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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 260025	Period: From 10/01/2014 To 09/30/2015	Worksheet S Parts I-III Date/Time Prepared: 2/26/2016 2:35 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/26/2016 Time: 2:35 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HANNIBAL REGIONAL HOSPITAL (260025) for the cost reporting period beginning 10/01/2014 and ending 09/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-137,146	-1,326	930,829	1,105,131	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		12,679		0	10.00
10.01	RURAL HEALTH CLINIC II	0		14,428		0	10.01
10.02	RURAL HEALTH CLINIC III	0		31,480		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		40,522		0	10.03
10.04	RURAL HEALTH CLINIC V	0		42,530		0	10.04
200.00	Total	0	-137,146	140,313	930,829	1,105,131	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2016 1:59 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: HIGHWAY 36, 6000 HOSPITAL DRIVE	PO Box:			1.00
2.00	City: HANNIBAL	State: MO	Zip Code: 63401	County: MARION	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	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 - SHELBINA	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
15.03	Hospital-Based Health Clinic - RHC IV	HANNIBAL REG - LOUISIANA	268723	99926		04/01/2014	N	O	O	15.03
15.04	Hospital-Based Health Clinic - RHC V	HANNIBAL REG - BOWLING GREEN	268724	99926		04/01/2014	N	O	O	15.04
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2014	09/30/2015	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)	N	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	881	0	40	0	1,388	0	24.00

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		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	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		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.	10/01/2014	09/30/2015	36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

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

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

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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00

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		1.00	2.00	3.00	
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	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	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			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	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

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

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

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	297,338	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/26/2016 1:59 pm

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
					1.00	
	Multicampus					
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
							1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.50	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)	10/01/2014	09/30/2015	170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 2/26/2016 1:59 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	12/15/2015	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	01/11/2016	Y	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)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 2/26/2016 1:59 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions					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
	Interest Expense					
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
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.					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
	Provider-Based Physicians					
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	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			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	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JIM	MCMAKIN	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.MCMAKIN@HRHONLINE.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 2/26/2016 1:59 pm

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	01/11/2016			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		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		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 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 2/26/2016 1:59 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	91	30,325	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)		91	30,325	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	43.00				0	13.00
14.00	Total (see instructions)		99	33,245	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						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
26.03	RURAL HEALTH CLINIC IV	88.03				0	26.03
26.04	RURAL HEALTH CLINIC V	88.04				0	26.04
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		99				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 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 2/26/2016 1:59 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	8,741	644	13,688			1.00
2.00	HMO and other (see instructions)	943	1,428				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)	8,741	644	13,688			7.00
8.00	INTENSIVE CARE UNIT	1,409	131	2,072			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		93	1,291			13.00
14.00	Total (see instructions)	10,150	868	17,051	0.00	730.24	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	3,703	275	6,397	0.00	11.28	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	820	128	4,044	0.00	7.94	26.00
26.01	RURAL HEALTH CLINIC II	964	522	4,110	0.00	7.03	26.01
26.02	RURAL HEALTH CLINIC III	1,690	201	5,484	0.00	8.72	26.02
26.03	RURAL HEALTH CLINIC IV	2,087	713	7,747	0.00	8.27	26.03
26.04	RURAL HEALTH CLINIC V	1,780	478	6,982	0.00	8.71	26.04
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	782.19	27.00
28.00	Observation Bed Days		0	948			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	13	181			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 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 2/26/2016 1:59 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,275	203	4,232	1.00
2.00	HMO and other (see instructions)			201	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	2,275	203	4,232	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						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
26.03	RURAL HEALTH CLINIC IV	0.00					26.03
26.04	RURAL HEALTH CLINIC V	0.00					26.04
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part II Date/Time Prepared: 2/26/2016 1:59 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	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	50,571,800	0	50,571,800	1,626,964.00	31.08	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		441,627	0	441,627	2,063.50	214.02	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		6,626,686	0	6,626,686	41,713.50	158.86	5.00
6.00	Non-physician-Part B		1,662,110	0	1,662,110	41,767.00	39.79	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)		8,310,780	-179,084	8,131,696	209,487.18	38.82	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,722,027	0	1,722,027	23,333.98	73.80	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		318,385	0	318,385	1,884.50	168.95	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
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		14,657,440	0	14,657,440			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		2,305,330	0	2,305,330			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		22,708	0	22,708			22.00
22.01	Physician Part A - Teaching		459,042	0	459,042			22.01
23.00	Physician Part B		459,631	0	459,631			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	464,385	179,084	643,469	28,681.00	22.44	26.00
27.00	Administrative & General	5.00	10,283,049	0	10,283,049	319,546.00	32.18	27.00
28.00	Administrative & General under contract (see inst.)		831,908	0	831,908	4,509.00	184.50	28.00
29.00	Maintenance & Repairs	6.00	317,736	0	317,736	19,050.00	16.68	29.00
30.00	Operation of Plant	7.00	691,983	0	691,983	30,557.00	22.65	30.00
31.00	Laundry & Linen Service	8.00	30,847	0	30,847	2,847.00	10.83	31.00
32.00	Housekeeping	9.00	578,124	0	578,124	46,916.00	12.32	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	770,590	0	770,590	53,296.00	14.46	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	636,276	0	636,276	20,723.00	30.70	38.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part II Date/Time Prepared: 2/26/2016 1:59 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	
39.00	Central Services and Supply	14.00	127,262	0	127,262	7,496.00	16.98	39.00
40.00	Pharmacy	15.00	1,586,325	0	1,586,325	37,675.00	42.11	40.00
41.00	Medical Records & Medical Records Library	16.00	682,856	0	682,856	34,040.00	20.06	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 10/01/2014 To 09/30/2015 | Worksheet S-3 Part III Date/Time Prepared: 2/26/2016 1:59 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	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		43,114,912	0	43,114,912	1,547,992.50	27.85	1.00
2.00	Excluded area salaries (see instructions)		8,310,780	-179,084	8,131,696	209,487.18	38.82	2.00
3.00	Subtotal salaries (line 1 minus line 2)		34,804,132	179,084	34,983,216	1,338,505.32	26.14	3.00
4.00	Subtotal other wages & related costs (see inst.)		2,040,412	0	2,040,412	25,218.48	80.91	4.00
5.00	Subtotal wage-related costs (see inst.)		14,680,148	0	14,680,148	0.00	41.96	5.00
6.00	Total (sum of lines 3 thru 5)		51,524,692	179,084	51,703,776	1,363,723.80	37.91	6.00
7.00	Total overhead cost (see instructions)		17,001,341	179,084	17,180,425	605,336.00	28.38	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part IV Date/Time Prepared: 2/26/2016 1:59 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	2,083,776	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1,960,000	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	2,140	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	27,900	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	9,645,750	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	-4,431	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	51,619	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)	132,742	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	28,327	14.00
15.00	'Workers' Compensation Insurance	375,270	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
	TAXES		
17.00	FICA-Employers Portion Only	3,143,504	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	30,266	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	290,071	21.00
22.00	Day Care Cost and Allowances	29,058	22.00
23.00	Tuition Reimbursement	108,159	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	17,904,151	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part V Date/Time Prepared: 2/26/2016 1:59 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	2,874,314	0	1.00
2.00	Hospital	2,872,320	0	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	1,994	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	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
14.03	Hospital-Based Health Clinic RHC 3	0	0	14.03
14.04	Hospital-Based Health Clinic RHC 4	0	0	14.04
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 260025 | Component CCN: 267282 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-4 | Date/Time Prepared: 2/26/2016 1:59 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	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	2,592	11	114	2,717	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	312.00	32.00	193.00	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	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			1.00	0.00	1.00	4.00
5.00	Other Administrative Personnel			1.28	0.00	1.28	5.00
6.00	Direct Nursing Service			6.00	0.00	6.00	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			2.00	0.00	2.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.00	0.00	1.00	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
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			3			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
20.02				50089			20.02
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,863	138	95	39	2,135	21.00
22.00	Skilled Nursing Visit Charges	270,135	19,604	13,775	5,655	309,169	22.00
23.00	Physical Therapy Visits	1,179	13	14	32	1,238	23.00
24.00	Physical Therapy Visit Charges	182,745	2,015	2,170	4,960	191,890	24.00
25.00	Occupational Therapy Visits	81	0	0	0	81	25.00
26.00	Occupational Therapy Visit Charges	12,555	0	0	0	12,555	26.00
27.00	Speech Pathology Visits	14	0	1	0	15	27.00
28.00	Speech Pathology Visit Charges	2,170	0	155	0	2,325	28.00
29.00	Medical Social Service Visits	12	1	0	1	14	29.00
30.00	Medical Social Service Visit Charges	1,860	155	0	155	2,170	30.00
31.00	Home Health Aide Visits	180	16	1	23	220	31.00
32.00	Home Health Aide Visit Charges	12,600	1,120	70	1,610	15,400	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,329	168	111	95	3,703	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)	482,065	22,894	16,170	12,380	533,509	35.00
36.00	Total Number of Episodes (standard/non outlier)	285		37	5	327	36.00
37.00	Total Number of Outlier Episodes		4		0	4	37.00
38.00	Total Non-Routine Medical Supply Charges	21,068	931	940	74	23,013	38.00

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

Provider CCN: 260025 Component CCN: 268512 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-8 Date/Time Prepared: 2/26/2016 1:59 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	SHELBINA	MO	63468	2.00

		1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00

		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			09:00	17:00	09:00	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)						15.00

			County			
			4.00			
2.00	City, State, ZIP Code, County		SHELBY			2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	17:00	09:00	17:00	09:00	17:00	11.00

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

Provider CCN: 260025
Component CCN: 268512

Period:
From 10/01/2014
To 09/30/2015

Worksheet S-8

Date/Time Prepared:
2/26/2016 1:59 pm

Rural Health Clinic (RHC) I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	09:00	17:00				11.00

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

Provider CCN: 260025 Component CCN: 263984 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-8 | Date/Time Prepared: 2/26/2016 1:59 pm

				Rural Health Clinic (RHC) II	Cost	
				1.00		
	Clinic Address and Identification					
1.00	Street			1802 ELM STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	CANTON		MO	63435	2.00
					1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
				Grant Award	Date	
				1.00	2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0		6.00
7.00	Appalachian Regional Commission			0		7.00
8.00	Look-Alikes			0		8.00
9.00	OTHER (SPECIFY)			0		9.00
				1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			09:00	17:00	09:00	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)						15.00

			County				
			4.00				
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	
	Facility hours of operations (1)						
11.00	Clinic	17:00	09:00	17:00	09:00	17:00	11.00

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

Provider CCN: 260025
Component CCN: 263984

Period:
From 10/01/2014
To 09/30/2015

Worksheet S-8

Date/Time Prepared:
2/26/2016 1:59 pm

Rural Health Clinic (RHC) II

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	09:00	17:00				11.00

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

Provider CCN: 260025 Component CCN: 268513 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-8 | Date/Time Prepared: 2/26/2016 1:59 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	MO	63456	2.00

		1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00

		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			09:00	17:00	09:00	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)						15.00

			County			
			4.00			
2.00	City, State, ZIP Code, County		MONROE			2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	17:00	09:00	17:00	09:00	17:00	11.00

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

Provider CCN: 260025
Component CCN: 268513

Period:
From 10/01/2014
To 09/30/2015

Worksheet S-8

Date/Time Prepared:
2/26/2016 1:59 pm

Rural Health Clinic (RHC) III

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	09:00	17:00				11.00

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

Provider CCN: 260025 Component CCN: 268723 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-8 | Date/Time Prepared: 2/26/2016 1:59 pm

Rural Health Clinic (RHC) IV | Cost

					1.00	
	Clinic Address and Identification					
1.00	Street			211 SOUTH 3RD STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	LOUISIANA		MO	63353	2.00
					1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
				Grant Award	Date	
				1.00	2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0		6.00
7.00	Appalachian Regional Commission			0		7.00
8.00	Look-Alikes			0		8.00
9.00	OTHER (SPECIFY)			0		9.00
				1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			09:00	17:00	09:00	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)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		PIKE				2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	17:00	09:00	17:00	09:00	17:00	11.00

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

Provider CCN: 260025
Component CCN: 268723

Period:
From 10/01/2014
To 09/30/2015

Worksheet S-8

Date/Time Prepared:
2/26/2016 1:59 pm

Rural Health Clinic (RHC) IV

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	09:00	17:00				11.00

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

Provider CCN: 260025 Component CCN: 268724 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-8 | Date/Time Prepared: 2/26/2016 1:59 pm

Rural Health Clinic (RHC) V | Cost

					1.00	
	Clinic Address and Identification					
1.00	Street			905 HWY 161		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	BOWLING GREEN		MO	63334	2.00
					1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
				Grant Award	Date	
				1.00	2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0		6.00
7.00	Appalachian Regional Commission			0		7.00
8.00	Look-Alikes			0		8.00
9.00	OTHER (SPECIFY)			0		9.00
				1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			09:00	17:00	09:00	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)						15.00

			County			
			4.00			
2.00	City, State, ZIP Code, County		PIKE			2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	17:00	09:00	17:00	09:00	17:00	11.00

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

Provider CCN: 260025
Component CCN: 268724

Period:
From 10/01/2014
To 09/30/2015

Worksheet S-8

Date/Time Prepared:
2/26/2016 1:59 pm

Rural Health Clinic (RHC) V

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	09:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-10 | Date/Time Prepared: 2/26/2016 1:59 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.317966	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	6,405,342	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	1,980,404	5.00
6.00	Medicaid charges	27,446,426	6.00
7.00	Medicaid cost (line 1 times line 6)	8,727,030	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)	341,284	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	341,284	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	7,298,383	1,137,398	8,435,781	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	2,320,638	361,654	2,682,292	21.00
22.00	Partial payment by patients approved for charity care	30,639	4,733	35,372	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,289,999	356,921	2,646,920	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)	6,148,259	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	490,597	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	5,657,662	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,798,944	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,445,864	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,787,148	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/26/2016 1:59 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,639,731	2,639,731	687,671	3,327,402	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		6,181,016	6,181,016	-1,879,949	4,301,067	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	464,385	11,007,847	11,472,232	208,142	11,680,374	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,283,049	8,418,059	18,701,108	1,031,882	19,732,990	5.00
6.00	00600	MAINTENANCE & REPAIRS	317,736	57,729	375,465	0	375,465	6.00
7.00	00700	OPERATION OF PLANT	691,983	2,544,303	3,236,286	-462,465	2,773,821	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	30,847	266,062	296,909	0	296,909	8.00
9.00	00900	HOUSEKEEPING	578,124	226,572	804,696	462,465	1,267,161	9.00
10.00	01000	DIETARY	770,590	754,039	1,524,629	0	1,524,629	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	636,276	393,411	1,029,687	0	1,029,687	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	127,262	114,362	241,624	-11,615	230,009	14.00
15.00	01500	PHARMACY	1,586,325	766,886	2,353,211	0	2,353,211	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	682,856	514,306	1,197,162	0	1,197,162	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,620,529	2,402,843	8,023,372	62,152	8,085,524	30.00
31.00	03100	INTENSIVE CARE UNIT	1,648,437	417,449	2,065,886	22,578	2,088,464	31.00
43.00	04300	NURSERY	302,310	126,426	428,736	6,033	434,769	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,030,618	1,373,901	2,404,519	-20,050	2,384,469	50.00
51.00	05100	RECOVERY ROOM	883,395	170,482	1,053,877	0	1,053,877	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	893,811	206,189	1,100,000	5,582	1,105,582	52.00
53.00	05300	ANESTHESIOLOGY	2,560,879	262,819	2,823,698	218,096	3,041,794	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,149,944	597,184	1,747,128	307,034	2,054,162	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	806,080	598,106	1,404,186	98,756	1,502,942	55.00
56.00	05600	RADIOISOTOPE	102,266	82,970	185,236	0	185,236	56.00
57.00	05700	CT SCAN	243,611	180,738	424,349	106,683	531,032	57.00
58.00	05800	MRI	88,020	230,518	318,538	0	318,538	58.00
59.00	05900	CARDIAC CATHETERIZATION	411,872	1,543,158	1,955,030	-641,320	1,313,710	59.00
60.00	06000	LABORATORY	2,069,817	1,880,910	3,950,727	105,786	4,056,513	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	94,632	503,610	598,242	0	598,242	62.00
64.00	06400	INTRAVENOUS THERAPY	352,860	59,435	412,295	0	412,295	64.00
65.00	06500	RESPIRATORY THERAPY	805,961	221,328	1,027,289	26,448	1,053,737	65.00
66.00	06600	PHYSICAL THERAPY	298,188	585,161	883,349	0	883,349	66.00
67.00	06700	OCCUPATIONAL THERAPY	39,755	100,246	140,001	0	140,001	67.00
68.00	06800	SPEECH PATHOLOGY	150,129	37,011	187,140	0	187,140	68.00
69.00	06900	ELECTROCARDIOLOGY	53,762	49,656	103,418	0	103,418	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	164,888	31,647	196,535	0	196,535	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,308,570	8,308,570	-861,024	7,447,546	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,522,394	1,522,394	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,744,266	2,744,266	0	2,744,266	73.00
74.00	07400	RENAL DIALYSIS	0	108,893	108,893	0	108,893	74.00
76.00	03190	CHEMOTHERAPY	0	0	0	0	0	76.00
76.01	03950	DIABETES CENTER	26,888	5,727	32,615	0	32,615	76.01
76.97	07697	CARDIAC REHABILITATION	126,700	28,968	155,668	0	155,668	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	80,954	21,383	102,337	0	102,337	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	406,772	346,641	753,413	0	753,413	88.00
88.01	08801	RURAL HEALTH CLINIC II	409,266	270,420	679,686	27,789	707,475	88.01
88.02	08802	RURAL HEALTH CLINIC III	621,301	176,557	797,858	0	797,858	88.02
88.03	08803	RURAL HEALTH CLINIC IV	769,312	341,429	1,110,741	-272,888	837,853	88.03
88.04	08804	RURAL HEALTH CLINIC V	384,300	149,259	533,559	272,888	806,447	88.04
91.00	09100	EMERGENCY	3,494,330	3,105,280	6,599,610	0	6,599,610	91.00
91.01	09101	OUTPATIENT PSYCH	0	0	0	0	0	91.01
91.02	09102	WOUND CARE	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	768,023	230,664	998,687	0	998,687	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		814,926	814,926	-814,926	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	43,029,043	62,199,093	105,228,136	208,142	105,436,278	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,635,001	1,755,156	8,390,157	0	8,390,157	192.00
194.00	07950	RENTAL PROPERTIES	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	851,143	206,577	1,057,720	-208,142	849,578	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	56,613	40,991	97,604	0	97,604	194.04
200.00		TOTAL (SUM OF LINES 118-199)	50,571,800	64,201,817	114,773,617	0	114,773,617	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/26/2016 1:59 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-261,331	3,066,071		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-7,678	4,293,389		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	118,570	11,798,944		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,619,373	23,352,363		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	375,465		6.00
7.00	00700	OPERATION OF PLANT	-11,909	2,761,912		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	296,909		8.00
9.00	00900	HOUSEKEEPING	0	1,267,161		9.00
10.00	01000	DIETARY	-569,022	955,607		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,029,687		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	230,009		14.00
15.00	01500	PHARMACY	0	2,353,211		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-43,952	1,153,210		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,430,212	6,655,312		30.00
31.00	03100	INTENSIVE CARE UNIT	-4,916	2,083,548		31.00
43.00	04300	NURSERY	-988	433,781		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-594,090	1,790,379		50.00
51.00	05100	RECOVERY ROOM	0	1,053,877		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-1,602	1,103,980		52.00
53.00	05300	ANESTHESIOLOGY	-2,491,776	550,018		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,194	2,051,968		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	-32,880	1,470,062		55.00
56.00	05600	RADIOISOTOPE	0	185,236		56.00
57.00	05700	CT SCAN	0	531,032		57.00
58.00	05800	MRI	0	318,538		58.00
59.00	05900	CARDIAC CATHETERIZATION	-476,905	836,805		59.00
60.00	06000	LABORATORY	-870,938	3,185,575		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	598,242		62.00
64.00	06400	INTRAVENOUS THERAPY	0	412,295		64.00
65.00	06500	RESPIRATORY THERAPY	-11,409	1,042,328		65.00
66.00	06600	PHYSICAL THERAPY	-39,461	843,888		66.00
67.00	06700	OCCUPATIONAL THERAPY	-89,545	50,456		67.00
68.00	06800	SPEECH PATHOLOGY	-110,475	76,665		68.00
69.00	06900	ELECTROCARDIOLOGY	-4,339	99,079		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-28,951	167,584		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,447,546		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,522,394		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,744,266		73.00
74.00	07400	RENAL DIALYSIS	0	108,893		74.00
76.00	03190	CHEMOTHERAPY	0	0		76.00
76.01	03950	DIABETES CENTER	0	32,615		76.01
76.97	07697	CARDIAC REHABILITATION	0	155,668		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	102,337		76.98
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-17	753,396		88.00
88.01	08801	RURAL HEALTH CLINIC II	-271	707,204		88.01
88.02	08802	RURAL HEALTH CLINIC III	-558	797,300		88.02
88.03	08803	RURAL HEALTH CLINIC IV	-81	837,772		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	806,447		88.04
91.00	09100	EMERGENCY	-3,845,966	2,753,644		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				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	998,687		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-7,193,523	98,242,755		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	8,390,157		192.00
194.00	07950	RENTAL PROPERTIES	0	0		194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	849,578		194.01
194.02	07952	HWY 61 BUILDING	0	0		194.02
194.03	07953	MEDICAL BUILDING	0	0		194.03
194.04	07954	PHYSICIAN OFFICES PITTSFIELD	0	97,604		194.04
200.00		TOTAL (SUM OF LINES 118-199)	-7,193,523	107,580,094		200.00

RECLASSIFICATIONS | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/26/2016 1:59 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - ADMISSION KITS					
1.00		0.00	0	0		1.00
2.00	NURSERY	43.00	0	6,033		2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	0	5,582		3.00
	0		0	11,615		
	B - INTEREST EXP ON BONDS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	634,269		1.00
	0		0	634,269		
	C - CAPITAL LEASE EXP					
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	RADIOLOGY - THERAPEUTIC	55.00	0	90,265		10.00
11.00	RURAL HEALTH CLINIC II	88.01	0	25,400		11.00
	0		0	1,920,481		
	D - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	93,934		1.00
	0		0	93,934		
	E - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,522,394		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		0	1,522,394		
	F - CAP LEASE INTEREST					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	96,798		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	5,344		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	1,941		3.00
4.00	ANESTHESIOLOGY	53.00	0	18,752		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	26,399		5.00
6.00	CT SCAN	57.00	0	9,173		6.00
7.00	LABORATORY	60.00	0	9,096		7.00
8.00	RESPIRATORY THERAPY	65.00	0	2,274		8.00
9.00	RADIOLOGY - THERAPEUTIC	55.00	0	8,491		9.00
10.00	RURAL HEALTH CLINIC II	88.01	0	2,389		10.00
	0		0	180,657		
	G - CHILDREN'S CENTER					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	179,084	29,058		1.00
	0		179,084	29,058		
	H - LOUISIANA CLINIC					
1.00	RURAL HEALTH CLINIC V	88.04	383,453	126,618		1.00
	0		383,453	126,618		
	I - BOWLING GREEN CLINIC					
1.00	RURAL HEALTH CLINIC IV	88.03	191,187	45,996		1.00
	0		191,187	45,996		
	J - OUTSIDE CLEANING SERVICE					
1.00	HOUSEKEEPING	9.00	0	462,465		1.00
	TOTALS		0	462,465		
500.00	Grand Total: Increases		753,724	5,027,487		500.00

RECLASSIFICATIONS | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/26/2016 1:59 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - ADMISSION KITS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	11,615	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		0	11,615			
	B - INTEREST EXP ON BONDS						
1.00	INTEREST EXPENSE	113.00	0	634,269	11		1.00
	0		0	634,269			
	C - CAPITAL LEASE EXP						
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			
	D - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	93,934	5		1.00
	0		0	93,934			
	E - IMPLANTS						
1.00	OPERATING ROOM	50.00	0	20,050	0		1.00
2.00	CARDIAC CATHETERIZATION	59.00	0	641,320	0		2.00
3.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	861,024	0		3.00
	0		0	1,522,394			
	F - CAP LEASE INTEREST						
1.00	INTEREST EXPENSE	113.00	0	180,657	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
5.00		0.00	0	0	0		5.00
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	180,657			
	G - CHILDREN'S CENTER						
1.00	CHILD DEVELOPMENT CENTER	194.01	179,084	29,058	0		1.00
	0		179,084	29,058			
	H - LOUISIANA CLINIC						
1.00	RURAL HEALTH CLINIC IV	88.03	383,453	126,618	0		1.00
	0		383,453	126,618			
	I - BOWLING GREEN CLINIC						
1.00	RURAL HEALTH CLINIC V	88.04	191,187	45,996	0		1.00
	0		191,187	45,996			
	J - OUTSIDE CLEANING SERVICE						
1.00	OPERATION OF PLANT	7.00	0	462,465	0		1.00
	TOTALS		0	462,465			
500.00	Grand Total: Decreases		753,724	5,027,487			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 2/26/2016 1:59 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,693,370	0	0	0	0	1.00
2.00	Land Improvements	7,113,729	4,400	0	4,400	0	2.00
3.00	Buildings and Fixtures	44,043,753	0	0	0	0	3.00
4.00	Building Improvements	18,614,031	2,040,781	0	2,040,781	8,868	4.00
5.00	Fixed Equipment	321,581	58,040	0	58,040	0	5.00
6.00	Movable Equipment	63,461,686	7,509,699	0	7,509,699	3,523,456	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	136,248,150	9,612,920	0	9,612,920	3,532,324	8.00
9.00	Reconciling Items	-825,417	-5,299,712	0	-5,299,712	-4,923,946	9.00
10.00	Total (line 8 minus line 9)	137,073,567	14,912,632	0	14,912,632	8,456,270	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,693,370	0	1.00
2.00	Land Improvements	7,118,129	0	2.00
3.00	Buildings and Fixtures	44,043,753	0	3.00
4.00	Building Improvements	20,645,944	0	4.00
5.00	Fixed Equipment	379,621	0	5.00
6.00	Movable Equipment	67,447,929	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	142,328,746	0	8.00
9.00	Reconciling Items	-1,201,183	0	9.00
10.00	Total (line 8 minus line 9)	143,529,929	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part II Date/Time Prepared: 2/26/2016 1:59 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	2,615,342	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,181,016	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	8,796,358	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	24,389	2,639,731	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	6,181,016	2.00
3.00	Total (sum of lines 1-2)	24,389	8,820,747	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 2/26/2016 1:59 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	74,501,196	0	74,501,196	0.568507	53,402	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	67,827,550	11,281,560	56,545,990	0.431493	40,532	2.00
3.00	Total (sum of lines 1-2)	142,328,746	11,281,560	131,047,186	1.000000	93,934	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	53,402	2,473,080	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	40,532	4,252,857	0	2.00
3.00	Total (sum of lines 1-2)	0	0	93,934	6,725,937	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	515,200	53,402	0	24,389	3,066,071	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	40,532	0	0	4,293,389	2.00
3.00	Total (sum of lines 1-2)	515,200	93,934	0	24,389	7,359,460	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/26/2016 1:59 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
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	-119,069	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	-8,687	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	-9,959,722			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	-569,022	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-43,952	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	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/26/2016 1:59 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME	B	-11,031	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	RECRUITMENT FEES	A	-359,981	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	STAFF DEVELOPMENT	B	-14,277	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	NON ALLOWED ADVERTISING COSTS	A	-1,412,893	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	NURSERY PHOTOS	B	-988	NURSERY	43.00	0	37.00
38.00	ULTRAFAST LAB TEST	B	-663	LABORATORY	60.00	0	38.00
39.00	FRA TAX ASSESSMENT	A	6,282,621	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	LOBBYING EXPENSE	A	-29,962	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	ALCOHOLIC BEVERAGE EXPENSE	A	-2,462	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	EEG CONTRACT SERVICE	B	-15,398	ELECTROENCEPHALOGRAPHY	70.00	0	42.00
43.00	P/T CONTRACT SERVICE	B	-39,461	PHYSICAL THERAPY	66.00	0	43.00
44.00	EMPLOYED PHYSICIAN BENEFITS	A	-1,436,310	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	44.00
45.00	DEVELOPMENT SALARIES	A	-278,269	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	DEVELOPMENT EXPENSE	A	-138,484	ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.02	SPEECH CONTRACT SERVICE	B	-110,475	SPEECH PATHOLOGY	68.00	0	45.02
45.03	A&G - OTHER - MISC	B	-52,941	ADMINISTRATIVE & GENERAL	5.00	0	45.03
45.04	RADIOLOGY - MISC REVENUE	B	-2,194	RADIOLOGY-DIAGNOSTIC	54.00	0	45.04
45.05	L&D - MISC REVENUE	B	-1,602	DELIVERY ROOM & LABOR ROOM	52.00	0	45.05
45.06	BUILDING RENTAL INCOME	B	-142,262	CAP REL COSTS-BLDG & FIXT	1.00	9	45.06
45.07	PLANT OPERATIONS OTHER REV	B	-3,222	OPERATION OF PLANT	7.00	0	45.07
45.08	CONTRIBUTIONS	A	-13,495	ADMINISTRATIVE & GENERAL	5.00	0	45.08
45.09	ADVERTISING EMPLOYEE BENEFITS	A	-78,032	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.09
45.10	FOUNDATION EMPLOYEE BENEFITS	A	-69,235	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.10
45.11	RHC-MONROE CIT OTHER REV	B	-558	RURAL HEALTH CLINIC III	88.02	0	45.11
45.12	EMERGENCY OTHER REV	B	-4,989	EMERGENCY	91.00	0	45.12
45.13	DEFINED BENEFIT PENSION PLAN	A	1,868,483	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.13
45.14	COMMUNICATIONS OTHER REVENUE	B	-71,956	ADMINISTRATIVE & GENERAL	5.00	0	45.14
45.15			0		0.00	0	45.15
45.16	RHC - SHELBINA OTHER REVENUE	B	-17	RURAL HEALTH CLINIC	88.00	0	45.16
45.17	RHC - CANTON/LAGRANGE OTHER REVENUE	B	-271	RURAL HEALTH CLINIC II	88.01	0	45.17
45.18	MISC REVENUE	B	-10,000	ADULTS & PEDIATRICS	30.00	0	45.18
45.19	MISC REVENUE	B	-4,339	ELECTROCARDIOLOGY	69.00	0	45.19
45.20	MISC REVENUE	B	-4,916	INTENSIVE CARE UNIT	31.00	0	45.20
45.21	MISC REVENUE	B	-10,000	LABORATORY	60.00	0	45.21
45.22	PATIENT PHONE	A	-27,855	ADMINISTRATIVE & GENERAL	5.00	0	45.22
45.23	PATIENT PHONE	A	-7,678	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.23
45.24	MEDICAL RECORDS REVENUE	B	-7,035	ADMINISTRATIVE & GENERAL	5.00	0	45.24
45.25	RHC - LOUISIANA OTHER REVENUE	B	-81	RURAL HEALTH CLINIC IV	88.03	0	45.25
45.26	DAYCARE REVENUE	B	-166,336	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.26
45.27			0		0.00	0	45.27
45.28	SLEEP CONTRACT SERVICE	B	-13,553	ELECTROENCEPHALOGRAPHY	70.00	0	45.28
45.29	R/T CONTRACT SERVICE	B	-11,409	RESPIRATORY THERAPY	65.00	0	45.29
45.30	O/T CONTRACT SERVICE	B	-89,545	OCCUPATIONAL THERAPY	67.00	0	45.30
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,193,523				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 10/01/2014 To 09/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 2/26/2016 1:59 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	341,772	190,152	151,620	159,800	1,283	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,420,212	1,420,212	0	0	0	2.00
3.00	50.00	OPERATING ROOM	622,756	507,591	115,165	182,900	326	3.00
4.00	53.00	ANESTHESIOLOGY	2,527,799	2,433,579	94,220	167,500	436	4.00
5.00	55.00	RADIOLOGY - THERAPEUTIC	60,000	0	60,000	159,800	353	5.00
6.00	60.00	LABORATORY	912,479	820,506	91,973	208,000	512	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	59.00	CARDIAC CATHETERIZATION	476,905	476,905	0	0	0	8.00
9.00	91.00	EMERGENCY	3,921,186	3,674,152	247,034	159,800	1,038	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			10,283,109	9,523,097	760,012		3,948	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	98,569	4,928	1,343	596	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	5,588	0	0	2.00
3.00	50.00	OPERATING ROOM	28,666	1,433	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	35,111	1,756	24,466	912	0	4.00
5.00	55.00	RADIOLOGY - THERAPEUTIC	27,120	1,356	0	0	0	5.00
6.00	60.00	LABORATORY	51,200	2,560	9,961	1,004	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	79,746	3,987	7,349	463	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			320,412	16,020	48,707	2,975	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	99,165	52,455	242,607		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,420,212		2.00
3.00	50.00	OPERATING ROOM	0	28,666	86,499	594,090		3.00
4.00	53.00	ANESTHESIOLOGY	0	36,023	58,197	2,491,776		4.00
5.00	55.00	RADIOLOGY - THERAPEUTIC	0	27,120	32,880	32,880		5.00
6.00	60.00	LABORATORY	0	52,204	39,769	860,275		6.00
7.00	0.00		0	0	0	0		7.00
8.00	59.00	CARDIAC CATHETERIZATION	0	0	0	476,905		8.00
9.00	91.00	EMERGENCY	0	80,209	166,825	3,840,977		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	323,387	436,625	9,959,722		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/26/2016 1:59 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,066,071	3,066,071				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,293,389		4,293,389			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	11,798,944	29,967	4,083	11,832,994		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	23,352,363	622,920	2,233,806	2,590,389	28,799,478	5.00
6.00	00600	MAINTENANCE & REPAIRS	375,465	0	640	86,688	462,793	6.00
7.00	00700	OPERATION OF PLANT	2,761,912	169,611	80,156	188,794	3,200,473	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	296,909	7,774	39	8,416	313,138	8.00
9.00	00900	HOUSEKEEPING	1,267,161	8,123	703	157,730	1,433,717	9.00
10.00	01000	DIETARY	955,607	25,984	11,038	210,240	1,202,869	10.00
11.00	01100	CAFETERIA	0	16,447	0	0	16,447	11.00
13.00	01300	NURSING ADMINISTRATION	1,029,687	3,380	90,402	173,595	1,297,064	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	230,009	11,914	0	34,721	276,644	14.00
15.00	01500	PHARMACY	2,353,211	14,665	74,675	432,797	2,875,348	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,153,210	47,663	7,413	186,304	1,394,590	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,655,312	303,857	42,742	1,274,805	8,276,716	30.00
31.00	03100	INTENSIVE CARE UNIT	2,083,548	50,833	16,134	449,743	2,600,258	31.00
43.00	04300	NURSERY	433,781	3,633	10,494	82,479	530,387	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,790,379	78,495	310,212	281,184	2,460,270	50.00
51.00	05100	RECOVERY ROOM	1,053,877	60,808	1,100	241,017	1,356,802	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,103,980	0	3,567	243,858	1,351,405	52.00
53.00	05300	ANESTHESIOLOGY	550,018	3,275	37,769	18,853	609,915	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,051,968	95,701	165,568	313,739	2,626,976	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1,470,062	168,047	145,476	219,923	2,003,508	55.00
56.00	05600	RADIOISOTOPE	185,236	10,839	66,244	27,901	290,220	56.00
57.00	05700	CT SCAN	531,032	4,996	3,128	66,464	605,620	57.00
58.00	05800	MRI	318,538	7,372	10,386	24,014	360,310	58.00
59.00	05900	CARDIAC CATHETERIZATION	836,805	31,836	26,733	112,371	1,007,745	59.00
60.00	06000	LABORATORY	3,185,575	56,415	162,770	339,327	3,744,087	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	598,242	1,179	438	25,818	625,677	62.00
64.00	06400	INTRAVENOUS THERAPY	412,295	44,588	80,914	96,271	634,068	64.00
65.00	06500	RESPIRATORY THERAPY	1,042,328	16,944	9,744	219,890	1,288,906	65.00
66.00	06600	PHYSICAL THERAPY	843,888	44,117	2,796	81,355	972,156	66.00
67.00	06700	OCCUPATIONAL THERAPY	50,456	1,581	0	10,846	62,883	67.00
68.00	06800	SPEECH PATHOLOGY	76,665	559	0	40,960	118,184	68.00
69.00	06900	ELECTROCARDIOLOGY	99,079	0	101,242	14,668	214,989	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	167,584	6,271	4,105	44,986	222,946	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,447,546	0	0	0	7,447,546	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,522,394	0	0	0	1,522,394	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,744,266	0	0	0	2,744,266	73.00
74.00	07400	RENAL DIALYSIS	108,893	0	0	0	108,893	74.00
76.00	03190	CHEMOTHERAPY	0	0	0	0	0	76.00
76.01	03950	DIABETES CENTER	32,615	0	283	7,336	40,234	76.01
76.97	07697	CARDIAC REHABILITATION	155,668	23,120	13,525	34,568	226,881	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	102,337	3,074	0	22,087	127,498	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	753,396	0	27,765	110,980	892,141	88.00
88.01	08801	RURAL HEALTH CLINIC II	707,204	0	32,793	111,660	851,657	88.01
88.02	08802	RURAL HEALTH CLINIC III	797,300	50,109	4,769	169,510	1,021,688	88.02
88.03	08803	RURAL HEALTH CLINIC IV	837,772	0	132,304	157,435	1,127,511	88.03
88.04	08804	RURAL HEALTH CLINIC V	806,447	0	0	157,305	963,752	88.04
91.00	09100	EMERGENCY	2,753,644	256,465	85,294	543,396	3,638,799	91.00
91.01	09101	OUTPATIENT PSYCH	0	0	0	0	0	91.01
91.02	09102	WOUND CARE	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	998,687	26,203	2,633	209,540	1,237,063	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	98,242,755	2,308,765	4,003,883	9,823,963	95,186,912	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,390,157	629,069	284,074	1,810,227	11,113,527	192.00
194.00	07950	RENTAL PROPERTIES	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	849,578	105,423	5,432	183,358	1,143,791	194.01
194.02	07952	HWY 61 BUILDING	0	22,814	0	0	22,814	194.02
194.03	07953	MEDICAL BUILDING	0	0	0	0	0	194.03

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/26/2016 1:59 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
194.04	07954	PHYSICIAN OFFICES PITTSFIELD	97,604	0	0	15,446	113,050	194.04
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)	107,580,094	3,066,071	4,293,389	11,832,994	107,580,094	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/26/2016 1:59 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	
		GENERAL SERVICE COST CENTERS						
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	28,799,478					5.00
6.00	00600	MAINTENANCE & REPAIRS	169,181	631,974				6.00
7.00	00700	OPERATION OF PLANT	1,169,984	44,418	4,414,875			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	114,473	2,036	15,297	444,944		8.00
9.00	00900	HOUSEKEEPING	524,118	2,127	15,984	0	1,975,946	9.00
10.00	01000	DIETARY	439,728	6,805	51,132	0	23,048	10.00
11.00	01100	CAFETERIA	6,012	4,307	32,363	0	14,588	11.00
13.00	01300	NURSING ADMINISTRATION	474,162	885	6,651	0	2,998	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	101,132	3,120	23,443	0	10,567	14.00
15.00	01500	PHARMACY	1,051,129	3,840	28,857	0	13,008	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	509,815	12,482	93,791	0	42,277	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,025,686	79,575	597,925	172,424	269,520	30.00
31.00	03100	INTENSIVE CARE UNIT	950,566	13,312	100,029	24,943	45,089	31.00
43.00	04300	NURSERY	193,891	952	7,150	0	3,223	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	899,391	20,557	154,461	69,155	69,625	50.00
51.00	05100	RECOVERY ROOM	496,001	15,925	119,657	13,936	53,937	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	494,028	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	222,964	858	6,445	0	2,905	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	960,333	25,063	188,320	30,181	84,887	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	732,414	44,009	330,682	7,808	149,058	55.00
56.00	05600	RADIOISOTOPE	106,095	2,839	21,329	0	9,614	56.00
57.00	05700	CT SCAN	221,394	1,308	9,831	0	4,431	57.00
58.00	05800	MRI	131,717	1,931	14,506	0	6,539	58.00
59.00	05900	CARDIAC CATHETERIZATION	368,397	8,337	62,647	4,900	28,239	59.00
60.00	06000	LABORATORY	1,368,711	14,774	111,012	2	50,040	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	228,726	309	2,320	0	1,046	62.00
64.00	06400	INTRAVENOUS THERAPY	231,794	11,677	87,741	7,705	39,550	64.00
65.00	06500	RESPIRATORY THERAPY	471,180	4,437	33,343	0	15,030	65.00
66.00	06600	PHYSICAL THERAPY	355,387	11,553	86,813	1,203	39,132	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,988	414	3,111	0	1,402	67.00
68.00	06800	SPEECH PATHOLOGY	43,204	146	1,100	0	496	68.00
69.00	06900	ELECTROCARDIOLOGY	78,593	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	81,501	1,642	12,340	1,858	5,563	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,722,570	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	556,535	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,003,210	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	39,808	0	0	0	0	74.00
76.00	03190	CHEMOTHERAPY	0	0	0	0	0	76.00
76.01	03950	DIABETES CENTER	14,708	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	82,940	6,055	45,495	0	20,507	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	46,609	805	6,050	0	2,727	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	326,136	0	0	205	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	311,337	0	0	136	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	373,494	13,123	98,603	390	44,446	88.02
88.03	08803	RURAL HEALTH CLINIC IV	412,180	0	0	571	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	352,315	0	0	571	0	88.04
91.00	09100	EMERGENCY	1,330,221	67,164	504,668	108,803	227,484	91.00
91.01	09101	OUTPATIENT PSYCH	0	0	0	0	0	91.01
91.02	09102	WOUND CARE	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	452,228	6,862	51,562	0	23,242	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,268,986	433,647	2,924,658	444,791	1,304,218	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,062,694	164,743	1,237,875	17	557,982	192.00
194.00	07950	RENTAL PROPERTIES	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	418,131	27,609	207,449	0	93,510	194.01
194.02	07952	HWY 61 BUILDING	8,340	5,975	44,893	0	20,236	194.02
194.03	07953	MEDICAL BUILDING	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN OFFICES PITTSFIELD	41,327	0	0	136	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	28,799,478	631,974	4,414,875	444,944	1,975,946	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/26/2016 1:59 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
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	1,723,582					10.00
11.00	01100	CAFETERIA	1,216,271	1,289,988				11.00
13.00	01300	NURSING ADMINISTRATION	0	29,903	1,811,663			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,808	0	425,714		14.00
15.00	01500	PHARMACY	0	54,372	0	0	4,026,554	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	49,148	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	441,374	304,621	1,205,778	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	65,937	83,525	352,489	0	0	31.00
43.00	04300	NURSERY	0	16,573	69,953	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	60,737	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	46,116	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	40,291	170,070	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	28,612	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	53,382	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	4,504	0	0	0	56.00
57.00	05700	CT SCAN	0	11,529	0	0	0	57.00
58.00	05800	MRI	0	4,053	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	18,284	0	0	0	59.00
60.00	06000	LABORATORY	0	95,895	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	5,614	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	19,966	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	42,183	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	13,901	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,111	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,023	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,092	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,446	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	360,517	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	65,197	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,026,554	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03190	CHEMOTHERAPY	0	0	0	0	0	76.00
76.01	03950	DIABETES CENTER	0	1,381	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	6,065	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	3,182	13,373	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
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
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
91.00	09100	EMERGENCY	0	136,967	0	0	0	91.00
91.01	09101	OUTPATIENT PSYCH	0	0	0	0	0	91.01
91.02	09102	WOUND CARE	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,723,582	1,157,284	1,811,663	425,714	4,026,554	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	132,704	0	0	0	192.00
194.00	07950	RENTAL PROPERTIES	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
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)	1,723,582	1,289,988	1,811,663	425,714	4,026,554	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/26/2016 1:59 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
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	2,102,103					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,408,338	15,781,957	167,946	15,949,903		30.00
31.00	03100	INTENSIVE CARE UNIT	273,286	4,509,434	-23,736	4,485,698		31.00
43.00	04300	NURSERY	105,138	927,267	0	927,267		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,734,196	0	3,734,196		50.00
51.00	05100	RECOVERY ROOM	0	2,102,374	0	2,102,374		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,055,794	0	2,055,794		52.00
53.00	05300	ANESTHESIOLOGY	0	871,699	0	871,699		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,969,142	0	3,969,142		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	3,267,479	0	3,267,479		55.00
56.00	05600	RADIOISOTOPE	0	434,601	0	434,601		56.00
57.00	05700	CT SCAN	0	854,113	0	854,113		57.00
58.00	05800	MRI	0	519,056	0	519,056		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,498,549	0	1,498,549		59.00
60.00	06000	LABORATORY	0	5,384,521	0	5,384,521		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	863,692	0	863,692		62.00
64.00	06400	INTRAVENOUS THERAPY	0	1,032,501	-144,210	888,291		64.00
65.00	06500	RESPIRATORY THERAPY	0	1,855,079	0	1,855,079		65.00
66.00	06600	PHYSICAL THERAPY	0	1,480,145	0	1,480,145		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	91,909	0	91,909		67.00
68.00	06800	SPEECH PATHOLOGY	0	167,153	0	167,153		68.00
69.00	06900	ELECTROCARDIOLOGY	0	296,674	0	296,674		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	333,296	0	333,296		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	10,530,633	0	10,530,633		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,144,126	0	2,144,126		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,774,030	0	7,774,030		73.00
74.00	07400	RENAL DIALYSIS	0	148,701	0	148,701		74.00
76.00	03190	CHEMOTHERAPY	0	0	0	0		76.00
76.01	03950	DIABETES CENTER	0	56,323	0	56,323		76.01
76.97	07697	CARDIAC REHABILITATION	0	387,943	0	387,943		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	200,244	0	200,244		76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,218,482	0	1,218,482		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,163,130	0	1,163,130		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,551,744	0	1,551,744		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	1,540,262	0	1,540,262		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	1,316,638	0	1,316,638		88.04
91.00	09100	EMERGENCY	315,341	6,329,447	0	6,329,447		91.00
91.01	09101	OUTPATIENT PSYCH	0	0	0	0		91.01
91.02	09102	WOUND CARE	0	0	0	0		91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,770,957	0	1,770,957		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,102,103	88,163,291	0	88,163,291		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	17,269,542	0	17,269,542		192.00
194.00	07950	RENTAL PROPERTIES	0	0	0	0		194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	1,890,490	0	1,890,490		194.01
194.02	07952	HWY 61 BUILDING	0	102,258	0	102,258		194.02
194.03	07953	MEDICAL BUILDING	0	0	0	0		194.03
194.04	07954	PHYSICIAN OFFICES PITTSFIELD	0	154,513	0	154,513		194.04
200.00		Cross Foot Adjustments		0	0	0		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/26/2016 1:59 pm

	Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		16.00	24.00	25.00	26.00		
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	2,102,103	107,580,094	0	107,580,094		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/26/2016 1:59 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
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	1,238	29,967	4,083	35,288	35,288	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,170,975	622,920	2,233,806	4,027,701	7,714	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,947	0	640	2,587	259	6.00
7.00	00700	OPERATION OF PLANT	29,855	169,611	80,156	279,622	563	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	581	7,774	39	8,394	25	8.00
9.00	00900	HOUSEKEEPING	7,858	8,123	703	16,684	471	9.00
10.00	01000	DIETARY	3,901	25,984	11,038	40,923	627	10.00
11.00	01100	CAFETERIA	0	16,447	0	16,447	0	11.00
13.00	01300	NURSING ADMINISTRATION	293,564	3,380	90,402	387,346	518	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	181	11,914	0	12,095	104	14.00
15.00	01500	PHARMACY	6,533	14,665	74,675	95,873	1,291	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,420	47,663	7,413	63,496	556	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	118,310	303,857	42,742	464,909	3,803	30.00
31.00	03100	INTENSIVE CARE UNIT	31,955	50,833	16,134	98,922	1,342	31.00
43.00	04300	NURSERY	665	3,633	10,494	14,792	246	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	122,739	78,495	310,212	511,446	839	50.00
51.00	05100	RECOVERY ROOM	2,753	60,808	1,100	64,661	719	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,524	0	3,567	9,091	728	52.00
53.00	05300	ANESTHESIOLOGY	219,886	3,275	37,769	260,930	56	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	311,878	95,701	165,568	573,147	936	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	109,414	168,047	145,476	422,937	656	55.00
56.00	05600	RADIOISOTOPE	3,358	10,839	66,244	80,441	83	56.00
57.00	05700	CT SCAN	106,705	4,996	3,128	114,829	198	57.00
58.00	05800	MRI	75,578	7,372	10,386	93,336	72	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,708	31,836	26,733	60,277	335	59.00
60.00	06000	LABORATORY	118,896	56,415	162,770	338,081	1,012	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	594	1,179	438	2,211	77	62.00
64.00	06400	INTRAVENOUS THERAPY	1,428	44,588	80,914	126,930	287	64.00
65.00	06500	RESPIRATORY THERAPY	53,649	16,944	9,744	80,337	656	65.00
66.00	06600	PHYSICAL THERAPY	1,793	44,117	2,796	48,706	243	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,581	0	1,581	32	67.00
68.00	06800	SPEECH PATHOLOGY	846	559	0	1,405	122	68.00
69.00	06900	ELECTROCARDIOLOGY	1,167	0	101,242	102,409	44	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	912	6,271	4,105	11,288	134	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03190	CHEMOTHERAPY	0	0	0	0	0	76.00
76.01	03950	DIABETES CENTER	0	0	283	283	22	76.01
76.97	07697	CARDIAC REHABILITATION	1,079	23,120	13,525	37,724	103	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	3,074	0	3,074	66	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	15,798	0	27,765	43,563	331	88.00
88.01	08801	RURAL HEALTH CLINIC II	84,851	0	32,793	117,644	333	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,246	50,109	4,769	56,124	506	88.02
88.03	08803	RURAL HEALTH CLINIC IV	56,086	0	132,304	188,390	470	88.03
88.04	08804	RURAL HEALTH CLINIC V	28,645	0	0	28,645	469	88.04
91.00	09100	EMERGENCY	9,706	256,465	85,294	351,465	1,621	91.00
91.01	09101	OUTPATIENT PSYCH	0	0	0	0	0	91.01
91.02	09102	WOUND CARE	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,510	26,203	2,633	31,346	625	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,014,732	2,308,765	4,003,883	9,327,380	29,294	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	25,958	629,069	284,074	939,101	5,401	192.00
194.00	07950	RENTAL PROPERTIES	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	3,817	105,423	5,432	114,672	547	194.01
194.02	07952	HWY 61 BUILDING	0	22,814	0	22,814	0	194.02
194.03	07953	MEDICAL BUILDING	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN OFFICES PITTSFIELD	8,369	0	0	8,369	46	194.04

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II Date/Time Prepared: 2/26/2016 1:59 pm

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
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)	3,052,876	3,066,071	4,293,389	10,412,336	35,288	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/26/2016 1:59 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	
		GENERAL SERVICE COST CENTERS						
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	4,035,415					5.00
6.00	00600	MAINTENANCE & REPAIRS	23,706	26,552				6.00
7.00	00700	OPERATION OF PLANT	163,938	1,866	445,989			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	16,040	86	1,545	26,090		8.00
9.00	00900	HOUSEKEEPING	73,439	89	1,615	0	92,298	9.00
10.00	01000	DIETARY	61,615	286	5,165	0	1,077	10.00
11.00	01100	CAFETERIA	842	181	3,269	0	681	11.00
13.00	01300	NURSING ADMINISTRATION	66,440	37	672	0	140	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14,171	131	2,368	0	494	14.00
15.00	01500	PHARMACY	147,284	161	2,915	0	608	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	71,435	524	9,475	0	1,975	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	423,958	3,343	60,402	10,110	12,590	30.00
31.00	03100	INTENSIVE CARE UNIT	133,193	559	10,105	1,463	2,106	31.00
43.00	04300	NURSERY	27,168	40	722	0	151	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	126,022	864	15,604	4,055	3,252	50.00
51.00	05100	RECOVERY ROOM	69,499	669	12,088	817	2,519	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	69,223	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	31,242	36	651	0	136	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	134,562	1,053	19,024	1,770	3,965	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	102,626	1,849	33,405	458	6,963	55.00
56.00	05600	RADIOISOTOPE	14,866	119	2,155	0	449	56.00
57.00	05700	CT SCAN	31,022	55	993	0	207	57.00
58.00	05800	MRI	18,456	81	1,465	0	305	58.00
59.00	05900	CARDIAC CATHETERIZATION	51,620	350	6,329	287	1,319	59.00
60.00	06000	LABORATORY	191,783	621	11,214	0	2,337	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	32,049	13	234	0	49	62.00
64.00	06400	INTRAVENOUS THERAPY	32,479	491	8,864	452	1,847	64.00
65.00	06500	RESPIRATORY THERAPY	66,022	186	3,368	0	702	65.00
66.00	06600	PHYSICAL THERAPY	49,797	485	8,770	71	1,828	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,221	17	314	0	66	67.00
68.00	06800	SPEECH PATHOLOGY	6,054	6	111	0	23	68.00
69.00	06900	ELECTROCARDIOLOGY	11,012	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	11,420	69	1,247	109	260	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	381,486	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	77,982	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	140,570	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	5,578	0	0	0	0	74.00
76.00	03190	CHEMOTHERAPY	0	0	0	0	0	76.00
76.01	03950	DIABETES CENTER	2,061	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	11,622	254	4,596	0	958	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	6,531	34	611	0	127	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	45,698	0	0	12	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	43,624	0	0	8	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	52,334	551	9,961	23	2,076	88.02
88.03	08803	RURAL HEALTH CLINIC IV	57,754	0	0	33	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	49,366	0	0	33	0	88.04
91.00	09100	EMERGENCY	186,390	2,822	50,981	6,380	10,626	91.00
91.01	09101	OUTPATIENT PSYCH	0	0	0	0	0	91.01
91.02	09102	WOUND CARE	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	63,366	288	5,209	0	1,086	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,400,566	18,216	295,447	26,081	60,922	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	569,301	6,925	125,051	1	26,063	192.00
194.00	07950	RENTAL PROPERTIES	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	58,588	1,160	20,956	0	4,368	194.01
194.02	07952	HWY 61 BUILDING	1,169	251	4,535	0	945	194.02
194.03	07953	MEDICAL BUILDING	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN OFFICES PITTSFIELD	5,791	0	0	8	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,035,415	26,552	445,989	26,090	92,298	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II Date/Time Prepared: 2/26/2016 1:59 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
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	109,693					10.00
11.00	01100	CAFETERIA	77,407	98,827				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,291	457,444			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	828	0	30,191		14.00
15.00	01500	PHARMACY	0	4,166	0	0	252,298	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,765	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,090	23,334	304,459	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,196	6,399	89,003	0	0	31.00
43.00	04300	NURSERY	0	1,270	17,663	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,653	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	3,533	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,087	42,942	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,192	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,090	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	345	0	0	0	56.00
57.00	05700	CT SCAN	0	883	0	0	0	57.00
58.00	05800	MRI	0	311	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,401	0	0	0	59.00
60.00	06000	LABORATORY	0	7,347	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	430	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	1,530	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,232	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,065	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	85	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	308	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	237	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	570	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	25,567	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,624	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	252,298	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03190	CHEMOTHERAPY	0	0	0	0	0	76.00
76.01	03950	DIABETES CENTER	0	106	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	465	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	244	3,377	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
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
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
91.00	09100	EMERGENCY	0	10,493	0	0	0	91.00
91.01	09101	OUTPATIENT PSYCH	0	0	0	0	0	91.01
91.02	09102	WOUND CARE	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	109,693	88,660	457,444	30,191	252,298	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,167	0	0	0	192.00
194.00	07950	RENTAL PROPERTIES	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
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)	109,693	98,827	457,444	30,191	252,298	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/26/2016 1:59 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
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	151,226					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	101,316	1,436,314	0	1,436,314		30.00
31.00	03100	INTENSIVE CARE UNIT	19,660	366,948	0	366,948		31.00
43.00	04300	NURSERY	7,564	69,616	0	69,616		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	666,735	0	666,735		50.00
51.00	05100	RECOVERY ROOM	0	154,505	0	154,505		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	125,071	0	125,071		52.00
53.00	05300	ANESTHESIOLOGY	0	295,243	0	295,243		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	738,547	0	738,547		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	568,894	0	568,894		55.00
56.00	05600	RADIOISOTOPE	0	98,458	0	98,458		56.00
57.00	05700	CT SCAN	0	148,187	0	148,187		57.00
58.00	05800	MRI	0	114,026	0	114,026		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	121,918	0	121,918		59.00
60.00	06000	LABORATORY	0	552,395	0	552,395		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	35,063	0	35,063		62.00
64.00	06400	INTRAVENOUS THERAPY	0	172,880	0	172,880		64.00
65.00	06500	RESPIRATORY THERAPY	0	154,503	0	154,503		65.00
66.00	06600	PHYSICAL THERAPY	0	110,965	0	110,965		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,316	0	5,316		67.00
68.00	06800	SPEECH PATHOLOGY	0	8,029	0	8,029		68.00
69.00	06900	ELECTROCARDIOLOGY	0	113,702	0	113,702		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	25,097	0	25,097		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	407,053	0	407,053		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	82,606	0	82,606		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	392,868	0	392,868		73.00
74.00	07400	RENAL DIALYSIS	0	5,578	0	5,578		74.00
76.00	03190	CHEMOTHERAPY	0	0	0	0		76.00
76.01	03950	DIABETES CENTER	0	2,472	0	2,472		76.01
76.97	07697	CARDIAC REHABILITATION	0	55,722	0	55,722		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	14,064	0	14,064		76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	89,604	0	89,604		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	161,609	0	161,609		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	121,575	0	121,575		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	246,647	0	246,647		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	78,513	0	78,513		88.04
91.00	09100	EMERGENCY	22,686	643,464	0	643,464		91.00
91.01	09101	OUTPATIENT PSYCH	0	0	0	0		91.01
91.02	09102	WOUND CARE	0	0	0	0		91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	101,920	0	101,920		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	151,226	8,486,107	0	8,486,107		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,682,010	0	1,682,010		192.00
194.00	07950	RENTAL PROPERTIES	0	0	0	0		194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	200,291	0	200,291		194.01
194.02	07952	HWY 61 BUILDING	0	29,714	0	29,714		194.02
194.03	07953	MEDICAL BUILDING	0	0	0	0		194.03
194.04	07954	PHYSICIAN OFFICES PITTSFIELD	0	14,214	0	14,214		194.04
200.00		Cross Foot Adjustments		0	0	0		200.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II Date/Time Prepared: 2/26/2016 1:59 pm

	Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		16.00	24.00	25.00	26.00		
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	151,226	10,412,336	0	10,412,336		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/26/2016 1:59 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	351,039					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,965,741				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,431	3,771	43,371,382			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	71,319	2,063,336	9,494,594	-28,799,478	78,780,616	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	591	317,736	0	462,793	6.00
7.00	00700	OPERATION OF PLANT	19,419	74,039	691,983	0	3,200,473	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	890	36	30,847	0	313,138	8.00
9.00	00900	HOUSEKEEPING	930	649	578,124	0	1,433,717	9.00
10.00	01000	DIETARY	2,975	10,196	770,590	0	1,202,869	10.00
11.00	01100	CAFETERIA	1,883	0	0	0	16,447	11.00
13.00	01300	NURSING ADMINISTRATION	387	83,503	636,276	0	1,297,064	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,364	0	127,262	0	276,644	14.00
15.00	01500	PHARMACY	1,679	68,976	1,586,325	0	2,875,348	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,457	6,847	682,856	0	1,394,590	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,789	39,480	4,672,525	0	8,276,716	30.00
31.00	03100	INTENSIVE CARE UNIT	5,820	14,903	1,648,437	0	2,600,258	31.00
43.00	04300	NURSERY	416	9,693	302,310	0	530,387	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,987	286,538	1,030,618	0	2,460,270	50.00
51.00	05100	RECOVERY ROOM	6,962	1,016	883,395	0	1,356,802	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,295	893,811	0	1,351,405	52.00
53.00	05300	ANESTHESIOLOGY	375	34,887	69,103	0	609,915	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,957	152,933	1,149,944	0	2,626,976	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	19,240	134,374	806,080	0	2,003,508	55.00
56.00	05600	RADIOISOTOPE	1,241	61,189	102,266	0	290,220	56.00
57.00	05700	CT SCAN	572	2,889	243,611	0	605,620	57.00
58.00	05800	MRI	844	9,593	88,020	0	360,310	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,645	24,693	411,872	0	1,007,745	59.00
60.00	06000	LABORATORY	6,459	150,348	1,243,730	0	3,744,087	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	135	405	94,632	0	625,677	62.00
64.00	06400	INTRAVENOUS THERAPY	5,105	74,739	352,860	0	634,068	64.00
65.00	06500	RESPIRATORY THERAPY	1,940	9,000	805,961	0	1,288,906	65.00
66.00	06600	PHYSICAL THERAPY	5,051	2,583	298,188	0	972,156	66.00
67.00	06700	OCCUPATIONAL THERAPY	181	0	39,755	0	62,883	67.00
68.00	06800	SPEECH PATHOLOGY	64	0	150,129	0	118,184	68.00
69.00	06900	ELECTROCARDIOLOGY	0	93,516	53,762	0	214,989	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	718	3,792	164,888	0	222,946	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	7,447,546	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,522,394	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,744,266	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	108,893	74.00
76.00	03190	CHEMOTHERAPY	0	0	0	0	0	76.00
76.01	03950	DIABETES CENTER	0	261	26,888	0	40,234	76.01
76.97	07697	CARDIAC REHABILITATION	2,647	12,493	126,700	0	226,881	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	352	0	80,954	0	127,498	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	25,646	406,772	0	892,141	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	30,290	409,266	0	851,657	88.01
88.02	08802	RURAL HEALTH CLINIC III	5,737	4,405	621,301	0	1,021,688	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	122,207	577,046	0	1,127,511	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	576,567	0	963,752	88.04
91.00	09100	EMERGENCY	29,363	78,785	1,991,702	0	3,638,799	91.00
91.01	09101	OUTPATIENT PSYCH	0	0	0	0	0	91.01
91.02	09102	WOUND CARE	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,000	2,432	768,023	0	1,237,063	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	264,334	3,698,329	36,007,709	-28,799,478	66,387,434	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	72,023	262,395	6,635,001	0	11,113,527	192.00
194.00	07950	RENTAL PROPERTIES	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	12,070	5,017	672,059	0	1,143,791	194.01
194.02	07952	HWY 61 BUILDING	2,612	0	0	0	22,814	194.02
194.03	07953	MEDICAL BUILDING	0	0	0	0	0	194.03

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/26/2016 1:59 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
194.04	07954	PHYSICIAN OFFICES PITTSFIELD	0	0	56,613	0	113,050	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,066,071	4,293,389	11,832,994		28,799,478	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.734275	1.082620	0.272830		0.365566	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			35,288		4,035,415	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000814		0.051223	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/26/2016 1:59 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	
		GENERAL SERVICE COST CENTERS						
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	276,289					6.00
7.00	00700	OPERATION OF PLANT	19,419	256,870				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	890	890	474,083			8.00
9.00	00900	HOUSEKEEPING	930	930	0	255,050		9.00
10.00	01000	DIETARY	2,975	2,975	0	2,975	246,314	10.00
11.00	01100	CAFETERIA	1,883	1,883	0	1,883	173,815	11.00
13.00	01300	NURSING ADMINISTRATION	387	387	0	387	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,364	1,364	0	1,364	0	14.00
15.00	01500	PHARMACY	1,679	1,679	0	1,679	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,457	5,457	0	5,457	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,789	34,789	183,717	34,789	63,076	30.00
31.00	03100	INTENSIVE CARE UNIT	5,820	5,820	26,576	5,820	9,423	31.00
43.00	04300	NURSERY	416	416	0	416	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,987	8,987	73,684	8,987	0	50.00
51.00	05100	RECOVERY ROOM	6,962	6,962	14,849	6,962	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	375	375	0	375	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,957	10,957	32,157	10,957	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	19,240	19,240	8,319	19,240	0	55.00
56.00	05600	RADIOISOTOPE	1,241	1,241	0	1,241	0	56.00
57.00	05700	CT SCAN	572	572	0	572	0	57.00
58.00	05800	MRI	844	844	0	844	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,645	3,645	5,221	3,645	0	59.00
60.00	06000	LABORATORY	6,459	6,459	2	6,459	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	135	135	0	135	0	62.00
64.00	06400	INTRAVENOUS THERAPY	5,105	5,105	8,210	5,105	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,940	1,940	0	1,940	0	65.00
66.00	06600	PHYSICAL THERAPY	5,051	5,051	1,282	5,051	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	181	181	0	181	0	67.00
68.00	06800	SPEECH PATHOLOGY	64	64	0	64	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	718	718	1,980	718	0	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03190	CHEMOTHERAPY	0	0	0	0	0	76.00
76.01	03950	DIABETES CENTER	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	2,647	2,647	0	2,647	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	352	352	0	352	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	218	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	145	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	5,737	5,737	416	5,737	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	608	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	608	0	0	88.04
91.00	09100	EMERGENCY	29,363	29,363	115,928	29,363	0	91.00
91.01	09101	OUTPATIENT PSYCH	0	0	0	0	0	91.01
91.02	09102	WOUND CARE	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,000	3,000	0	3,000	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	189,584	170,165	473,920	168,345	246,314	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	72,023	72,023	18	72,023	0	192.00
194.00	07950	RENTAL PROPERTIES	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	12,070	12,070	0	12,070	0	194.01
194.02	07952	HWY 61 BUILDING	2,612	2,612	0	2,612	0	194.02
194.03	07953	MEDICAL BUILDING	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN OFFICES PITTSFIELD	0	0	145	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/26/2016 1:59 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	
202.00	Cost to be allocated (per Wkst. B, Part I)	631,974	4,414,875	444,944	1,975,946	1,723,582	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	2.287366	17.187196	0.938536	7.747289	6.997499	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	26,552	445,989	26,090	92,298	109,693	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.096102	1.736244	0.055033	0.361882	0.445338	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/26/2016 1:59 pm

		Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
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	42,966					11.00
13.00	01300	NURSING ADMINISTRATION	996	297,364				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	360	0	8,794,362			14.00
15.00	01500	PHARMACY	1,811	0	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,637	0	0	0	28,991	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,146	197,915	0	0	19,423	30.00
31.00	03100	INTENSIVE CARE UNIT	2,782	57,857	0	0	3,769	31.00
43.00	04300	NURSERY	552	11,482	0	0	1,450	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,023	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	1,536	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,342	27,915	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	953	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,778	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	150	0	0	0	0	56.00
57.00	05700	CT SCAN	384	0	0	0	0	57.00
58.00	05800	MRI	135	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	609	0	0	0	0	59.00
60.00	06000	LABORATORY	3,194	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	187	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	665	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,405	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	463	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	37	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	134	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	103	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	248	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	7,447,546	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,346,816	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03190	CHEMOTHERAPY	0	0	0	0	0	76.00
76.01	03950	DIABETES CENTER	46	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	202	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	106	2,195	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
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
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
91.00	09100	EMERGENCY	4,562	0	0	0	4,349	91.00
91.01	09101	OUTPATIENT PSYCH	0	0	0	0	0	91.01
91.02	09102	WOUND CARE	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	38,546	297,364	8,794,362	100	28,991	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,420	0	0	0	0	192.00
194.00	07950	RENTAL PROPERTIES	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
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/26/2016 1:59 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	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,289,988	1,811,663	425,714	4,026,554	2,102,103	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	30.023460	6.092409	0.048408	40,265.540000	72.508813	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	98,827	457,444	30,191	252,298	151,226	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	2.300121	1.538330	0.003433	2,522.980000	5.216309	205.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-2 | Date/Time Prepared: 2/26/2016 1:59 pm

		Description	Worksheet Part	Worksheet Line No.	Amount	
		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
7.00		IV THERAPY OBSERVATION COSTS TO A&PS	1	30.00	144,210	7.00
8.00		IV THERAPY OBSERVATION COSTS TO A&PS	1	64.00	-144,210	8.00
9.00		ICU OBSERVATION COSTS TO A&PS	1	30.00	23,736	9.00
10.00		ICU OBSERVATION COSTS TO A&PS	1	31.00	-23,736	10.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/26/2016 1:59 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	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,949,903		15,949,903	0	15,949,903	30.00
31.00	03100	INTENSIVE CARE UNIT	4,485,698		4,485,698	0	4,485,698	31.00
43.00	04300	NURSERY	927,267		927,267	0	927,267	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,734,196		3,734,196	86,499	3,820,695	50.00
51.00	05100	RECOVERY ROOM	2,102,374		2,102,374	0	2,102,374	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,055,794		2,055,794	0	2,055,794	52.00
53.00	05300	ANESTHESIOLOGY	871,699		871,699	58,197	929,896	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,969,142		3,969,142	0	3,969,142	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	3,267,479		3,267,479	32,880	3,300,359	55.00
56.00	05600	RADIOISOTOPE	434,601		434,601	0	434,601	56.00
57.00	05700	CT SCAN	854,113		854,113	0	854,113	57.00
58.00	05800	MRI	519,056		519,056	0	519,056	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,498,549		1,498,549	0	1,498,549	59.00
60.00	06000	LABORATORY	5,384,521		5,384,521	39,769	5,424,290	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	863,692		863,692	0	863,692	62.00
64.00	06400	INTRAVENOUS THERAPY	888,291		888,291	0	888,291	64.00
65.00	06500	RESPIRATORY THERAPY	1,855,079	0	1,855,079	0	1,855,079	65.00
66.00	06600	PHYSICAL THERAPY	1,480,145	0	1,480,145	0	1,480,145	66.00
67.00	06700	OCCUPATIONAL THERAPY	91,909	0	91,909	0	91,909	67.00
68.00	06800	SPEECH PATHOLOGY	167,153	0	167,153	0	167,153	68.00
69.00	06900	ELECTROCARDIOLOGY	296,674		296,674	0	296,674	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	333,296		333,296	0	333,296	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,530,633		10,530,633	0	10,530,633	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,144,126		2,144,126	0	2,144,126	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,774,030		7,774,030	0	7,774,030	73.00
74.00	07400	RENAL DIALYSIS	148,701		148,701	0	148,701	74.00
76.00	03190	CHEMOTHERAPY	0		0	0	0	76.00
76.01	03950	DIABETES CENTER	56,323		56,323	0	56,323	76.01
76.97	07697	CARDIAC REHABILITATION	387,943		387,943	0	387,943	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	200,244		200,244	0	200,244	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,218,482		1,218,482	0	1,218,482	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,163,130		1,163,130	0	1,163,130	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,551,744		1,551,744	0	1,551,744	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,540,262		1,540,262	0	1,540,262	88.03
88.04	08804	RURAL HEALTH CLINIC V	1,316,638		1,316,638	0	1,316,638	88.04
91.00	09100	EMERGENCY	6,329,447		6,329,447	166,825	6,496,272	91.00
91.01	09101	OUTPATIENT PSYCH	0		0	0	0	91.01
91.02	09102	WOUND CARE	0		0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,033,102		1,033,102		1,033,102	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,770,957		1,770,957		1,770,957	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	89,196,393	0	89,196,393	384,170	89,580,563	200.00
201.00		Less Observation Beds	1,033,102		1,033,102		1,033,102	201.00
202.00		Total (see instructions)	88,163,291	0	88,163,291	384,170	88,547,461	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/26/2016 1:59 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,754,436		5,754,436			30.00
31.00	03100	INTENSIVE CARE UNIT	1,718,390		1,718,390			31.00
43.00	04300	NURSERY	346,871		346,871			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,748,792	9,775,956	20,524,748	0.181936	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,431,249	2,402,093	3,833,342	0.548444	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	776,042	166,515	942,557	2.181082	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	3,461,545	2,531,929	5,993,474	0.145441	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,468,969	6,310,764	8,779,733	0.452080	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	23,573	6,997,589	7,021,162	0.465376	0.000000	55.00
56.00	05600	RADIOISOTOPE	610,429	1,642,133	2,252,562	0.192936	0.000000	56.00
57.00	05700	CT SCAN	4,058,148	11,735,231	15,793,379	0.054080	0.000000	57.00
58.00	05800	MRI	704,697	3,823,341	4,528,038	0.114632	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,608,155	3,823,137	6,431,292	0.233009	0.000000	59.00
60.00	06000	LABORATORY	11,847,725	21,926,853	33,774,578	0.159425	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	706,072	527,505	1,233,577	0.700152	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	306,960	2,260,218	2,567,178	0.346018	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	432,457	174,597	607,054	3.055871	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	861,488	443,957	1,305,445	1.133824	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	141,203	1,056	142,259	0.646068	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	55,241	62,112	117,353	1.424361	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	499,673	1,123,516	1,623,189	0.182772	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	21,661	648,565	670,226	0.497289	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	55,120,594	31,006,440	86,127,034	0.122269	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,014,623	3,516,787	4,531,410	0.473170	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,362,223	21,436,168	50,798,391	0.153037	0.000000	73.00
74.00	07400	RENAL DIALYSIS	79,125	0	79,125	1.879318	0.000000	74.00
76.00	03190	CHEMOTHERAPY	0	0	0	0.000000	0.000000	76.00
76.01	03950	DIABETES CENTER	100	13,385	13,485	4.176715	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	2,398	295,242	297,640	1.303397	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	350	20,772	21,122	9.480352	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	597,891	597,891			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	692,794	692,794			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,245,859	1,245,859			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	995,045	995,045			88.03
88.04	08804	RURAL HEALTH CLINIC V	0	995,045	995,045			88.04
91.00	09100	EMERGENCY	352,179	2,144,194	2,496,373	2.535457	0.000000	91.00
91.01	09101	OUTPATIENT PSYCH	0	0	0	0.000000	0.000000	91.01
91.02	09102	WOUND CARE	0	0	0	0.000000	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	282,900	1,150,920	1,433,820	0.720524	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	986,869	986,869			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	135,798,268	141,474,478	277,272,746			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	135,798,268	141,474,478	277,272,746			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/26/2016 1:59 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.186151		50.00
51.00	05100	RECOVERY ROOM	0.548444		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.181082		52.00
53.00	05300	ANESTHESIOLOGY	0.155151		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.452080		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.470059		55.00
56.00	05600	RADIOISOTOPE	0.192936		56.00
57.00	05700	CT SCAN	0.054080		57.00
58.00	05800	MRI	0.114632		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.233009		59.00
60.00	06000	LABORATORY	0.160603		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.700152		62.00
64.00	06400	INTRAVENOUS THERAPY	0.346018		64.00
65.00	06500	RESPIRATORY THERAPY	3.055871		65.00
66.00	06600	PHYSICAL THERAPY	1.133824		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.646068		67.00
68.00	06800	SPEECH PATHOLOGY	1.424361		68.00
69.00	06900	ELECTROCARDIOLOGY	0.182772		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.497289		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.122269		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.473170		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.153037		73.00
74.00	07400	RENAL DIALYSIS	1.879318		74.00
76.00	03190	CHEMOTHERAPY	0.000000		76.00
76.01	03950	DIABETES CENTER	4.176715		76.01
76.97	07697	CARDIAC REHABILITATION	1.303397		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	9.480352		76.98
		OUTPATIENT SERVICE COST CENTERS			
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
88.03	08803	RURAL HEALTH CLINIC IV			88.03
88.04	08804	RURAL HEALTH CLINIC V			88.04
91.00	09100	EMERGENCY	2.602284		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	0.720524		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
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 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/26/2016 1:59 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,949,903		15,949,903	0	15,949,903	30.00
31.00	03100	INTENSIVE CARE UNIT	4,485,698		4,485,698	0	4,485,698	31.00
43.00	04300	NURSERY	927,267		927,267	0	927,267	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,734,196		3,734,196	86,499	3,820,695	50.00
51.00	05100	RECOVERY ROOM	2,102,374		2,102,374	0	2,102,374	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,055,794		2,055,794	0	2,055,794	52.00
53.00	05300	ANESTHESIOLOGY	871,699		871,699	58,197	929,896	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,969,142		3,969,142	0	3,969,142	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	3,267,479		3,267,479	32,880	3,300,359	55.00
56.00	05600	RADIOISOTOPE	434,601		434,601	0	434,601	56.00
57.00	05700	CT SCAN	854,113		854,113	0	854,113	57.00
58.00	05800	MRI	519,056		519,056	0	519,056	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,498,549		1,498,549	0	1,498,549	59.00
60.00	06000	LABORATORY	5,384,521		5,384,521	39,769	5,424,290	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	863,692		863,692	0	863,692	62.00
64.00	06400	INTRAVENOUS THERAPY	888,291		888,291	0	888,291	64.00
65.00	06500	RESPIRATORY THERAPY	1,855,079	0	1,855,079	0	1,855,079	65.00
66.00	06600	PHYSICAL THERAPY	1,480,145	0	1,480,145	0	1,480,145	66.00
67.00	06700	OCCUPATIONAL THERAPY	91,909	0	91,909	0	91,909	67.00
68.00	06800	SPEECH PATHOLOGY	167,153	0	167,153	0	167,153	68.00
69.00	06900	ELECTROCARDIOLOGY	296,674		296,674	0	296,674	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	333,296		333,296	0	333,296	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,530,633		10,530,633	0	10,530,633	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,144,126		2,144,126	0	2,144,126	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,774,030		7,774,030	0	7,774,030	73.00
74.00	07400	RENAL DIALYSIS	148,701		148,701	0	148,701	74.00
76.00	03190	CHEMOTHERAPY	0		0	0	0	76.00
76.01	03950	DIABETES CENTER	56,323		56,323	0	56,323	76.01
76.97	07697	CARDIAC REHABILITATION	387,943		387,943	0	387,943	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	200,244		200,244	0	200,244	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,218,482		1,218,482	0	1,218,482	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,163,130		1,163,130	0	1,163,130	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,551,744		1,551,744	0	1,551,744	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,540,262		1,540,262	0	1,540,262	88.03
88.04	08804	RURAL HEALTH CLINIC V	1,316,638		1,316,638	0	1,316,638	88.04
91.00	09100	EMERGENCY	6,329,447		6,329,447	166,825	6,496,272	91.00
91.01	09101	OUTPATIENT PSYCH	0		0	0	0	91.01
91.02	09102	WOUND CARE	0		0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,033,102		1,033,102		1,033,102	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,770,957		1,770,957		1,770,957	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	89,196,393	0	89,196,393	384,170	89,580,563	200.00
201.00		Less Observation Beds	1,033,102		1,033,102		1,033,102	201.00
202.00		Total (see instructions)	88,163,291	0	88,163,291	384,170	88,547,461	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/26/2016 1:59 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,754,436		5,754,436			30.00
31.00	03100	INTENSIVE CARE UNIT	1,718,390		1,718,390			31.00
43.00	04300	NURSERY	346,871		346,871			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,748,792	9,775,956	20,524,748	0.181936	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,431,249	2,402,093	3,833,342	0.548444	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	776,042	166,515	942,557	2.181082	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	3,461,545	2,531,929	5,993,474	0.145441	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,468,969	6,310,764	8,779,733	0.452080	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	23,573	6,997,589	7,021,162	0.465376	0.000000	55.00
56.00	05600	RADIOISOTOPE	610,429	1,642,133	2,252,562	0.192936	0.000000	56.00
57.00	05700	CT SCAN	4,058,148	11,735,231	15,793,379	0.054080	0.000000	57.00
58.00	05800	MRI	704,697	3,823,341	4,528,038	0.114632	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,608,155	3,823,137	6,431,292	0.233009	0.000000	59.00
60.00	06000	LABORATORY	11,847,725	21,926,853	33,774,578	0.159425	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	706,072	527,505	1,233,577	0.700152	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	306,960	2,260,218	2,567,178	0.346018	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	432,457	174,597	607,054	3.055871	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	861,488	443,957	1,305,445	1.133824	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	141,203	1,056	142,259	0.646068	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	55,241	62,112	117,353	1.424361	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	499,673	1,123,516	1,623,189	0.182772	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	21,661	648,565	670,226	0.497289	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	55,120,594	31,006,440	86,127,034	0.122269	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,014,623	3,516,787	4,531,410	0.473170	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,362,223	21,436,168	50,798,391	0.153037	0.000000	73.00
74.00	07400	RENAL DIALYSIS	79,125	0	79,125	1.879318	0.000000	74.00
76.00	03190	CHEMOTHERAPY	0	0	0	0.000000	0.000000	76.00
76.01	03950	DIABETES CENTER	100	13,385	13,485	4.176715	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	2,398	295,242	297,640	1.303397	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	350	20,772	21,122	9.480352	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	597,891	597,891	2.037967	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	692,794	692,794	1.678897	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,245,859	1,245,859	1.245521	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	995,045	995,045	1.547932	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	995,045	995,045	1.323194	0.000000	88.04
91.00	09100	EMERGENCY	352,179	2,144,194	2,496,373	2.535457	0.000000	91.00
91.01	09101	OUTPATIENT PSYCH	0	0	0	0.000000	0.000000	91.01
91.02	09102	WOUND CARE	0	0	0	0.000000	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	282,900	1,150,920	1,433,820	0.720524	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	986,869	986,869			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	135,798,268	141,474,478	277,272,746			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	135,798,268	141,474,478	277,272,746			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/26/2016 1:59 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
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
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
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
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03190	CHEMOTHERAPY	0.000000		76.00
76.01	03950	DIABETES CENTER	0.000000		76.01
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
		OUTPATIENT SERVICE COST CENTERS			
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
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		88.04
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
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
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 10/01/2014 To 09/30/2015 | Worksheet D Part I | Date/Time Prepared: 2/26/2016 1:59 pm

Title XVIII | Hospital | PPS

	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)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,436,314	0	1,436,314	14,636	98.14	30.00
31.00	INTENSIVE CARE UNIT	366,948		366,948	2,072	177.10	31.00
43.00	NURSERY	69,616		69,616	1,291	53.92	43.00
200.00	Total (lines 30-199)	1,872,878		1,872,878	17,999		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	8,741	857,842	30.00
31.00	INTENSIVE CARE UNIT	1,409	249,534	31.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	10,150	1,107,376	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part II Date/Time Prepared: 2/26/2016 1:59 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	666,735	20,524,748	0.032484	5,971,836	193,989	50.00
51.00	05100	RECOVERY ROOM	154,505	3,833,342	0.040306	728,834	29,376	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	125,071	942,557	0.132693	85,971	11,408	52.00
53.00	05300	ANESTHESIOLOGY	295,243	5,993,474	0.049261	1,748,057	86,111	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	738,547	8,779,733	0.084120	1,592,809	133,987	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	568,894	7,021,162	0.081026	15,180	1,230	55.00
56.00	05600	RADIOISOTOPE	98,458	2,252,562	0.043709	405,829	17,738	56.00
57.00	05700	CT SCAN	148,187	15,793,379	0.009383	2,551,438	23,940	57.00
58.00	05800	MRI	114,026	4,528,038	0.025182	461,912	11,632	58.00
59.00	05900	CARDIAC CATHETERIZATION	121,918	6,431,292	0.018957	1,429,897	27,107	59.00
60.00	06000	LABORATORY	552,395	33,774,578	0.016355	7,805,521	127,659	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	35,063	1,233,577	0.028424	466,779	13,268	62.00
64.00	06400	INTRAVENOUS THERAPY	172,880	2,567,178	0.067342	263,796	17,765	64.00
65.00	06500	RESPIRATORY THERAPY	154,503	607,054	0.254513	238,999	60,828	65.00
66.00	06600	PHYSICAL THERAPY	110,965	1,305,445	0.085002	630,471	53,591	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,316	142,259	0.037368	95,243	3,559	67.00
68.00	06800	SPEECH PATHOLOGY	8,029	117,353	0.068418	27,321	1,869	68.00
69.00	06900	ELECTROCARDIOLOGY	113,702	1,623,189	0.070049	352,891	24,720	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	25,097	670,226	0.037446	15,695	588	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	407,053	86,127,034	0.004726	27,365,055	129,327	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	82,606	4,531,410	0.018230	652,270	11,891	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	392,868	50,798,391	0.007734	15,784,194	122,075	73.00
74.00	07400	RENAL DIALYSIS	5,578	79,125	0.070496	58,050	4,092	74.00
76.00	03190	CHEMOTHERAPY	0	0	0.000000	0	0	76.00
76.01	03950	DIABETES CENTER	2,472	13,485	0.183315	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	55,722	297,640	0.187213	7	1	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	14,064	21,122	0.665846	100	67	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	89,604	597,891	0.149867	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	161,609	692,794	0.233271	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	121,575	1,245,859	0.097583	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	246,647	995,045	0.247875	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	78,513	995,045	0.078904	0	0	88.04
91.00	09100	EMERGENCY	643,464	2,496,373	0.257760	352,179	90,778	91.00
91.01	09101	OUTPATIENT PSYCH	0	0	0.000000	0	0	91.01
91.02	09102	WOUND CARE	0	0	0.000000	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	93,033	1,433,820	0.064885	167,670	10,879	92.00
200.00		Total (lines 50-199)	6,604,342	268,466,180		69,268,004	1,209,475	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part III Date/Time Prepared: 2/26/2016 1:59 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	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	31.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	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	14,636	0.00	8,741	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,072	0.00	1,409	0		31.00
43.00	04300	NURSERY	1,291	0.00	0	0		43.00
200.00		Total (lines 30-199)	17,999		10,150	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV Date/Time Prepared: 2/26/2016 1:59 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03190	CHEMOTHERAPY	0	0	0	0	0	76.00
76.01	03950	DIABETES CENTER	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
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
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	OUTPATIENT PSYCH	0	0	0	0	0	91.01
91.02	09102	WOUND CARE	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV Date/Time Prepared: 2/26/2016 1:59 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	20,524,748	0.000000	0.000000	5,971,836	50.00
51.00	05100	RECOVERY ROOM	0	3,833,342	0.000000	0.000000	728,834	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	942,557	0.000000	0.000000	85,971	52.00
53.00	05300	ANESTHESIOLOGY	0	5,993,474	0.000000	0.000000	1,748,057	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,779,733	0.000000	0.000000	1,592,809	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	7,021,162	0.000000	0.000000	15,180	55.00
56.00	05600	RADIOISOTOPE	0	2,252,562	0.000000	0.000000	405,829	56.00
57.00	05700	CT SCAN	0	15,793,379	0.000000	0.000000	2,551,438	57.00
58.00	05800	MRI	0	4,528,038	0.000000	0.000000	461,912	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	6,431,292	0.000000	0.000000	1,429,897	59.00
60.00	06000	LABORATORY	0	33,774,578	0.000000	0.000000	7,805,521	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,233,577	0.000000	0.000000	466,779	62.00
64.00	06400	INTRAVENOUS THERAPY	0	2,567,178	0.000000	0.000000	263,796	64.00
65.00	06500	RESPIRATORY THERAPY	0	607,054	0.000000	0.000000	238,999	65.00
66.00	06600	PHYSICAL THERAPY	0	1,305,445	0.000000	0.000000	630,471	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	142,259	0.000000	0.000000	95,243	67.00
68.00	06800	SPEECH PATHOLOGY	0	117,353	0.000000	0.000000	27,321	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,623,189	0.000000	0.000000	352,891	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	670,226	0.000000	0.000000	15,695	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	86,127,034	0.000000	0.000000	27,365,055	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,531,410	0.000000	0.000000	652,270	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	50,798,391	0.000000	0.000000	15,784,194	73.00
74.00	07400	RENAL DIALYSIS	0	79,125	0.000000	0.000000	58,050	74.00
76.00	03190	CHEMOTHERAPY	0	0	0.000000	0.000000	0	76.00
76.01	03950	DIABETES CENTER	0	13,485	0.000000	0.000000	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	297,640	0.000000	0.000000	7	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	21,122	0.000000	0.000000	100	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	597,891	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	692,794	0.000000	0.000000	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,245,859	0.000000	0.000000	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	995,045	0.000000	0.000000	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	995,045	0.000000	0.000000	0	88.04
91.00	09100	EMERGENCY	0	2,496,373	0.000000	0.000000	352,179	91.00
91.01	09101	OUTPATIENT PSYCH	0	0	0.000000	0.000000	0	91.01
91.02	09102	WOUND CARE	0	0	0.000000	0.000000	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,433,820	0.000000	0.000000	167,670	92.00
200.00		Total (lines 50-199)	0	268,466,180			69,268,004	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV Date/Time Prepared: 2/26/2016 1:59 pm

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		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	3,448,852	0		50.00
51.00	05100	RECOVERY ROOM	0	1,033,283	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	31,872	0		52.00
53.00	05300	ANESTHESIOLOGY	0	785,460	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,834,319	0		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	3,372,773	0		55.00
56.00	05600	RADIOISOTOPE	0	760,361	0		56.00
57.00	05700	CT SCAN	0	3,914,387	0		57.00
58.00	05800	MRI	0	1,387,514	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,704,468	0		59.00
60.00	06000	LABORATORY	0	4,966,416	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	208,573	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	922,259	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	72,726	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	444,272	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	284,954	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,169,974	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,997,047	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,924,363	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03190	CHEMOTHERAPY	0	0	0		76.00
76.01	03950	DIABETES CENTER	0	0	0		76.01
76.97	07697	CARDIAC REHABILITATION	0	170,719	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	5,936	0		76.98
		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
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0		88.04
91.00	09100	EMERGENCY	0	538,735	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	505,080	0		92.00
200.00		Total (lines 50-199)	0	44,484,343	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/26/2016 1:59 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.181936	3,448,852	0	0	627,470	50.00
51.00	05100	RECOVERY ROOM	0.548444	1,033,283	0	0	566,698	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.181082	31,872	4	0	69,515	52.00
53.00	05300	ANESTHESIOLOGY	0.145441	785,460	0	0	114,238	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.452080	1,834,319	0	0	829,259	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.465376	3,372,773	0	0	1,569,608	55.00
56.00	05600	RADIOISOTOPE	0.192936	760,361	0	0	146,701	56.00
57.00	05700	CT SCAN	0.054080	3,914,387	0	0	211,690	57.00
58.00	05800	MRI	0.114632	1,387,514	0	0	159,054	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.233009	1,704,468	4,280	0	397,156	59.00
60.00	06000	LABORATORY	0.159425	4,966,416	137	0	791,771	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.700152	208,573	0	0	146,033	62.00
64.00	06400	INTRAVENOUS THERAPY	0.346018	922,259	0	0	319,118	64.00
65.00	06500	RESPIRATORY THERAPY	3.055871	72,726	0	0	222,241	65.00
66.00	06600	PHYSICAL THERAPY	1.133824	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.646068	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.424361	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.182772	444,272	0	0	81,200	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.497289	284,954	0	0	141,704	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.122269	9,169,974	0	0	1,121,204	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.473170	1,997,047	0	3,345	944,943	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.153037	6,924,363	0	0	1,059,684	73.00
74.00	07400	RENAL DIALYSIS	1.879318	0	0	0	0	74.00
76.00	03190	CHEMOTHERAPY	0.000000	0	0	0	0	76.00
76.01	03950	DIABETES CENTER	4.176715	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	1.303397	170,719	0	0	222,515	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	9.480352	5,936	0	0	56,275	76.98
		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
88.03	08803	RURAL HEALTH CLINIC IV	0.000000				0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000				0	88.04
91.00	09100	EMERGENCY	2.535457	538,735	0	0	1,365,939	91.00
91.01	09101	OUTPATIENT PSYCH	0.000000	0	0	0	0	91.01
91.02	09102	WOUND CARE	0.000000	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.720524	505,080	0	0	363,922	92.00
200.00		Subtotal (see instructions)		44,484,343	4,421	3,345	11,527,938	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		44,484,343	4,421	3,345	11,527,938	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/26/2016 1:59 pm

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		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	997	0		59.00
60.00	06000	LABORATORY	22	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
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	1,583		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03190	CHEMOTHERAPY	0	0		76.00
76.01	03950	DIABETES CENTER	0	0		76.01
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
		OUTPATIENT SERVICE COST CENTERS				
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
88.03	08803	RURAL HEALTH CLINIC IV	0	0		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0		88.04
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
200.00		Subtotal (see instructions)	1,028	1,583		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	1,028	1,583		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/26/2016 1:59 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.181936	0	264,412	0	0	50.00
51.00	05100	RECOVERY ROOM	0.548444	0	161,065	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.181082	0	2,604	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.145441	0	72,757	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.452080	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.465376	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.192936	0	0	0	0	56.00
57.00	05700	CT SCAN	0.054080	0	0	0	0	57.00
58.00	05800	MRI	0.114632	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.233009	0	86,095	0	0	59.00
60.00	06000	LABORATORY	0.159425	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.700152	0	7,472	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.346018	0	390,683	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3.055871	0	7,783	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1.133824	0	19,689	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.646068	0	7,492	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.424361	0	18,880	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.182772	0	104,605	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.497289	0	59,768	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.122269	0	2,484,082	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.473170	0	197,654	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.153037	0	1,159,917	0	0	73.00
74.00	07400	RENAL DIALYSIS	1.879318	0	0	0	0	74.00
76.00	03190	CHEMOTHERAPY	0.000000	0	0	0	0	76.00
76.01	03950	DIABETES CENTER	4.176715	0	329	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	1.303397	0	3,332	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	9.480352	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2.037967				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.678897				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1.245521				0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1.547932				0	88.03
88.04	08804	RURAL HEALTH CLINIC V	1.323194				0	88.04
91.00	09100	EMERGENCY	2.535457	0	101,623	0	0	91.00
91.01	09101	OUTPATIENT PSYCH	0.000000	0	0	0	0	91.01
91.02	09102	WOUND CARE	0.000000	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.720524	0	71,070	0	0	92.00
200.00		Subtotal (see instructions)		0	5,221,312	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	5,221,312	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/26/2016 1:59 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	48,106	0		50.00
51.00	05100	RECOVERY ROOM	88,335	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,680	0		52.00
53.00	05300	ANESTHESIOLOGY	10,582	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	20,061	0		59.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	5,232	0		62.00
64.00	06400	INTRAVENOUS THERAPY	135,183	0		64.00
65.00	06500	RESPIRATORY THERAPY	23,784	0		65.00
66.00	06600	PHYSICAL THERAPY	22,324	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	4,840	0		67.00
68.00	06800	SPEECH PATHOLOGY	26,892	0		68.00
69.00	06900	ELECTROCARDIOLOGY	19,119	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	29,722	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	303,726	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	93,524	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	177,510	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03190	CHEMOTHERAPY	0	0		76.00
76.01	03950	DIABETES CENTER	1,374	0		76.01
76.97	07697	CARDIAC REHABILITATION	4,343	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
		OUTPATIENT SERVICE COST CENTERS				
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
88.03	08803	RURAL HEALTH CLINIC IV	0	0		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0		88.04
91.00	09100	EMERGENCY	257,661	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	51,208	0		92.00
200.00		Subtotal (see instructions)	1,329,206	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	1,329,206	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/26/2016 1:59 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14,636	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,636	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)	13,688	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)	8,741	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
	SWING BED ADJUSTMENT		
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)	15,949,903	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)	15,949,903	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	15,949,903	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,089.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	9,525,680	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)	9,525,680	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/26/2016 1:59 pm

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	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	4,485,698	2,072	2,164.91	1,409	3,050,358	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)	13,806,792	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	26,382,830	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)	1,107,376	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,209,475	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,316,851	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	24,065,979	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/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	948	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,089.77	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,033,102	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/26/2016 1:59 pm

Title XVIII | Hospital | PPS

	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	1,436,314	15,949,903	0.090052	1,033,102	93,033	90.00
91.00	Nursing School cost	0	15,949,903	0.000000	1,033,102	0	91.00
92.00	Allied health cost	0	15,949,903	0.000000	1,033,102	0	92.00
93.00	All other Medical Education	0	15,949,903	0.000000	1,033,102	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/26/2016 1:59 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14,636	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,636	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)	13,688	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)	644	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)	1,291	15.00
16.00	Nursery days (title V or XIX only)	93	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	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)	15,949,903	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)	15,949,903	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	15,949,903	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,089.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	701,812	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)	701,812	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/26/2016 1:59 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	927,267	1,291	718.25	93	66,797	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,485,698	2,072	2,164.91	131	283,603	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)	718,709	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,770,921	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	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/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	948	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,089.77	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,033,102	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/26/2016 1:59 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,436,314	15,949,903	0.090052	1,033,102	93,033	90.00
91.00	Nursing School cost	0	15,949,903	0.000000	1,033,102	0	91.00
92.00	Allied health cost	0	15,949,903	0.000000	1,033,102	0	92.00
93.00	All other Medical Education	0	15,949,903	0.000000	1,033,102	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/26/2016 1:59 pm

Title XVIII | Hospital | PPS

		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		4,047,776		30.00
31.00	03100	INTENSIVE CARE UNIT		1,176,454		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.186151	5,971,836	1,111,663	50.00
51.00	05100	RECOVERY ROOM	0.548444	728,834	399,725	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.181082	85,971	187,510	52.00
53.00	05300	ANESTHESIOLOGY	0.155151	1,748,057	271,213	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.452080	1,592,809	720,077	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.470059	15,180	7,135	55.00
56.00	05600	RADIOISOTOPE	0.192936	405,829	78,299	56.00
57.00	05700	CT SCAN	0.054080	2,551,438	137,982	57.00
58.00	05800	MRI	0.114632	461,912	52,950	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.233009	1,429,897	333,179	59.00
60.00	06000	LABORATORY	0.160603	7,805,521	1,253,590	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.700152	466,779	326,816	62.00
64.00	06400	INTRAVENOUS THERAPY	0.346018	263,796	91,278	64.00
65.00	06500	RESPIRATORY THERAPY	3.055871	238,999	730,350	65.00
66.00	06600	PHYSICAL THERAPY	1.133824	630,471	714,843	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.646068	95,243	61,533	67.00
68.00	06800	SPEECH PATHOLOGY	1.424361	27,321	38,915	68.00
69.00	06900	ELECTROCARDIOLOGY	0.182772	352,891	64,499	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.497289	15,695	7,805	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.122269	27,365,055	3,345,898	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.473170	652,270	308,635	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.153037	15,784,194	2,415,566	73.00
74.00	07400	RENAL DIALYSIS	1.879318	58,050	109,094	74.00
76.00	03190	CHEMOTHERAPY	0.000000	0	0	76.00
76.01	03950	DIABETES CENTER	4.176715	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	1.303397	7	9	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	9.480352	100	948	76.98
		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
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		0	88.04
91.00	09100	EMERGENCY	2.602284	352,179	916,470	91.00
91.01	09101	OUTPATIENT PSYCH	0.000000	0	0	91.01
91.02	09102	WOUND CARE	0.000000	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.720524	167,670	120,810	92.00
200.00		Total (sum of lines 50-94 and 96-98)		69,268,004	13,806,792	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)		69,268,004		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/26/2016 1:59 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		198,852		30.00
31.00	03100	INTENSIVE CARE UNIT		85,417		31.00
43.00	04300	NURSERY		13,202		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.181936	49,439	8,995	50.00
51.00	05100	RECOVERY ROOM	0.548444	28,970	15,888	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.181082	9,947	21,695	52.00
53.00	05300	ANESTHESIOLOGY	0.145441	34,105	4,960	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.452080	143,527	64,886	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.465376	0	0	55.00
56.00	05600	RADIOISOTOPE	0.192936	15,526	2,996	56.00
57.00	05700	CT SCAN	0.054080	206,467	11,166	57.00
58.00	05800	MRI	0.114632	36,462	4,180	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.233009	70,857	16,510	59.00
60.00	06000	LABORATORY	0.159425	576,348	91,884	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.700152	10,532	7,374	62.00
64.00	06400	INTRAVENOUS THERAPY	0.346018	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3.055871	10,916	33,358	65.00
66.00	06600	PHYSICAL THERAPY	1.133824	20,984	23,792	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.646068	2,586	1,671	67.00
68.00	06800	SPEECH PATHOLOGY	1.424361	4,232	6,028	68.00
69.00	06900	ELECTROCARDIOLOGY	0.182772	53,028	9,692	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.497289	2,105	1,047	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.122269	1,125,403	137,602	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.473170	76,389	36,145	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.153037	1,365,513	208,974	73.00
74.00	07400	RENAL DIALYSIS	1.879318	5,250	9,866	74.00
76.00	03190	CHEMOTHERAPY	0.000000	0	0	76.00
76.01	03950	DIABETES CENTER	4.176715	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	1.303397	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	9.480352	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	2.037967	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.678897	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1.245521	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1.547932	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	1.323194	0	0	88.04
91.00	09100	EMERGENCY	2.535457	0	0	91.00
91.01	09101	OUTPATIENT PSYCH	0.000000	0	0	91.01
91.02	09102	WOUND CARE	0.000000	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.720524	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,848,586	718,709	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)		3,848,586		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E Part A Date/Time Prepared: 2/26/2016 1:59 pm

Title XVIII | Hospital | PPS

			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments		0			1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		17,231,695			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		0			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0			1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0			1.04
2.00	Outlier payments for discharges. (see instructions)		259,787			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		129,838			3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		88.48			4.00
	Indirect Medical Education Adjustment					
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), 64 FR 26340 (May 12, 1998), and 67 FR 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
22.01	IME payment adjustment - Managed Care (see instructions)		0			22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA					
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
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0			28.01
29.00	Total IME payment (sum of lines 22 and 28)		0			29.00

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			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0			29.01
	Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.70			30.00
31.00	Percentage of Medicaid patient days (see instructions)		13.40			31.00
32.00	Sum of lines 30 and 31		18.10			32.00
33.00	Allowable disproportionate share percentage (see instructions)		4.52			33.00
34.00	Disproportionate share adjustment (see instructions)		194,718			34.00

			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
	Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0		7,647,644,885	35.00
35.01	Factor 3 (see instructions)		0.000000000		0.000082172	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0		628,422	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0		628,422	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		628,422			36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
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 an 685. (see instructions)		0	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 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 an 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)		18,314,622			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		22,325,980			48.00
49.00	Total payment for inpatient operating costs (see instructions)		22,325,980			49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,396,096			50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0			51.00
52.00	Direct graduate medical education payment (from Wkst. 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		0			54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0			55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0			56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0			57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0			58.00
59.00	Total (sum of amounts on lines 49 through 58)		23,722,076			59.00
60.00	Primary payer payments		2,798			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		23,719,278			61.00

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			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
62.00	Deductibles billed to program beneficiaries		2,155,780			62.00
63.00	Coinsurance billed to program beneficiaries		26,057			63.00
64.00	Allowable bad debts (see instructions)		577,265			64.00
65.00	Adjusted reimbursable bad debts (see instructions)		375,222			65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		490,081			66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		21,912,663			67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (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 MIS ADJ		0			70.00
70.50	RURAL DEMONSTRATION PROJECT		0			70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0			70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0			70.91
70.92	Bundled Model 1 discount amount (see instructions)		0			70.92
70.93	HVBP payment adjustment amount (see instructions)		61,635			70.93
70.94	HRR adjustment amount (see instructions)		-36,187			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
70.99	HAC adjustment amount (see instructions)		0			70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		21,938,111			71.00
71.01	Sequestration adjustment (see instructions)		438,762			71.01
72.00	Interim payments		21,636,495			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)		-137,146			74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0			75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0			90.00
91.00	Capital outlier from Wkst. L, Pt. 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 10/01/2014 To 09/30/2015	Worksheet E Part A Date/Time Prepared: 2/26/2016 1:59 pm
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		Prior to 10/1		On/After 10/1	
		1.00	1.01	2.00	
	HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)			0	100.00
	HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)			0	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
	HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)			0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 260025	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part B Date/Time Prepared: 2/26/2016 1:59 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,611	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	11,527,938	2.00
3.00	PPS payments	8,541,310	3.00
4.00	Outlier payment (see instructions)	425,361	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	10,167,641	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	88.19	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	2,611	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	7,766	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	7,766	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	7,766	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	5,155	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)	2,611	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)	8,966,671	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,755,753	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	7,213,529	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	7,213,529	30.00
31.00	Primary payer payments	1,958	31.00
32.00	Subtotal (line 30 minus line 31)	7,211,571	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	177,500	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	115,375	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	109,655	36.00
37.00	Subtotal (see instructions)	7,326,946	37.00
38.00	MSP-LCC reconciliation amount from PS&R	752	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	7,326,194	40.00
40.01	Sequestration adjustment (see instructions)	146,524	40.01
41.00	Interim payments	7,180,996	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-1,326	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 2/26/2016 1:59 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		21,636,495		7,180,996	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)		21,636,495		7,180,996	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		137,146		1,326	6.02
7.00	Total Medicare program liability (see instructions)		21,499,349		7,179,670	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 10/01/2014 To 09/30/2015	Worksheet E-1 Part II Date/Time Prepared: 2/26/2016 1:59 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	4,232	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	10,150	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	943	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	15,760	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	277,272,746	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	8,435,781	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	949,826	8.00
9.00	Sequestration adjustment amount (see instructions)	18,997	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	930,829	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	930,829	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-3 Part VII | Date/Time Prepared: 2/26/2016 1:59 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	1,770,921		1.00
2.00	Medical and other services		1,329,206	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	1,770,921	1,329,206	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	1,770,921	1,329,206	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	297,471		8.00
9.00	Ancillary service charges	3,848,586	5,221,312	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	4,146,057	5,221,312	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	4,146,057	5,221,312	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	2,375,136	3,892,106	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	1,770,921	1,329,206	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	1,770,921	1,329,206	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	1,770,921	1,329,206	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	1,770,921	1,329,206	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	1,770,921	1,329,206	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	1,770,921	1,329,206	40.00
41.00	Interim payments	637,455	1,357,541	41.00
42.00	Balance due provider/program (line 40 minus line 41)	1,133,466	-28,335	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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 10/01/2014 To 09/30/2015 | Worksheet G | Date/Time Prepared: 2/26/2016 1:59 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	17,492,467	0	0	0	1.00
2.00	Temporary investments	1,580,945	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	14,681,850	0	0	0	4.00
5.00	Other receivable	1,234,660	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,699,743	0	0	0	7.00
8.00	Prepaid expenses	773,239	0	0	0	8.00
9.00	Other current assets	560,466	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)	39,023,370	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,693,370	0	0	0	12.00
13.00	Land improvements	7,118,129	0	0	0	13.00
14.00	Accumulated depreciation	-5,525,231	0	0	0	14.00
15.00	Buildings	44,043,753	0	0	0	15.00
16.00	Accumulated depreciation	-26,770,955	0	0	0	16.00
17.00	Leasehold improvements	20,645,944	0	0	0	17.00
18.00	Accumulated depreciation	-10,420,080	0	0	0	18.00
19.00	Fixed equipment	379,621	0	0	0	19.00
20.00	Accumulated depreciation	-125,928	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	67,447,929	0	0	0	23.00
24.00	Accumulated depreciation	-52,629,192	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	1,201,183	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	48,058,543	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	48,058,543	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	6,900,166	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	54,958,709	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	142,040,622	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	7,112,378	0	0	0	37.00
38.00	Salaries, wages, and fees payable	8,108,149	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	3,477,988	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	9,981,427	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	28,679,942	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	11,047,969	0	0	0	47.00
48.00	Unsecured loans	3,758,875	0	0	0	48.00
49.00	Other long term liabilities	5,015,009	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	19,821,853	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	48,501,795	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	93,538,827				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)	93,538,827	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	142,040,622	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-1 | Date/Time Prepared: 2/26/2016 1:59 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		92,686,813		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,004,956				2.00
3.00	Total (sum of line 1 and line 2)		97,691,769		0		3.00
4.00	NET ASSETS RELEASED FROM RESTRICTION	916,413		0		0	4.00
5.00	FOUNDATION CHANGES	19,900		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)		936,313		0		10.00
11.00	Subtotal (line 3 plus line 10)		98,628,082		0		11.00
12.00	CHANGE IN UNREALIZED INVESTMENTS	2,372,541		0		0	12.00
13.00	CHANGE IN MINIMUM PENSION LIABILITY	2,716,714		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)		5,089,255		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		93,538,827		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	NET ASSETS RELEASED FROM RESTRICTION		0		4.00
5.00	FOUNDATION CHANGES		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	CHANGE IN UNREALIZED INVESTMENTS		0		12.00
13.00	CHANGE IN MINIMUM PENSION LIABILITY		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 10/01/2014 To 09/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/26/2016 1:59 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,101,307		6,101,307	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)	6,101,307		6,101,307	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,718,390		1,718,390	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)	1,718,390		1,718,390	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	7,819,697		7,819,697	17.00
18.00	Ancillary services	127,342,442	132,666,911	260,009,353	18.00
19.00	Outpatient services	282,900	3,647,293	3,930,193	19.00
20.00	RURAL HEALTH CLINIC	0	597,891	597,891	20.00
20.01	RURAL HEALTH CLINIC II	0	692,794	692,794	20.01
20.02	RURAL HEALTH CLINIC III	0	1,245,859	1,245,859	20.02
20.03	RURAL HEALTH CLINIC IV	0	995,045	995,045	20.03
20.04	RURAL HEALTH CLINIC V	0	995,045	995,045	20.04
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		986,869	986,869	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN REVENUE	3,947,469	5,764,120	9,711,589	27.00
27.01	PHYSICIAN REVENUE - NRCC	0	9,938,984	9,938,984	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	139,392,508	157,530,811	296,923,319	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		114,773,617		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)		114,773,617		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-3 | Date/Time Prepared: 2/26/2016 1:59 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	296,923,319	1.00
2.00	Less contractual allowances and discounts on patients' accounts	182,500,023	2.00
3.00	Net patient revenues (line 1 minus line 2)	114,423,296	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	114,773,617	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-350,321	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	917,708	6.00
7.00	Income from investments	119,069	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	569,022	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	7,035	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	330,492	22.00
23.00	Governmental appropriations	0	23.00
24.00	DAY CARE INCOME	751,591	24.00
24.01	NON OPERATING INCOME	978,096	24.01
24.02	OTHER REVENUE	1,897,384	24.02
24.03	EHR MEANINGFUL USE	133,875	24.03
25.00	Total other income (sum of lines 6-24)	5,704,272	25.00
26.00	Total (line 5 plus line 25)	5,353,951	26.00
27.00	FOUNDATION LOSSES	348,995	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	348,995	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,004,956	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 260025 | HHA CCN: 267282 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H | Date/Time Prepared: 2/26/2016 1:59 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		2,387	2,387	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	1,154	1,154	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	140,361	17,820	0	0	120,803	278,984	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	379,627	48,197	0	0	6,978	434,802	6.00
7.00	Physical Therapy	173,877	22,075	0	0	0	195,952	7.00
8.00	Occupational Therapy	8,707	1,105	0	0	518	10,330	8.00
9.00	Speech Pathology	10,797	1,371	0	0	539	12,707	9.00
10.00	Medical Social Services	2,429	308	0	0	0	2,737	10.00
11.00	Home Health Aide	52,226	6,631	0	0	0	58,857	11.00
12.00	Supplies (see instructions)	0	0	0	0	777	777	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
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)	768,024	97,507	0	0	133,156	998,687	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			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	2,387	0	2,387			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	1,154	0	1,154			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	278,984	0	278,984			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	434,802	0	434,802			6.00
7.00	Physical Therapy	0	195,952	0	195,952			7.00
8.00	Occupational Therapy	0	10,330	0	10,330			8.00
9.00	Speech Pathology	0	12,707	0	12,707			9.00
10.00	Medical Social Services	0	2,737	0	2,737			10.00
11.00	Home Health Aide	0	58,857	0	58,857			11.00
12.00	Supplies (see instructions)	0	777	0	777			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
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	998,687	0	998,687			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 10/01/2014 To 09/30/2015 | Worksheet H-1 Part I | Date/Time Prepared: 2/26/2016 1:59 pm

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	2,387	2,387				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	1,154	0	0	1,154		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	278,984	2,387	0	1,154	0	282,525	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	434,802	0	0	0	0	434,802	6.00
7.00	Physical Therapy	195,952	0	0	0	0	195,952	7.00
8.00	Occupational Therapy	10,330	0	0	0	0	10,330	8.00
9.00	Speech Pathology	12,707	0	0	0	0	12,707	9.00
10.00	Medical Social Services	2,737	0	0	0	0	2,737	10.00
11.00	Home Health Aide	58,857	0	0	0	0	58,857	11.00
12.00	Supplies (see instructions)	777	0	0	0	0	777	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
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)	998,687	2,387	0	1,154	0	998,687	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
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	282,525		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	171,528	606,330	6.00
7.00	Physical Therapy	77,303	273,255	7.00
8.00	Occupational Therapy	4,075	14,405	8.00
9.00	Speech Pathology	5,013	17,720	9.00
10.00	Medical Social Services	1,080	3,817	10.00
11.00	Home Health Aide	23,219	82,076	11.00
12.00	Supplies (see instructions)	307	1,084	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
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)		998,687	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 260025 | HHA CCN: 267282 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-1 Part II | Date/Time Prepared: 2/26/2016 1:59 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	650				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	650		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	650	0	650	0	-282,525	716,162	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	434,802	6.00
7.00	Physical Therapy	0	0	0	0	0	195,952	7.00
8.00	Occupational Therapy	0	0	0	0	0	10,330	8.00
9.00	Speech Pathology	0	0	0	0	0	12,707	9.00
10.00	Medical Social Services	0	0	0	0	0	2,737	10.00
11.00	Home Health Aide	0	0	0	0	0	58,857	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	777	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
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)	650	0	650	0	-282,525	716,162	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	2,387	0	1,154	0		282,525	25.00
26.00	Unit Cost Multiplier	3.672308	0.000000	1.775385	0.000000		0.394499	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 260025 | HHA CCN: 267282 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-2 Part I | Date/Time Prepared: 2/26/2016 1:59 pm

Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	26,203	2,633	38,295	67,131	24,541	1.00
2.00	Skilled Nursing Care	606,330	0	0	103,572	709,902	259,515	2.00
3.00	Physical Therapy	273,255	0	0	47,439	320,694	117,235	3.00
4.00	Occupational Therapy	14,405	0	0	2,376	16,781	6,135	4.00
5.00	Speech Pathology	17,720	0	0	2,946	20,666	7,555	5.00
6.00	Medical Social Services	3,817	0	0	663	4,480	1,638	6.00
7.00	Home Health Aide	82,076	0	0	14,249	96,325	35,213	7.00
8.00	Supplies (see instructions)	1,084	0	0	0	1,084	396	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)	998,687	26,203	2,633	209,540	1,237,063	452,228	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	6,862	51,562	0	23,242	0	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) (2)	6,862	51,562	0	23,242	0	0	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 | HHA CCN: 267282 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-2 Part I | Date/Time Prepared: 2/26/2016 1:59 pm

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	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	14.00	15.00	16.00	24.00	25.00	
1.00	Administrative and General	0	0	0	0	173,338	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	969,417	0	2.00
3.00	Physical Therapy	0	0	0	0	437,929	0	3.00
4.00	Occupational Therapy	0	0	0	0	22,916	0	4.00
5.00	Speech Pathology	0	0	0	0	28,221	0	5.00
6.00	Medical Social Services	0	0	0	0	6,118	0	6.00
7.00	Home Health Aide	0	0	0	0	131,538	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	1,480	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)	0	0	0	0	1,770,957	0	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	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs				
		26.00	27.00	28.00				
1.00	Administrative and General	173,338						1.00
2.00	Skilled Nursing Care	969,417	105,179	1,074,596				2.00
3.00	Physical Therapy	437,929	47,514	485,443				3.00
4.00	Occupational Therapy	22,916	2,486	25,402				4.00
5.00	Speech Pathology	28,221	3,062	31,283				5.00
6.00	Medical Social Services	6,118	664	6,782				6.00
7.00	Home Health Aide	131,538	14,272	145,810				7.00
8.00	Supplies (see instructions)	1,480	161	1,641				8.00
9.00	Drugs	0	0	0				9.00
10.00	DME	0	0	0				10.00
11.00	Home Dialysis Aide Services	0	0	0				11.00
12.00	Respiratory Therapy	0	0	0				12.00
13.00	Private Duty Nursing	0	0	0				13.00
14.00	Clinic	0	0	0				14.00
15.00	Health Promotion Activities	0	0	0				15.00
16.00	Day Care Program	0	0	0				16.00
17.00	Home Delivered Meals Program	0	0	0				17.00
18.00	Homemaker Service	0	0	0				18.00
19.00	All Others (specify)	0	0	0				19.00
20.00	Total (sum of lines 1-19) (2)	1,770,957	173,338	1,770,957				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.		0.108498					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 10/01/2014 To 09/30/2015

Worksheet H-2 Part II Date/Time Prepared: 2/26/2016 1:59 pm

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	3,000	2,432	140,361	0	67,131	3,000	1.00
2.00	Skilled Nursing Care	0	0	379,626	0	709,902	0	2.00
3.00	Physical Therapy	0	0	173,877	0	320,694	0	3.00
4.00	Occupational Therapy	0	0	8,707	0	16,781	0	4.00
5.00	Speech Pathology	0	0	10,797	0	20,666	0	5.00
6.00	Medical Social Services	0	0	2,429	0	4,480	0	6.00
7.00	Home Health Aide	0	0	52,226	0	96,325	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	1,084	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)	3,000	2,432	768,023		1,237,063	3,000	20.00
21.00	Total cost to be allocated	26,203	2,633	209,540		452,228	6,862	21.00
22.00	Unit cost multiplier	8.734333	1.082648	0.272830		0.365566	2.287333	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	3,000	0	3,000	0	0	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)	3,000	0	3,000	0	0	0	20.00
21.00	Total cost to be allocated	51,562	0	23,242	0	0	0	21.00
22.00	Unit cost multiplier	17.187333	0.000000	7.747333	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 260025 | HHA CCN: 267282 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-2 Part II | Date/Time Prepared: 2/26/2016 1:59 pm

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-3 Part I | Date/Time Prepared: 2/26/2016 1:59 pm

HHA CCN: 267282 | Title XVIII | 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 (cols. 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	1,074,596		1,074,596	3,917	274.34	1.00
2.00	Physical Therapy	3.00	485,443	0	485,443	1,997	243.09	2.00
3.00	Occupational Therapy	4.00	25,402	0	25,402	100	254.02	3.00
4.00	Speech Pathology	5.00	31,283	0	31,283	124	252.28	4.00
5.00	Medical Social Services	6.00	6,782		6,782	20	339.10	5.00
6.00	Home Health Aide	7.00	145,810		145,810	239	610.08	6.00
7.00	Total (sum of lines 1-6)		1,769,316	0	1,769,316	6,397		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99926	0	421			8.00
8.01	Skilled Nursing Care		99914	0	280			8.01
8.02	Skilled Nursing Care		50089	0	1,434			8.02
9.00	Physical Therapy		99926	0	274			9.00
9.01	Physical Therapy		99914	0	205			9.01
9.02	Physical Therapy		50089	0	759			9.02
10.00	Occupational Therapy		99926	0	16			10.00
10.01	Occupational Therapy		99914	0	3			10.01
10.02	Occupational Therapy		50089	0	62			10.02
11.00	Speech Pathology		99926	0	3			11.00
11.01	Speech Pathology		99914	0	0			11.01
11.02	Speech Pathology		50089	0	12			11.02
12.00	Medical Social Services		99926	0	5			12.00
12.01	Medical Social Services		99914	0	1			12.01
12.02	Medical Social Services		50089	0	8			12.02
13.00	Home Health Aide		99926	0	60			13.00
13.01	Home Health Aide		99914	0	0			13.01
13.02	Home Health Aide		50089	0	160			13.02
14.00	Total (sum of lines 8-13)			0	3,703			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 (cols. 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	1,641	8,736	10,377	71,449	0.145236	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B 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	0	2,135		0	585,716		1.00
2.00	Physical Therapy	0	1,238		0	300,945		2.00
3.00	Occupational Therapy	0	81		0	20,576		3.00
4.00	Speech Pathology	0	15		0	3,784		4.00
5.00	Medical Social Services	0	14		0	4,747		5.00
6.00	Home Health Aide	0	220		0	134,218		6.00
7.00	Total (sum of lines 1-6)	0	3,703		0	1,049,986		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-3 Part I | Date/Time Prepared: 2/26/2016 1:59 pm

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	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00

		Program Covered Charges			Cost of Services			
			Part B			Part B		
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	23,013	0	0	3,342	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	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	585,716	1.00
2.00	Physical Therapy	300,945	2.00
3.00	Occupational Therapy	20,576	3.00
4.00	Speech Pathology	3,784	4.00
5.00	Medical Social Services	4,747	5.00
6.00	Home Health Aide	134,218	6.00
7.00	Total (sum of lines 1-6)	1,049,986	7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
8.01	Skilled Nursing Care		8.01
8.02	Skilled Nursing Care		8.02
9.00	Physical Therapy		9.00
9.01	Physical Therapy		9.01
9.02	Physical Therapy		9.02
10.00	Occupational Therapy		10.00
10.01	Occupational Therapy		10.01
10.02	Occupational Therapy		10.02
11.00	Speech Pathology		11.00
11.01	Speech Pathology		11.01
11.02	Speech Pathology		11.02
12.00	Medical Social Services		12.00
12.01	Medical Social Services		12.01
12.02	Medical Social Services		12.02
13.00	Home Health Aide		13.00
13.01	Home Health Aide		13.01
13.02	Home Health Aide		13.02
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 260025 | HHA CCN: 267282 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-3 Part II | Date/Time Prepared: 2/26/2016 1:59 pm

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	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		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	1.133824	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.646068	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	1.424361	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.122269	71,449	8,736	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.153037	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-4 Part I-II | Date/Time Prepared: 2/26/2016 1:59 pm

HHA CCN: 267282 | Title XVIII | Home Health Agency I | PPS

		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	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
	Customary Charges				
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	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	612,436	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	8,095	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	15,246	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	6,378	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	3,850	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	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	646,005	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	646,005	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	646,005	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)	0	646,005	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
31.00	Subtotal (see instructions)	0	646,005	31.00
31.01	Sequestration adjustment (see instructions)	0	12,920	31.01
32.00	Interim payments (see instructions)	0	633,085	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, chapter 1, §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 10/01/2014 To 09/30/2015

Worksheet H-5

Date/Time Prepared: 2/26/2016 1:59 pm

Home Health Agency I

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		0		633,085	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)		0		633,085	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)		0		633,085	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT | Provider CCN: 260025 | Period: From 10/01/2014 To 09/30/2015 | Worksheet L Parts I-III Date/Time Prepared: 2/26/2016 1:59 pm

Title XVIII | Hospital | PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,369,367	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	26,729	1.01
2.00	Capital DRG outlier payments	0	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)	43.67	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, columns 1 and 1.01)(see instructions)	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 (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	1,396,096	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
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	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
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 HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Provider CCN: 260025 Component CCN: 268512 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-1 | Date/Time Prepared: 2/26/2016 1:59 pm

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	20,330	0	20,330	0	20,330	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	168,279	0	168,279	0	168,279	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	113,858	0	113,858	0	113,858	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 through 9)	302,467	0	302,467	0	302,467	10.00
11.00	Physician Services Under Agreement	0	160,006	160,006	0	160,006	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	12,056	12,056	0	12,056	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	172,062	172,062	0	172,062	14.00
15.00	Medical Supplies	0	8,084	8,084	0	8,084	15.00
16.00	Transportation (Health Care Staff)	0	111	111	0	111	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	8,195	8,195	0	8,195	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	302,467	180,257	482,724	0	482,724	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	9,056	9,056	0	9,056	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	9,056	9,056	0	9,056	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	7,616	7,616	0	7,616	29.00
30.00	Administrative Costs	104,305	149,712	254,017	0	254,017	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	104,305	157,328	261,633	0	261,633	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	406,772	346,641	753,413	0	753,413	32.00

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

Provider CCN: 260025 | Component CCN: 268512 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-1 | Date/Time Prepared: 2/26/2016 1:59 pm

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	20,330		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	168,279		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	113,858		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	302,467		10.00
11.00	Physician Services Under Agreement	0	160,006		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	12,056		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	172,062		14.00
15.00	Medical Supplies	0	8,084		15.00
16.00	Transportation (Health Care Staff)	0	111		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	8,195		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	482,724		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	9,056		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	9,056		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	7,616		29.00
30.00	Administrative Costs	-17	254,000		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-17	261,616		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-17	753,396		32.00

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

Provider CCN: 260025 Component CCN: 263984 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-1 | Date/Time Prepared: 2/26/2016 1:59 pm

Rural Health Clinic (RHC) II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	99,114	0	99,114	0	99,114	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	115,733	0	115,733	0	115,733	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	85,226	0	85,226	0	85,226	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 through 9)	300,073	0	300,073	0	300,073	10.00
11.00	Physician Services Under Agreement	0	62,715	62,715	0	62,715	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	20,106	20,106	0	20,106	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	82,821	82,821	0	82,821	14.00
15.00	Medical Supplies	0	9,550	9,550	0	9,550	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	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	9,550	9,550	0	9,550	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	300,073	92,371	392,444	0	392,444	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	9,864	9,864	0	9,864	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	9,864	9,864	0	9,864	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	10,757	10,757	0	10,757	29.00
30.00	Administrative Costs	109,193	157,428	266,621	27,789	294,410	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	109,193	168,185	277,378	27,789	305,167	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	409,266	270,420	679,686	27,789	707,475	32.00

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

Provider CCN: 260025 | Component CCN: 263984 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-1 | Date/Time Prepared: 2/26/2016 1:59 pm

Rural Health Clinic (RHC) II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	99,114		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	115,733		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	85,226		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	300,073		10.00
11.00	Physician Services Under Agreement	0	62,715		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	20,106		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	82,821		14.00
15.00	Medical Supplies	0	9,550		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	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	9,550		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	392,444		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	9,864		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	9,864		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	10,757		29.00
30.00	Administrative Costs	-271	294,139		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-271	304,896		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-271	707,204		32.00

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

Provider CCN: 260025 Component CCN: 268513 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-1 | Date/Time Prepared: 2/26/2016 1:59 pm

Rural Health Clinic (RHC) III | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	303,228	0	303,228	0	303,228	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	92,372	0	92,372	0	92,372	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	95,971	0	95,971	0	95,971	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 through 9)	491,571	0	491,571	0	491,571	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	909	909	0	909	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	909	909	0	909	14.00
15.00	Medical Supplies	0	9,667	9,667	0	9,667	15.00
16.00	Transportation (Health Care Staff)	0	111	111	0	111	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	9,778	9,778	0	9,778	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	491,571	10,687	502,258	0	502,258	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	40,635	40,635	0	40,635	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	40,635	40,635	0	40,635	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	164	164	0	164	29.00
30.00	Administrative Costs	129,730	125,071	254,801	0	254,801	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	129,730	125,235	254,965	0	254,965	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	621,301	176,557	797,858	0	797,858	32.00

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

Provider CCN: 260025 | Component CCN: 268513 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-1 | Date/Time Prepared: 2/26/2016 1:59 pm

Rural Health Clinic (RHC) III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	303,228		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	92,372		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	95,971		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	491,571		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	909		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	909		14.00
15.00	Medical Supplies	0	9,667		15.00
16.00	Transportation (Health Care Staff)	0	111		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	9,778		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	502,258		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	40,635		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	40,635		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	164		29.00
30.00	Administrative Costs	-558	254,243		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-558	254,407		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-558	797,300		32.00

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

Provider CCN: 260025 Component CCN: 268723 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-1 | Date/Time Prepared: 2/26/2016 1:59 pm

Rural Health Clinic (RHC) IV | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	20,034	0	20,034	0	20,034	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	550,964	0	550,964	0	550,964	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	75,433	0	75,433	0	75,433	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 through 9)	646,431	0	646,431	0	646,431	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	17,346	17,346	0	17,346	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	17,346	17,346	0	17,346	14.00
15.00	Medical Supplies	0	20,244	20,244	0	20,244	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	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	20,244	20,244	0	20,244	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	646,431	37,590	684,021	0	684,021	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	87,991	87,991	0	87,991	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	87,991	87,991	0	87,991	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	5,828	5,828	0	5,828	29.00
30.00	Administrative Costs	122,881	210,020	332,901	-272,888	60,013	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	122,881	215,848	338,729	-272,888	65,841	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	769,312	341,429	1,110,741	-272,888	837,853	32.00

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

Provider CCN: 260025 | Component CCN: 268723 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-1 | Date/Time Prepared: 2/26/2016 1:59 pm

Rural Health Clinic (RHC) IV | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	20,034		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	550,964		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	75,433		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	646,431		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	17,346		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	17,346		14.00
15.00	Medical Supplies	0	20,244		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	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	20,244		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	684,021		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	87,991		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	87,991		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	5,828		29.00
30.00	Administrative Costs	-81	59,932		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-81	65,760		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-81	837,772		32.00

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

Provider CCN: 260025 Component CCN: 268724 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-1 | Date/Time Prepared: 2/26/2016 1:59 pm

Rural Health Clinic (RHC) V | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	178,839	0	178,839	0	178,839	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	33,994	0	33,994	0	33,994	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 through 9)	212,833	0	212,833	0	212,833	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	13,730	13,730	0	13,730	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	13,730	13,730	0	13,730	14.00
15.00	Medical Supplies	0	7,946	7,946	0	7,946	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	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	7,946	7,946	0	7,946	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	212,833	21,676	234,509	0	234,509	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	92	92	0	92	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	92	92	0	92	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	5,263	5,263	0	5,263	29.00
30.00	Administrative Costs	171,467	122,228	293,695	272,888	566,583	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	171,467	127,491	298,958	272,888	571,846	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	384,300	149,259	533,559	272,888	806,447	32.00

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

Provider CCN: 260025 | Component CCN: 268724 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-1 | Date/Time Prepared: 2/26/2016 1:59 pm

Rural Health Clinic (RHC) V | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	178,839		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	33,994		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	212,833		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	13,730		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	13,730		14.00
15.00	Medical Supplies	0	7,946		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	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	7,946		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	234,509		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	92		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	92		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	5,263		29.00
30.00	Administrative Costs	0	566,583		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	571,846		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	806,447		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 260025 | Component CCN: 268512 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-2 | Date/Time Prepared: 2/26/2016 1:59 pm

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.73	1,670	4,200	3,066		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.60	2,374	2,100	3,360		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.33	4,044		6,426	6,426	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.33	4,044			6,426	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					482,724	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					9,056	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					491,780	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					0.981585	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)					261,616	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					465,086	15.00
16.00	Total overhead (sum of lines 14 and 15)					726,702	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					726,702	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					713,320	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,196,044	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 260025 Component CCN: 263984

Period: From 10/01/2014 To 09/30/2015

Worksheet M-2

Date/Time Prepared: 2/26/2016 1:59 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	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.67	1,299	4,200	2,814		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.00	2,811	2,100	2,100		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.67	4,110		4,914	4,914	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.67	4,110			4,914	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					392,444	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					9,864	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					402,308	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					0.975481	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)					304,896	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					455,926	15.00
16.00	Total overhead (sum of lines 14 and 15)					760,822	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					760,822	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					742,167	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,134,611	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 260025 | Component CCN: 268513 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-2 | Date/Time Prepared: 2/26/2016 1:59 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	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.98	2,656	4,200	4,116		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.60	2,828	2,100	3,360		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.58	5,484		7,476	7,476	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.58	5,484			7,476	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					502,258	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					40,635	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					542,893	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					0.925151	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)					254,407	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					754,444	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,008,851	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					1,008,851	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					933,340	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,435,598	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 260025 | Component CCN: 268723 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-2 | Date/Time Prepared: 2/26/2016 1:59 pm

Rural Health Clinic (RHC) IV | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.00	4,360	4,200	4,200		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.99	3,387	2,100	2,079		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.99	7,747		6,279	7,747	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.99	7,747			7,747	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					684,021	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					87,991	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					772,012	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					0.886024	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)					65,760	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					702,490	15.00
16.00	Total overhead (sum of lines 14 and 15)					768,250	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					768,250	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					680,688	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,364,709	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES | Provider CCN: 260025 | Component CCN: 268724 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-2 | Date/Time Prepared: 2/26/2016 1:59 pm

Rural Health Clinic (RHC) V | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.00	3,340	4,200	4,200		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.99	3,642	2,100	2,079		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.99	6,982		6,279	6,982	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.99	6,982			6,982	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					234,509	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					92	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					234,601	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					0.999608	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)					571,846	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					510,191	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,082,037	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					1,082,037	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					1,081,613	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,316,122	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 260025 | Component CCN: 268512 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-3 | Date/Time Prepared: 2/26/2016 1:59 pm

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

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		1,196,044	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		14,091	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,181,953	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		6,426	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		6,426	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		183.93	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.80	80.44	8.00
9.00	Rate for Program covered visits (see instructions)	79.80	80.44	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	820	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	65,961	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) *		65,961	16.00
16.01	Total program charges (see instructions)(from contractor's records)		97,238	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	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.)		43,464	16.04
16.05	Total program cost (see instructions)		43,464	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		11,631	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		17,121	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		43,464	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		12,240	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		55,704	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		55,704	26.00
26.01	Sequestration adjustment (see instructions)		1,114	26.01
27.00	Interim payments		41,911	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)		12,679	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 260025 Component CCN: 263984	Period: From 10/01/2014 To 09/30/2015	Worksheet M-3 Date/Time Prepared: 2/26/2016 1:59 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 Wkst. M-2, line 20)		1,134,611	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		18,946	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,115,665	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		4,914	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		4,914	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		227.04	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.80	80.44	8.00
9.00	Rate for Program covered visits (see instructions)	79.80	80.44	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	964	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	77,544	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) *		77,544	16.00
16.01	Total program charges (see instructions)(from contractor's records)		121,361	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		353	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		226	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.)		48,970	16.04
16.05	Total program cost (see instructions)		49,196	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		16,105	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		20,981	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		49,196	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		13,591	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		62,787	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		62,787	26.00
26.01	Sequestration adjustment (see instructions)		1,256	26.01
27.00	Interim payments		47,103	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)		14,428	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 260025 | Component CCN: 268513 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-3 | Date/Time Prepared: 2/26/2016 1:59 pm

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

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		1,435,598	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		51,550	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,384,048	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		7,476	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		7,476	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		185.13	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.80	80.44	8.00
9.00	Rate for Program covered visits (see instructions)	79.80	80.44	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,690	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	135,944	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) *		135,944	16.00
16.01	Total program charges (see instructions)(from contractor's records)		256,291	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		748	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		397	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.)		90,498	16.04
16.05	Total program cost (see instructions)		90,895	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		22,424	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		46,624	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		90,895	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		30,238	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		121,133	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		121,133	26.00
26.01	Sequestration adjustment (see instructions)		2,423	26.01
27.00	Interim payments		87,230	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)		31,480	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 260025 Component CCN: 268723	Period: From 10/01/2014 To 09/30/2015	Worksheet M-3 Date/Time Prepared: 2/26/2016 1:59 pm
	Title XVIII	Rural Health Clinic (RHC) IV	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		1,364,709	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		31,926	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,332,783	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		7,747	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		7,747	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		172.04	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.80	80.44	8.00
9.00	Rate for Program covered visits (see instructions)	79.80	80.44	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,087	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	167,878	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) *		167,878	16.00
16.01	Total program charges (see instructions)(from contractor's records)		243,689	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		3,090	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		2,129	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.)		118,514	16.04
16.05	Total program cost (see instructions)		120,643	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		17,606	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		44,599	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		120,643	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		23,015	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		143,658	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		143,658	26.00
26.01	Sequestration adjustment (see instructions)		2,873	26.01
27.00	Interim payments		100,263	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)		40,522	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 260025 Component CCN: 268724	Period: From 10/01/2014 To 09/30/2015	Worksheet M-3 Date/Time Prepared: 2/26/2016 1:59 pm
	Title XVIII	Rural Health Clinic (RHC) V	Cost

				1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)			1,316,122	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			49,095	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,267,027	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			6,982	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			6,982	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			181.47	7.00
		Calculation of Limit (1)			
		Prior to January 1	On on After January 1		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.80	80.44		8.00
9.00	Rate for Program covered visits (see instructions)	79.80	80.44		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,780		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	143,183		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) *		143,183		16.00
16.01	Total program charges (see instructions)(from contractor's records)		208,791		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,830		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,255		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.)		101,427		16.04
16.05	Total program cost (see instructions)		102,682		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		15,144		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		38,363		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		102,682		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		27,969		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		130,651		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
26.00	Net reimbursable amount (see instructions)		130,651		26.00
26.01	Sequestration adjustment (see instructions)		2,613		26.01
27.00	Interim payments		85,508		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)		42,530		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 260025 | Component CCN: 268512 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-4 | Date/Time Prepared: 2/26/2016 1:59 pm

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	302,467	302,467	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000550	0.004471	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	166	1,352	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)	2,222	3,402	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	482,724	482,724	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	726,702	726,702	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.004603	0.007048	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	3,345	5,122	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	5,567	8,524	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)	347.94	65.57	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)	4,175	8,065	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		14,091	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		12,240	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 260025 | Component CCN: 263984 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-4 | Date/Time Prepared: 2/26/2016 1:59 pm

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	300,073	300,073	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000576	0.007720	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	173	2,317	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,542	2,415	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,715	4,732	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	392,444	392,444	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	760,822	760,822	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.004370	0.012058	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	3,325	9,174	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	5,040	13,906	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	12	161	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	420.00	86.37	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	12	99	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	5,040	8,551	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		18,946	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		13,591	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 260025 | Component CCN: 268513 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-4 | Date/Time Prepared: 2/26/2016 1:59 pm

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	491,571	491,571	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001739	0.009320	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	855	4,581	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	7,198	4,500	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	8,053	9,081	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	502,258	502,258	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	1,008,851	1,008,851	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.016034	0.018080	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	16,176	18,240	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	24,229	27,321	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	56	300	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	432.66	91.07	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	36	161	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	15,576	14,662	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		51,550	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		30,238	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 260025 | Component CCN: 268723 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-4 | Date/Time Prepared: 2/26/2016 1:59 pm

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	646,431	646,431	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000604	0.012482	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	390	8,069	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,928	4,650	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	2,318	12,719	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	684,021	684,021	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	768,250	768,250	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.003389	0.018594	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	2,604	14,285	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	4,922	27,004	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	15	310	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	328.13	87.11	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	12	219	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	3,938	19,077	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		31,926	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		23,015	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 260025 | Component CCN: 268724 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-4 | Date/Time Prepared: 2/26/2016 1:59 pm

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	212,833	212,833	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000722	0.009079	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	154	1,932	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	2,699	3,960	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	2,853	5,892	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	234,509	234,509	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	1,082,037	1,082,037	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.012166	0.025125	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	13,164	27,186	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	16,017	33,078	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	21	264	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	762.71	125.30	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	14	138	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	10,678	17,291	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		49,095	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		27,969	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 10/01/2014 To 09/30/2015	Worksheet M-5 Date/Time Prepared: 2/26/2016 1:59 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		41,911	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)		41,911	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		12,679	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		54,590	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 10/01/2014 To 09/30/2015	Worksheet M-5 Date/Time Prepared: 2/26/2016 1:59 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		47,103	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)		47,103	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		14,428	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		61,531	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 10/01/2014 To 09/30/2015	Worksheet M-5 Date/Time Prepared: 2/26/2016 1:59 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		87,230	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)		87,230	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		31,480	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		118,710	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: 268723 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-5 | Date/Time Prepared: 2/26/2016 1:59 pm

Rural Health Clinic (RHC) IV | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		100,263	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)		100,263	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		40,522	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		140,785	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: 268724	Period: From 10/01/2014 To 09/30/2015	Worksheet M-5 Date/Time Prepared: 2/26/2016 1:59 pm
		Rural Health Clinic (RHC) V	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		85,508	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)		85,508	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		42,530	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		128,038	7.00

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