost Center Description	Part A	Program Visits		Part A	Part B	Ratio (col. 3 ÷ col. 4)
		Part B				
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			
	6.00	7.00	8.00	9.00	10.00	11.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	99	2,005		29,340	594,202	1.00
2.00	Physical Therapy	23	1,252		5,718	311,247	2.00
3.00	Occupational Therapy	0	47		0	16,719	3.00
4.00	Speech Pathology	0	50		0	13,243	4.00
5.00	Medical Social Services	0	9		0	2,672	5.00
6.00	Home Health Aide	7	338		2,341	113,031	6.00
7.00	Total (sum of lines 1-6)	129	3,701		37,399	1,051,114	7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 260025  
HHA CCN: 267282

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet H-3  
Part I  
Date/Time Prepared:  
2/27/2015 1:54 pm  
PPS

Title XVII

Home Health Agency I

Cost Center Description		6.00	7.00	8.00	9.00	10.00	11.00
<b>Limitation Cost Computation</b>							
8.00	Skilled Nursing Care						8.00
8.01	Skilled Nursing Care						8.01
9.00	Physical Therapy						9.00
9.01	Physical Therapy						9.01
10.00	Occupational Therapy						10.00
10.01	Occupational Therapy						10.01
11.00	Speech Pathology						11.00
11.01	Speech Pathology						11.01
12.00	Medical Social Services						12.00
12.01	Medical Social Services						12.01
13.00	Home Health Aide						13.00
13.01	Home Health Aide						13.01
14.00	Total (sum of lines 8-13)						14.00
Cost Center Description		Program Covered Charges			Cost of Services		
		Part A	Part B		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		6.00	7.00	8.00	9.00	10.00	11.00
<b>Supplies and Drugs Cost Computations</b>							
15.00	Cost of Medical Supplies						15.00
16.00	Cost of Drugs		0	0		0	16.00
Cost Center Description		Total Program Cost (sum of col.s. 9-10)					
		12.00					
<b>PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION</b>							
<b>Cost Per Visit Computation</b>							
1.00	Skilled Nursing Care	623,542					1.00
2.00	Physical Therapy	316,965					2.00
3.00	Occupational Therapy	16,719					3.00
4.00	Speech Pathology	13,243					4.00
5.00	Medical Social Services	2,672					5.00
6.00	Home Health Aide	115,372					6.00
7.00	Total (sum of lines 1-6)	1,088,513					7.00
Cost Center Description		12.00					
<b>Limitation Cost Computation</b>							
8.00	Skilled Nursing Care						8.00
8.01	Skilled Nursing Care						8.01
9.00	Physical Therapy						9.00
9.01	Physical Therapy						9.01
10.00	Occupational Therapy						10.00
10.01	Occupational Therapy						10.01
11.00	Speech Pathology						11.00
11.01	Speech Pathology						11.01
12.00	Medical Social Services						12.00
12.01	Medical Social Services						12.01
13.00	Home Health Aide						13.00
13.01	Home Health Aide						13.01
14.00	Total (sum of lines 8-13)						14.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 260025 HHA CCN: 267282	Period: From 10/01/2013 To 09/30/2014	Worksheet H-3 Part II Date/Time Prepared: 2/27/2015 1:54 pm
		Title XVIII	Home Health Agency I	PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
	0	1.00	2.00	3.00	4.00	
<b>PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS</b>						
1.00	Physical Therapy	66.00	1.083303	0	0	col. 2, line 2.00 1.00
2.00	Occupational Therapy	67.00	0.000000	0	0	col. 2, line 3.00 2.00
3.00	Speech Pathology	68.00	1.484639	0	0	col. 2, line 4.00 3.00
4.00	Cost of Medical Supplies	71.00	0.119793	0	0	col. 2, line 15.00 4.00
5.00	Cost of Drugs	73.00	0.161891	0	0	col. 2, line 16.00 5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 260025 HHA CCN: 267282	Period: From 10/01/2013 To 09/30/2014	Worksheet H-4 Part I-II Date/Time Prepared: 2/27/2015 1:54 pm	
		Title XVII I	Home Health Agency I	PPS	
		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
<b>PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES</b>					
Reasonable Cost of Part A & Part B Services					
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
<b>Customary Charges</b>					
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount 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(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00
			Part A Services	Part B Services	
			1.00	2.00	
<b>PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT</b>					
10.00	Total reasonable cost (see instructions)		0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers		17,348	579,739	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes		463	13,554	13.00
14.00	Total PPS Reimbursement - PEP Episodes		0	7,461	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0	16.00
17.00	Total Other Payments		0	0	17.00
18.00	DME Payments		0	0	18.00
19.00	Oxygen Payments		0	0	19.00
20.00	Prosthetic and Orthotic Payments		0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		17,811	600,754	22.00
23.00	Excess reasonable cost (from line 8)		0	0	23.00
24.00	Subtotal (line 22 minus line 23)		17,811	600,754	24.00
25.00	Coinsurance billed to program patients (from your records)		0	0	25.00
26.00	Net cost (line 24 minus line 25)		17,811	600,754	26.00
27.00	Reimbursable bad debts (from your records)				27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)				28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)		17,811	600,754	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)		17,811	600,754	31.00
31.01	Sequestration adjustment (see instructions)		0	12,015	31.01
32.00	Interim payments (see instructions)		17,811	588,739	32.00
33.00	Tentative settlement (for contractor use only)		0	0	33.00
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33		0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	0	35.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 260025  
HHA CCN: 267282

Period: From 10/01/2013 To 09/30/2014

Worksheet H-5  
Date/Time Prepared: 2/27/2015 1:54 pm  
PPS

		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		17,811		588,739	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			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			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. H-4, Part II, column as appropriate, line 32)		17,811		588,739	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		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			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		0		0	6.02
7.00	Total Medicare program liability (see instructions)		17,811		588,739	7.00
		0		Contractor Number	NPR Date (Mo/Day/Yr)	
				1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet L Parts I-III Date/Time Prepared: 2/27/2015 1:54 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		1,330,435	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		59,938	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		44.35	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		0	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		1,390,373	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 260025 Component CCN: 268512	Period: From 10/01/2013 To 09/30/2014	Worksheet M-1 Date/Time Prepared: 2/27/2015 1:54 pm
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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	
<b>FACILITY HEALTH CARE STAFF COSTS</b>							
1.00	Physician	121,027	0	121,027	0	121,027	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	184,293	0	184,293	0	184,293	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	89,866	0	89,866	0	89,866	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	395,186	0	395,186	0	395,186	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	7,438	7,438	0	7,438	13.00
14.00	Subtotal (sum of lines 11-13)	0	7,438	7,438	0	7,438	14.00
15.00	Medical Supplies	0	3,621	3,621	0	3,621	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	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	97,122	97,122	0	97,122	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	100,743	100,743	0	100,743	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	395,186	108,181	503,367	0	503,367	22.00
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
<b>FACILITY OVERHEAD</b>							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	127,756	176,716	304,472	0	304,472	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	127,756	176,716	304,472	0	304,472	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	522,942	284,897	807,839	0	807,839	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet M-1
	Component CCN: 268512	Rural Health Clinic (RHC) I	Date/Time Prepared: 2/27/2015 1:54 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
<b>FACILITY HEALTH CARE STAFF COSTS</b>				
1.00	Physician	0	121,027	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	184,293	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	89,866	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	0	395,186	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	7,438	13.00
14.00	Subtotal (sum of lines 11-13)	0	7,438	14.00
15.00	Medical Supplies	0	3,621	15.00
16.00	Transportation (Health Care Staff)	0	0	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	97,122	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	100,743	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	503,367	22.00
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
<b>FACILITY OVERHEAD</b>				
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	-2,024	302,448	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-2,024	302,448	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-2,024	805,815	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 260025 Component CCN: 263984	Period: From 10/01/2013 To 09/30/2014	Worksheet M-1 Date/Time Prepared: 2/27/2015 1:54 pm
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) II Reclassified	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>FACILITY HEALTH CARE STAFF COSTS</b>							
1.00	Physician	198,927	0	198,927	0	198,927	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	110,524	0	110,524	0	110,524	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	82,371	0	82,371	0	82,371	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	391,822	0	391,822	0	391,822	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	19,164	19,164	0	19,164	13.00
14.00	Subtotal (sum of lines 11-13)	0	19,164	19,164	0	19,164	14.00
15.00	Medical Supplies	0	7,878	7,878	0	7,878	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	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	11,484	11,484	0	11,484	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	19,362	19,362	0	19,362	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	391,822	38,526	430,348	0	430,348	22.00
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
<b>FACILITY OVERHEAD</b>							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	85,368	170,156	255,524	0	255,524	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	85,368	170,156	255,524	0	255,524	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	477,190	208,682	685,872	0	685,872	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet M-1
	Component CCN: 263984	Rural Health Clinic (RHC) II	Date/Time Prepared: 2/27/2015 1:54 pm Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
<b>FACILITY HEALTH CARE STAFF COSTS</b>			
1.00 Physician	0	198,927	1.00
2.00 Physician Assistant	0	0	2.00
3.00 Nurse Practitioner	0	110,524	3.00
4.00 Visiting Nurse	0	0	4.00
5.00 Other Nurse	0	82,371	5.00
6.00 Clinical Psychologist	0	0	6.00
7.00 Clinical Social Worker	0	0	7.00
8.00 Laboratory Technician	0	0	8.00
9.00 Other Facility Health Care Staff Costs	0	0	9.00
10.00 Subtotal (sum of lines 1-9)	0	391,822	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	19,164	13.00
14.00 Subtotal (sum of lines 11-13)	0	19,164	14.00
15.00 Medical Supplies	0	7,878	15.00
16.00 Transportation (Health Care Staff)	0	0	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	11,484	19.00
20.00 Allowable GME Costs	0	0	20.00
21.00 Subtotal (sum of lines 15-20)	0	19,362	21.00
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	430,348	22.00
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>			
23.00 Pharmacy	0	0	23.00
24.00 Dental	0	0	24.00
25.00 Optometry	0	0	25.00
26.00 All other nonreimbursable costs	0	0	26.00
27.00 Nonallowable GME costs	0	0	27.00
28.00 Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
<b>FACILITY OVERHEAD</b>			
29.00 Facility Costs	0	0	29.00
30.00 Administrative Costs	27,793	283,317	30.00
31.00 Total Facility Overhead (sum of lines 29 and 30)	27,793	283,317	31.00
32.00 Total facility costs (sum of lines 22, 28 and 31)	27,793	713,665	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 260025 Component CCN: 268513	Period: From 10/01/2013 To 09/30/2014	Worksheet M-1 Date/Time Prepared: 2/27/2015 1:54 pm
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	Reclassified	
		1.00	2.00	3.00	4.00	5.00	
<b>FACILITY HEALTH CARE STAFF COSTS</b>							
1.00	Physician	235,715	0	235,715	0	235,715	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	70,134	0	70,134	0	70,134	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	91,691	0	91,691	0	91,691	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	397,540	0	397,540	0	397,540	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	19,057	19,057	0	19,057	13.00
14.00	Subtotal (sum of lines 11-13)	0	19,057	19,057	0	19,057	14.00
15.00	Medical Supplies	0	5,127	5,127	0	5,127	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	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	41,924	41,924	0	41,924	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	47,051	47,051	0	47,051	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	397,540	66,108	463,648	0	463,648	22.00
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
<b>FACILITY OVERHEAD</b>							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	123,366	137,909	261,275	0	261,275	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	123,366	137,909	261,275	0	261,275	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	520,906	204,017	724,923	0	724,923	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet M-1
	Component CCN: 268513	Rural Health Clinic (RHC) III	Date/Time Prepared: 2/27/2015 1:54 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
<b>FACILITY HEALTH CARE STAFF COSTS</b>				
1.00	Physician	0	235,715	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	70,134	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	91,691	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	0	397,540	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	19,057	13.00
14.00	Subtotal (sum of lines 11-13)	0	19,057	14.00
15.00	Medical Supplies	0	5,127	15.00
16.00	Transportation (Health Care Staff)	0	0	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	41,924	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	47,051	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	463,648	22.00
<b>COSTS OTHER THAN RHC/FOHC SERVICES</b>				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
<b>FACILITY OVERHEAD</b>				
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	-25	261,250	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-25	261,250	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-25	724,898	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet M-2		
		Component CCN: 268512		Date/Time Prepared: 2/27/2015 1:54 pm		
			Rural Health Clinic (RHC) I	Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
<b>VISITS AND PRODUCTIVITY</b>						
<b>Positions</b>						
1.00	Physician	0.74	629	4,200	3,108	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	1.97	3,336	2,100	4,137	3.00
4.00	Subtotal (sum of lines 1-3)	2.71	3,965		7,245	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	2.71	3,965		7,245	8.00
9.00	Physician Services Under Agreements		758		758	9.00
					1.00	
<b>DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES</b>						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)				503,367	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				503,367	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)				302,448	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				500,699	15.00
16.00	Total overhead (sum of lines 14 and 15)				803,147	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				803,147	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				803,147	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				1,306,514	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet M-2		
		Component CCN: 263984		Date/Time Prepared: 2/27/2015 1:54 pm		
			Rural Health Clinic (RHC) II	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	
<b>VISITS AND PRODUCTIVITY</b>						
<b>Positions</b>						
1.00	Physician	1.00	2,591	4,200	4,200	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	1.00	2,285	2,100	2,100	3.00
4.00	Subtotal (sum of lines 1-3)	2.00	4,876		6,300	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	2.00	4,876		6,300	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
<b>DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES</b>						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)				430,348	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				430,348	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)				283,317	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				624,882	15.00
16.00	Total overhead (sum of lines 14 and 15)				908,199	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				908,199	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				908,199	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				1,338,547	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 260025 Component CCN: 268513	Period: From 10/01/2013 To 09/30/2014	Worksheet M-2 Date/Time Prepared: 2/27/2015 1:54 pm		
			Rural Health Clinic (RHC) III	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	
<b>VISITS AND PRODUCTIVITY</b>						
<b>Positions</b>						
1.00	Physician	1.01	2,896	4,200	4,242	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.70	1,240	2,100	1,470	3.00
4.00	Subtotal (sum of lines 1-3)	1.71	4,136		5,712	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	1.71	4,136		5,712	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
<b>DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES</b>						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)				463,648	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				463,648	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)				261,250	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				462,675	15.00
16.00	Total overhead (sum of lines 14 and 15)				723,925	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				723,925	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				723,925	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				1,187,573	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 260025	Period:	Worksheet M-3
		Component CCN: 268512	From 10/01/2013 To 09/30/2014	Date/Time Prepared: 2/27/2015 1:54 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
				1.00
<b>DETERMINATION OF RATE FOR RHC/FQHC SERVICES</b>				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		1,306,514	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		15,085	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,291,429	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		7,245	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		758	5.00
6.00	Total adjusted visits (line 4 plus line 5)		8,003	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		161.37	7.00
		<b>Calculation of Limit (1)</b>		
		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)	79.17	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	79.17	79.80	9.00
<b>CALCULATION OF SETTLEMENT</b>				
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,219	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	97,276	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		97,276	16.00
16.01	Total program charges (see instructions)(from contractor's records)		150,954	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		180	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		116	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.)		59,970	16.04
16.05	Total program cost (see instructions)		60,086	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		22,197	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		25,715	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		60,086	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		13,131	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		73,217	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (see instructions)		73,217	26.00
26.01	Sequestration adjustment (see instructions)		1,464	26.01
27.00	Interim payments		57,339	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		14,414	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter 1, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 260025	Period:	Worksheet M-3
		Component CCN: 263984	From 10/01/2013 To 09/30/2014	Date/Time Prepared: 2/27/2015 1:54 pm
		Title XVIII	Rural Health Clinic (RHC) II	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		1,338,547	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		19,755	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,318,792	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		6,300	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		6,300	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		209.33	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)	79.17	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	79.17	79.80	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,237	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	98,713	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		98,713	16.00
16.01	Total program charges (see instructions)(from contractor's records)		160,561	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		270	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		166	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.)		65,929	16.04
16.05	Total program cost (see instructions)		66,095	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		16,136	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		28,831	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		66,095	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		16,831	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		82,926	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (see instructions)		82,926	26.00
26.01	Sequestration adjustment (see instructions)		1,659	26.01
27.00	Interim payments		63,686	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		17,581	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter 1, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 260025	Period: From 10/01/2013 To 09/30/2014	Worksheet M-3
		Component CCN: 268513		Date/Time Prepared: 2/27/2015 1:54 pm
		Title XVIII	Rural Health Clinic (RHC) III	Cost
				1.00
<b>DETERMINATION OF RATE FOR RHC/FQHC SERVICES</b>				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		1,187,573	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		48,013	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,139,560	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		5,712	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		5,712	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		199.50	7.00
		<b>Calculation of Limit (1)</b>		
		<b>Prior to January 1</b>	<b>On or After January 1</b>	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.17	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	79.17	79.80	9.00
<b>CALCULATION OF SETTLEMENT</b>				
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,346	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	107,411	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		107,411	16.00
16.01	Total program charges (see instructions)(from contractor's records)		219,154	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		308	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		151	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.)		69,814	16.04
16.05	Total program cost (see instructions)		69,965	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		19,992	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		39,771	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		69,965	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		36,003	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		105,968	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (see instructions)		105,968	26.00
26.01	Sequestration adjustment (see instructions)		2,119	26.01
27.00	Interim payments		66,885	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		36,964	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter 1, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 260025 Component CCN: 268512	Period: From 10/01/2013 To 09/30/2014	Worksheet M-4 Date/Time Prepared: 2/27/2015 1:54 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	395,186	395,186	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000473	0.003844	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	187	1,519	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	2,056	2,050	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	2,243	3,569	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	503,367	503,367	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	803,147	803,147	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.004456	0.007090	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	3,579	5,694	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	5,822	9,263	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	16	130	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	363.88	71.25	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	12	123	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	4,367	8,764	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		15,085	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		13,131	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 260025 Component CCN: 263984	Period: From 10/01/2013 To 09/30/2014	Worksheet M-4 Date/Time Prepared: 2/27/2015 1:54 pm
		Title XVIII	Rural Health Clinic (RHC) II	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	391,822	391,822	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000280	0.005490	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	110	2,151	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	900	3,190	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,010	5,341	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	430,348	430,348	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	908,199	908,199	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002347	0.012411	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	2,132	11,272	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	3,142	16,613	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	7	137	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	448.86	121.26	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	4	124	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	1,795	15,036	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		19,755	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		16,831	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 260025 Component CCN: 268513	Period: From 10/01/2013 To 09/30/2014	Worksheet M-4 Date/Time Prepared: 2/27/2015 1:54 pm
		Title XVIII	Rural Health Clinic (RHC) III	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	397,540	397,540	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.003889	0.008720	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,546	3,467	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	10,667	3,065	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	12,213	6,532	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	463,648	463,648	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	723,925	723,925	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.026341	0.014088	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	19,069	10,199	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	31,282	16,731	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	83	186	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	376.89	89.95	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	54	174	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	20,352	15,651	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		48,013	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		36,003	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 260025 Component CCN: 268512	Period: From 10/01/2013 To 09/30/2014	Worksheet M-5 Date/Time Prepared: 2/27/2015 1:54 pm
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		57,339	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)		57,339	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		14,414	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		71,753	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 260025 Component CCN: 263984	Period: From 10/01/2013 To 09/30/2014	Worksheet M-5 Date/Time Prepared: 2/27/2015 1:54 pm
		Rural Health Clinic (RHC) II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		63,686	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)		63,686	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		17,581	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		81,267	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 260025 Component CCN: 268513	Period: From 10/01/2013 To 09/30/2014	Worksheet M-5 Date/Time Prepared: 2/27/2015 1:54 pm
		Rural Health Clinic (RHC) III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		66,885	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)		66,885	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		36,964	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		103,849	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00