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

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 26-0025	Period: From 10/01/2015 To 09/30/2016	Worksheet S Parts I-III Date/Time Prepared: 2/27/2017 9:02 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/27/2017 Time: 9:02 am
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 (26-0025) for the cost reporting period beginning 10/01/2015 and ending 09/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	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	-345,109	15,711	444,674	193,482	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		8,199		0	10.00
10.01	RURAL HEALTH CLINIC II	0		9,362		0	10.01
10.02	RURAL HEALTH CLINIC III	0		34,563		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		22,032		0	10.03
10.04	RURAL HEALTH CLINIC V	0		17,643		0	10.04
200.00	Total	0	-345,109	107,510	444,674	193,482	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: 26-0025	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part I Date/Time Prepared: 2/25/2017 1:17 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	HANNIBAL REGIONAL HOSPITAL	26T025	99926	5	10/01/2015	N	P	O	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)	10/01/2015	09/30/2016	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 §412.106(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.	3	N	23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2017 1:17 pm

		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.	918	251	19	0	1,102	15	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		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.	10/01/2015	09/30/2016	36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

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

		V	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2017 1:17 pm

		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
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2017 1:17 pm

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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 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.	Y			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00

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		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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	250,812	0	0	118.01

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		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
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.00	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 26-0025	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part I Date/Time Prepared: 2/25/2017 1:17 pm

							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)						0.25	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)					10/01/2015	09/30/2016	170.00
						1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part II | Date/Time Prepared: 2/25/2017 1:17 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	12/22/2016	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		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	01/08/2017	Y	01/08/2017	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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 2/25/2017 1:17 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		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.	KEVIN	WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446	KEVIN.WELLEN@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 26-0025	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part II Date/Time Prepared: 2/25/2017 1:17 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		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: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 2/25/2017 1:17 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	78	28,548	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)		78	28,548	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	8	2,928	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)		86	31,476	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	13	4,758		0	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	89.00				0	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: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 2/25/2017 1:17 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)	7,610	611	12,184			1.00
2.00	HMO and other (see instructions)	811	1,372				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)	7,610	611	12,184			7.00
8.00	INTENSIVE CARE UNIT	1,165	190	1,888			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		117	1,164			13.00
14.00	Total (see instructions)	8,775	918	15,236	0.00	725.58	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	1,276	0	1,700	0.00	11.30	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	3,968	214	6,541	0.00	11.99	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	712	92	3,658	0.00	6.64	26.00
26.01	RURAL HEALTH CLINIC II	840	243	3,047	0.00	7.11	26.01
26.02	RURAL HEALTH CLINIC III	1,689	364	5,478	0.00	8.03	26.02
26.03	RURAL HEALTH CLINIC IV	2,055	832	6,846	0.00	9.25	26.03
26.04	RURAL HEALTH CLINIC V	1,670	318	6,640	0.00	9.16	26.04
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	789.06	27.00
28.00	Observation Bed Days		0	1,043			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	15	179			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: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 2/25/2017 1:17 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	2,131	217	4,080	1.00
2.00	HMO and other (see instructions)			176	286		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	2,131	217	4,080	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	109	0	147	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	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 2/25/2017 1:17 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	53,444,341	0	53,444,341	1,647,550.00	32.44	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		491,628	0	491,628	2,222.25	221.23	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		6,227,390	0	6,227,390	48,446.75	128.54	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		1,152,664	0	1,152,664	65,330.00	17.64	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 and/or related organization 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)		11,097,026	-220,896	10,876,130	251,590.16	43.23	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,856,924	0	2,856,924	34,702.42	82.33	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		368,688	0	368,688	2,089.50	176.45	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
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)		12,316,637	0	12,316,637			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		2,917,217	0	2,917,217			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		70,500	0	70,500			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		1,057,195	0	1,057,195			23.00
24.00	Wage-related costs (RHC/FQHC)		527,195	0	527,195			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related		0	0	0			25.50
25.51	Related orgainzation wage-related		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	516,707	220,896	737,603	31,904.84	23.12	26.00
27.00	Administrative & General	5.00	11,053,189	0	11,053,189	343,806.00	32.15	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 2/25/2017 1:17 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	
28.00	Administrative & General under contract (see inst.)		1,107,531	0	1,107,531	5,219.85	212.18	28.00
29.00	Maintenance & Repairs	6.00	349,264	0	349,264	20,547.00	17.00	29.00
30.00	Operation of Plant	7.00	687,934	0	687,934	31,038.00	22.16	30.00
31.00	Laundry & Linen Service	8.00	30,253	0	30,253	2,931.00	10.32	31.00
32.00	Housekeeping	9.00	603,978	0	603,978	48,582.00	12.43	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	789,762	0	789,762	52,598.00	15.02	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	654,896	0	654,896	21,252.00	30.82	38.00
39.00	Central Services and Supply	14.00	146,456	0	146,456	8,715.00	16.81	39.00
40.00	Pharmacy	15.00	1,619,485	-1,619,485	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	774,611	0	774,611	39,292.00	19.71	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: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part III Date/Time Prepared: 2/25/2017 1:17 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)		47,171,818	0	47,171,818	1,538,993.10	30.65	1.00
2.00	Excluded area salaries (see instructions)		11,097,026	-220,896	10,876,130	251,590.16	43.23	2.00
3.00	Subtotal salaries (line 1 minus line 2)		36,074,792	220,896	36,295,688	1,287,402.94	28.19	3.00
4.00	Subtotal other wages & related costs (see inst.)		3,225,612	0	3,225,612	36,791.92	87.67	4.00
5.00	Subtotal wage-related costs (see inst.)		12,387,137	0	12,387,137	0.00	34.13	5.00
6.00	Total (sum of lines 3 thru 5)		51,687,541	220,896	51,908,437	1,324,194.86	39.20	6.00
7.00	Total overhead cost (see instructions)		18,334,066	-1,398,589	16,935,477	605,885.69	27.95	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part IV Date/Time Prepared: 2/25/2017 1:17 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	2,159,977	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1,109,452	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	512,514	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	25,863	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)	8,795,954	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	-6,554	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	61,635	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)	103,993	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	25,722	14.00
15.00	'Workers' Compensation Insurance	402,653	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	3,340,448	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	23,221	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))	206,044	21.00
22.00	Day Care Cost and Allowances	35,001	22.00
23.00	Tuition Reimbursement	75,204	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	16,871,127	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: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part V Date/Time Prepared: 2/25/2017 1:17 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	2,858,162	0	1.00
2.00	Hospital	2,856,924	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	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	1,238	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: 26-0025 | Component CCN: 26-7282 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-4 | Date/Time Prepared: 2/25/2017 1:17 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	2,745	0	97	2,842	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	333.00	31.00	175.00	539.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			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		2.00	0.00	2.00	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	1,881	82	90	27	2,080	21.00
22.00	Skilled Nursing Visit Charges	347,955	14,250	17,080	4,965	384,250	22.00
23.00	Physical Therapy Visits	1,374	7	20	25	1,426	23.00
24.00	Physical Therapy Visit Charges	269,150	1,335	3,800	4,775	279,060	24.00
25.00	Occupational Therapy Visits	191	0	5	6	202	25.00
26.00	Occupational Therapy Visit Charges	37,835	0	975	1,080	39,890	26.00
27.00	Speech Pathology Visits	38	0	0	0	38	27.00
28.00	Speech Pathology Visit Charges	7,320	0	0	0	7,320	28.00
29.00	Medical Social Service Visits	16	0	0	1	17	29.00
30.00	Medical Social Service Visit Charges	3,130	0	0	205	3,335	30.00
31.00	Home Health Aide Visits	199	0	0	6	205	31.00
32.00	Home Health Aide Visit Charges	21,960	0	0	720	22,680	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,699	89	115	65	3,968	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)	687,350	15,585	21,855	11,745	736,535	35.00
36.00	Total Number of Episodes (standard/non outlier)	313		38	5	356	36.00
37.00	Total Number of Outlier Episodes		2		0	2	37.00
38.00	Total Non-Routine Medical Supply Charges	19,735	4,435	812	422	25,404	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 26-0025 | Component CCN: 26-8512 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-8 | Date/Time Prepared: 2/25/2017 1:17 pm

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	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	Clinic			08:00	17:00	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC 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	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 26-0025
Component CCN: 26-8512

Period:
From 10/01/2015
To 09/30/2016

Worksheet S-8

Date/Time Prepared:
2/25/2017 1:17 pm

RHC I

Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 26-0025 | Component CCN: 26-3984 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-8 | Date/Time Prepared: 2/25/2017 1:17 pm

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	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	17:00	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC 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	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 26-0025
Component CCN: 26-3984

Period:
From 10/01/2015
To 09/30/2016

Worksheet S-8

Date/Time Prepared:
2/25/2017 1:17 pm

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	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 26-0025 | Component CCN: 26-8513 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-8 | Date/Time Prepared: 2/25/2017 1:17 pm

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	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	17:00	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC 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	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 26-0025
Component CCN: 26-8513

Period:
From 10/01/2015
To 09/30/2016

Worksheet S-8

Date/Time Prepared:
2/25/2017 1:17 pm

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	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 26-0025 | Component CCN: 26-8723 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-8 | Date/Time Prepared: 2/25/2017 1:17 pm

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	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	17:00	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC 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	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 26-0025
Component CCN: 26-8723

Period:
From 10/01/2015
To 09/30/2016

Worksheet S-8

Date/Time Prepared:
2/25/2017 1:17 pm

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	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 26-0025 | Component CCN: 26-8724 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-8 | Date/Time Prepared: 2/25/2017 1:17 pm

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	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	Clinic			08:00	17:00	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC 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	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 26-0025
Component CCN: 26-8724

Period:
From 10/01/2015
To 09/30/2016

Worksheet S-8

Date/Time Prepared:
2/25/2017 1:17 pm

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	08:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-10 | Date/Time Prepared: 2/25/2017 1:17 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)	0.306880	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	11,703,827	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	1,106,184	5.00
6.00	Medicaid charges	30,845,014	6.00
7.00	Medicaid cost (line 1 times line 6)	9,465,718	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	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 , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	7,463,929	1,212,703	8,676,632	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	2,290,531	372,154	2,662,685	21.00
22.00	Partial payment by patients approved for charity care	29,914	16,428	46,342	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,260,617	355,726	2,616,343	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)	7,808,613	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	527,301	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	7,281,312	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	2,234,489	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,850,832	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,850,832	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 2/25/2017 1:17 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		2,842,254	2,842,254	49,409	2,891,663	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		5,916,066	5,916,066	-1,081,281	4,834,785	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	516,707	10,550,013	11,066,720	273,514	11,340,234	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,053,189	9,040,084	20,093,273	-78,007	20,015,266	5.00
6.00	00600	MAINTENANCE & REPAIRS	349,264	57,490	406,754	0	406,754	6.00
7.00	00700	OPERATION OF PLANT	687,934	2,667,609	3,355,543	-541,774	2,813,769	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	30,253	263,841	294,094	0	294,094	8.00
9.00	00900	HOUSEKEEPING	603,978	216,134	820,112	541,774	1,361,886	9.00
10.00	01000	DIETARY	789,762	753,543	1,543,305	0	1,543,305	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	654,896	81,537	736,433	148,898	885,331	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	146,456	136,728	283,184	-11,255	271,929	14.00
15.00	01500	PHARMACY	1,619,485	859,622	2,479,107	-1,619,485	859,622	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	774,611	533,735	1,308,346	0	1,308,346	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,555,706	2,926,553	8,482,259	0	8,482,259	30.00
31.00	03100	INTENSIVE CARE UNIT	1,582,337	327,940	1,910,277	0	1,910,277	31.00
41.00	04100	SUBPROVIDER - IRF	585,197	744,093	1,329,290	0	1,329,290	41.00
43.00	04300	NURSERY	279,918	125,987	405,905	5,822	411,727	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,048,074	1,766,694	2,814,768	-247,133	2,567,635	50.00
51.00	05100	RECOVERY ROOM	870,402	155,811	1,026,213	0	1,026,213	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	900,228	174,695	1,074,923	5,433	1,080,356	52.00
53.00	05300	ANESTHESIOLOGY	2,219,818	226,578	2,446,396	0	2,446,396	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,191,343	712,294	1,903,637	137,045	2,040,682	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	867,082	606,421	1,473,503	407,028	1,880,531	55.00
56.00	05600	RADIOISOTOPE	99,281	125,792	225,073	121,456	346,529	56.00
57.00	05700	CT SCAN	270,666	195,471	466,137	89,384	555,521	57.00
58.00	05800	MRI	84,536	21,809	106,345	155,376	261,721	58.00
59.00	05900	CARDIAC CATHETERIZATION	503,259	1,848,654	2,351,913	-688,268	1,663,645	59.00
60.00	06000	LABORATORY	1,943,749	2,005,189	3,948,938	25,292	3,974,230	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	80,865	462,971	543,836	0	543,836	62.00
64.00	06400	INTRAVENOUS THERAPY	197,232	36,120	233,352	0	233,352	64.00
65.00	06500	RESPIRATORY THERAPY	803,400	254,404	1,057,804	0	1,057,804	65.00
66.00	06600	PHYSICAL THERAPY	344,346	731,107	1,075,453	0	1,075,453	66.00
67.00	06700	OCCUPATIONAL THERAPY	54,844	337,317	392,161	0	392,161	67.00
68.00	06800	SPEECH PATHOLOGY	151,674	54,034	205,708	0	205,708	68.00
69.00	06900	ELECTROCARDIOLOGY	57,139	50,100	107,239	0	107,239	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	169,505	27,147	196,652	0	196,652	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,110,114	9,110,114	-1,167,047	7,943,067	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,102,448	2,102,448	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,806,138	2,806,138	1,619,485	4,425,623	73.00
74.00	07400	RENAL DIALYSIS	0	96,297	96,297	0	96,297	74.00
76.00	03950	DIABETES CENTER	40,139	5,912	46,051	0	46,051	76.00
76.97	07697	CARDIAC REHABILITATION	161,725	30,581	192,306	0	192,306	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	90,728	13,977	104,705	0	104,705	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	335,720	323,970	659,690	0	659,690	88.00
88.01	08801	RURAL HEALTH CLINIC II	525,887	204,364	730,251	25,400	755,651	88.01
88.02	08802	RURAL HEALTH CLINIC III	582,582	200,803	783,385	0	783,385	88.02
88.03	08803	RURAL HEALTH CLINIC IV	806,881	319,402	1,126,283	-245,693	880,590	88.03
88.04	08804	RURAL HEALTH CLINIC V	440,660	161,567	602,227	245,693	847,920	88.04
91.00	09100	EMERGENCY	2,861,054	3,823,267	6,684,321	0	6,684,321	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	852,166	220,897	1,073,063	0	1,073,063	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		501,774	501,774	0	501,774	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	43,784,678	65,654,900	109,439,578	273,514	109,713,092	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	8,826,569	2,766,940	11,593,509	0	11,593,509	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	1,400	1,400	0	1,400	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	833,094	198,445	1,031,539	-273,514	758,025	194.01
194.02	07952	HWY 61 BUILDING	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	53,444,341	68,621,685	122,066,026	0	122,066,026	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 2/25/2017 1:17 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	-117,826	2,773,837		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-7,850	4,826,935		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-172,800	11,167,434		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,199,345	24,214,611		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	406,754		6.00
7.00	00700	OPERATION OF PLANT	-12,994	2,800,775		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	294,094		8.00
9.00	00900	HOUSEKEEPING	0	1,361,886		9.00
10.00	01000	DIETARY	-588,945	954,360		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	885,331		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	271,929		14.00
15.00	01500	PHARMACY	-1,166	858,456		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-57,695	1,250,651		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,024,964	6,457,295		30.00
31.00	03100	INTENSIVE CARE UNIT	-9,482	1,900,795		31.00
41.00	04100	SUBPROVIDER - IRF	-157,818	1,171,472		41.00
43.00	04300	NURSERY	-470	411,257		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-615,346	1,952,289		50.00
51.00	05100	RECOVERY ROOM	0	1,026,213		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-55	1,080,301		52.00
53.00	05300	ANESTHESIOLOGY	-2,211,140	235,256		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,791	2,038,891		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	1,880,531		55.00
56.00	05600	RADIOISOTOPE	0	346,529		56.00
57.00	05700	CT SCAN	0	555,521		57.00
58.00	05800	MRI	0	261,721		58.00
59.00	05900	CARDIAC CATHETERIZATION	-584,822	1,078,823		59.00
60.00	06000	LABORATORY	-904,768	3,069,462		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	543,836		62.00
64.00	06400	INTRAVENOUS THERAPY	0	233,352		64.00
65.00	06500	RESPIRATORY THERAPY	-1,291	1,056,513		65.00
66.00	06600	PHYSICAL THERAPY	-33,265	1,042,188		66.00
67.00	06700	OCCUPATIONAL THERAPY	-90,220	301,941		67.00
68.00	06800	SPEECH PATHOLOGY	-112,491	93,217		68.00
69.00	06900	ELECTROCARDIOLOGY	-4,780	102,459		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-21,977	174,675		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,943,067		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,102,448		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,425,623		73.00
74.00	07400	RENAL DIALYSIS	0	96,297		74.00
76.00	03950	DIABETES CENTER	0	46,051		76.00
76.97	07697	CARDIAC REHABILITATION	0	192,306		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	104,705		76.98
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	659,690		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	755,651		88.01
88.02	08802	RURAL HEALTH CLINIC III	-50	783,335		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	880,590		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	847,920		88.04
91.00	09100	EMERGENCY	-3,836,481	2,847,840		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	1,073,063		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-501,774	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-7,872,916	101,840,176		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11,593,509		192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	1,400		194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	758,025		194.01
194.02	07952	HWY 61 BUILDING	0	0		194.02
200.00		TOTAL (SUM OF LINES 118-199)	-7,872,916	114,193,110		200.00

RECLASSIFICATIONS | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 2/25/2017 1:17 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - ADMISSION KITS				
1.00	NURSERY	43.00	0	5,822	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	5,433	2.00
	0		0	11,255	
	C - CAPITAL LEASE EXP				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	13,204	1.00
2.00	NURSING ADMINISTRATION	13.00	0	148,898	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	137,045	3.00
4.00	RADIOLOGY - THERAPEUTIC	55.00	0	407,028	4.00
5.00	RADIOISOTOPE	56.00	0	121,456	5.00
6.00	CT SCAN	57.00	0	89,384	6.00
7.00	MRI	58.00	0	155,376	7.00
8.00	LABORATORY	60.00	0	25,292	8.00
9.00	RURAL HEALTH CLINIC II	88.01	0	25,400	9.00
	0		0	1,123,083	
	D - PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	91,211	1.00
	0		0	91,211	
	E - IMPLANTS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,102,448	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	2,102,448	
	G - CHILDREN'S CENTER				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	220,896	52,618	1.00
	0		220,896	52,618	
	H - LOUISIANA CLINIC				
1.00	RURAL HEALTH CLINIC V	88.04	398,920	108,598	1.00
	0		398,920	108,598	
	I - BOWLING GREEN CLINIC				
1.00	RURAL HEALTH CLINIC IV	88.03	217,918	43,907	1.00
	0		217,918	43,907	
	J - OUTSIDE CLEANING SERVICE				
1.00	HOUSEKEEPING	9.00	0	541,774	1.00
	0		0	541,774	
	K - PHARMACY SALARIES				
1.00	DRUGS CHARGED TO PATIENTS	73.00	1,619,485	0	1.00
	TOTALS		1,619,485	0	
500.00	Grand Total: Increases		2,457,219	4,074,894	500.00

RECLASSIFICATIONS | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 2/25/2017 1:17 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	11,255	0	1.00
2.00		0.00	0	0	0	2.00
	0		0	11,255		
	C - CAPITAL LEASE EXP					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,123,083	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
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
	0		0	1,123,083		
	D - PROPERTY INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	91,211	5	1.00
	0		0	91,211		
	E - IMPLANTS					
1.00	OPERATING ROOM	50.00	0	247,133	0	1.00
2.00	CARDIAC CATHETERIZATION	59.00	0	688,268	0	2.00
3.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,167,047	0	3.00
	0		0	2,102,448		
	G - CHILDREN'S CENTER					
1.00	CHILD DEVELOPMENT CENTER	194.01	220,896	52,618	0	1.00
	0		220,896	52,618		
	H - LOUISIANA CLINIC					
1.00	RURAL HEALTH CLINIC IV	88.03	398,920	108,598	0	1.00
	0		398,920	108,598		
	I - BOWLING GREEN CLINIC					
1.00	RURAL HEALTH CLINIC V	88.04	217,918	43,907	0	1.00
	0		217,918	43,907		
	J - OUTSIDE CLEANING SERVICE					
1.00	OPERATION OF PLANT	7.00	0	541,774	0	1.00
	0		0	541,774		
	K - PHARMACY SALARIES					
1.00	PHARMACY	15.00	1,619,485	0	0	1.00
	TOTALS		1,619,485	0		
500.00	Grand Total: Decreases		2,457,219	4,074,894		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part I | Date/Time Prepared: 2/25/2017 1:17 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,693,370	0	0	0	214,075	1.00
2.00	Land Improvements	7,118,129	17,655	0	17,655	23,305	2.00
3.00	Buildings and Fixtures	44,043,753	0	0	0	381,172	3.00
4.00	Building Improvements	20,645,944	641,423	0	641,423	0	4.00
5.00	Fixed Equipment	379,621	951,143	0	951,143	0	5.00
6.00	Movable Equipment	67,447,929	1,813,196	0	1,813,196	206,039	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	142,328,746	3,423,417	0	3,423,417	824,591	8.00
9.00	Reconciling Items	-1,201,183	-416,795	0	-416,795	-25,227	9.00
10.00	Total (line 8 minus line 9)	143,529,929	3,840,212	0	3,840,212	849,818	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,479,295	0	1.00
2.00	Land Improvements	7,112,479	0	2.00
3.00	Buildings and Fixtures	43,662,581	0	3.00
4.00	Building Improvements	21,287,367	0	4.00
5.00	Fixed Equipment	1,330,764	0	5.00
6.00	Movable Equipment	69,055,086	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	144,927,572	0	8.00
9.00	Reconciling Items	-1,592,751	0	9.00
10.00	Total (line 8 minus line 9)	146,520,323	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 2/25/2017 1:17 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	2,736,179	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,916,066	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	8,652,245	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	106,075	2,842,254	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,916,066	2.00
3.00	Total (sum of lines 1-2)	106,075	8,758,320	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 2/25/2017 1:17 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	74,541,722	0	74,541,722	0.541698	49,409	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	70,385,850	7,320,082	63,065,768	0.458302	41,802	2.00
3.00	Total (sum of lines 1-2)	144,927,572	7,320,082	137,607,490	1.000000	91,211	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	49,409	2,618,353	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	41,802	4,785,133	0	2.00
3.00	Total (sum of lines 1-2)	0	0	91,211	7,403,486	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	49,409	0	106,075	2,773,837	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	41,802	0	0	4,826,935	2.00
3.00	Total (sum of lines 1-2)	0	91,211	0	106,075	7,600,772	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8 | Date/Time Prepared: 2/25/2017 1:17 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	-501,774	INTEREST EXPENSE	113.00	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	-8,576	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	-10,324,745			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	-588,945	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	-39,001	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
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME - A&G	B	-155,493	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	MISC INCOME - A&P	B	-15,780	ADULTS & PEDIATRICS	30.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8 | Date/Time Prepared: 2/25/2017 1:17 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	
33.02	MISC INCOME - EKG	B	-4,780	ELECTROCARDIOLOGY	69.00	0	33.02
33.03	MISC INCOME - ICU	B	-3,987	INTENSIVE CARE UNIT	31.00	0	33.03
33.04	MISC INCOME - LAB	B	-6,975	LABORATORY	60.00	0	33.04
33.05	MISC INCOME - PHARMACY	B	-1,166	PHARMACY	15.00	0	33.05
33.06	MISC INCOME - RADIOLOGY	B	-1,791	RADIOLOGY-DIAGNOSTIC	54.00	0	33.06
33.07	MISC INCOME - L&D	B	-55	DELIVERY ROOM & LABOR ROOM	52.00	0	33.07
33.08	MISC INCOME - PLANT OPS	B	-4,418	OPERATION OF PLANT	7.00	0	33.08
33.09	MISC INCOME - ER	B	-3,013	EMERGENCY	91.00	0	33.09
33.12	MISC INCOME - RHC III (MONROE)	B	-50	RURAL HEALTH CLINIC III	88.02	0	33.12
33.13	MISC INCOME - IP REHAB	B	-1,388	SUBPROVIDER - IRF	41.00	0	33.13
34.00	NON ALLOWED ADVERTISING COSTS	A	-1,250,934	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	ADVERTISING EMPLOYEE BENEFITS	A	-62,127	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.01
35.00	LOBBYING EXPENSE	A	-18,894	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	ALCOHOLIC BEVERAGE EXPENSE	A	-856	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	DEVELOPMENT SALARIES	A	-88,220	ADMINISTRATIVE & GENERAL	5.00	0	37.00
37.01	DEVELOPMENT EXPENSE	A	-113,262	ADMINISTRATIVE & GENERAL	5.00	0	37.01
37.02	FOUNDATION EMPLOYEE BENEFITS	A	-18,660	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.02
38.00	DEFINED BENEFIT PENSION PLAN	A	1,109,452	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
39.00	CONTRIBUTIONS	A	-7,600	ADMINISTRATIVE & GENERAL	5.00	0	39.00
39.01	RECRUITMENT FEES	A	-737,266	ADMINISTRATIVE & GENERAL	5.00	0	39.01
39.02	RECRUITMENT FEES	A	-3,613	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.02
39.03	PATIENT PHONE	A	-29,536	ADMINISTRATIVE & GENERAL	5.00	0	39.03
39.04	PATIENT PHONE	A	-7,850	CAP REL COSTS-MVBLE EQUIP	2.00	9	39.04
39.05	DAYCARE REVENUE	B	-193,745	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.05
40.00	MEDICAID/FRA	A	6,792,360	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	EMPLOYED PHYSICIAN BENEFITS	A	-1,004,107	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	41.00
45.00	STAFF DEVELOPMENT	B	-23,743	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	NURSERY PHOTOS	B	-470	NURSERY	43.00	0	45.01
45.02	SPEECH CONTRACT SERVICE	B	-112,491	SPEECH PATHOLOGY	68.00	0	45.02
45.03	BUILDING RENTAL INCOME	B	-143,181	CAP REL COSTS-BLDG & FIXT	1.00	9	45.03
45.04	EEG CONTRACT SERVICE	B	-11,056	ELECTROENCEPHALOGRAPHY	70.00	0	45.04
45.05	PT CONTRACT SERVICE	B	-33,265	PHYSICAL THERAPY	66.00	0	45.05
45.06	MEDICAL RECORDS REVENUE	B	-18,694	MEDICAL RECORDS & LIBRARY	16.00	9	45.06
45.07	SLEEP CONTRACT SERVICE	B	-10,921	ELECTROENCEPHALOGRAPHY	70.00	0	45.07
45.08	R/T CONTRACT SERVICE	B	-1,291	RESPIRATORY THERAPY	65.00	0	45.08
45.09	O/T CONTRACT SERVICE	B	-90,220	OCCUPATIONAL THERAPY	67.00	0	45.09
45.10	PHYSICIAN PENSION EXPENSE	A	-257	ADMINISTRATIVE & GENERAL	5.00	0	45.10
45.11	PHYSICIAN PENSION EXPENSE	A	-37,729	ADULTS & PEDIATRICS	30.00	0	45.11
45.12	PHYSICIAN PENSION EXPENSE	A	-245	INTENSIVE CARE UNIT	31.00	0	45.12
45.13	PHYSICIAN PENSION EXPENSE	A	-180	SUBPROVIDER - IRF	41.00	0	45.13
45.14	PHYSICIAN PENSION EXPENSE	A	-73,451	ANESTHESIOLOGY	53.00	0	45.14
45.15	PHYSICIAN PENSION EXPENSE	A	-22,414	LABORATORY	60.00	0	45.15
45.16	PHYSICIAN PENSION EXPENSE	A	-21,868	EMERGENCY	91.00	0	45.16
45.17	PALMYRA CLINIC DEPRECIATION	A	25,355	CAP REL COSTS-BLDG & FIXT	1.00	9	45.17
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,872,916				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: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 2/25/2017 1:17 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	394,621	3,355	391,266	211,500	2,239	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,972,579	1,970,929	1,650	211,500	11	2.00
3.00	31.00	INTENSIVE CARE UNIT	5,250	5,250	0	0	0	3.00
4.00	41.00	SUBPROVIDER - IRF	156,250	156,250	0	0	0	4.00
5.00	50.00	OPERATING ROOM	615,346	615,346	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	2,184,621	2,097,865	86,756	239,400	401	6.00
7.00	59.00	CARDIAC CATHETERIZATION	584,822	584,822	0	0	0	7.00
8.00	60.00	LABORATORY	943,878	831,687	112,191	260,300	533	8.00
9.00	91.00	EMERGENCY	3,926,877	3,658,424	268,453	211,500	1,128	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			10,784,244	9,923,928	860,316		4,312	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	227,667	11,383	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,118	56	7,571	6	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	400	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	46,153	2,308	19,615	779	0	6.00
7.00	59.00	CARDIAC CATHETERIZATION	0	0	1,200	0	0	7.00
8.00	60.00	LABORATORY	66,702	3,335	15,115	1,797	0	8.00
9.00	91.00	EMERGENCY	114,698	5,735	8,464	579	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			456,338	22,817	52,365	3,161	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	227,667	163,599	166,954		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	1,124	526	1,971,455		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	5,250		3.00
4.00	41.00	SUBPROVIDER - IRF	0	0	0	156,250		4.00
5.00	50.00	OPERATING ROOM	0	0	0	615,346		5.00
6.00	53.00	ANESTHESIOLOGY	0	46,932	39,824	2,137,689		6.00
7.00	59.00	CARDIAC CATHETERIZATION	0	0	0	584,822		7.00
8.00	60.00	LABORATORY	0	68,499	43,692	875,379		8.00
9.00	91.00	EMERGENCY	0	115,277	153,176	3,811,600		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	459,499	400,817	10,324,745		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/25/2017 1:17 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	2,773,837	2,773,837				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,826,935		4,826,935			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	11,167,434	32,510	20,247	11,220,191		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	24,214,611	555,338	2,466,240	2,524,687	29,760,876	5.00
6.00	00600	MAINTENANCE & REPAIRS	406,754	0	770	82,690	490,214	6.00
7.00	00700	OPERATION OF PLANT	2,800,775	121,853	80,803	162,871	3,166,302	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	294,094	7,040	47	7,163	308,344	8.00
9.00	00900	HOUSEKEEPING	1,361,886	7,356	671	142,994	1,512,907	9.00
10.00	01000	DIETARY	954,360	23,532	13,017	186,979	1,177,888	10.00
11.00	01100	CAFETERIA	0	14,895	0	0	14,895	11.00
13.00	01300	NURSING ADMINISTRATION	885,331	4,097	181,992	155,049	1,226,469	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	271,929	10,789	0	34,674	317,392	14.00
15.00	01500	PHARMACY	858,456	13,281	93,957	0	965,694	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,250,651	40,214	87	183,392	1,474,344	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,457,295	272,191	43,916	1,075,720	7,849,122	30.00
31.00	03100	INTENSIVE CARE UNIT	1,900,795	46,036	21,309	373,382	2,341,522	31.00
41.00	04100	SUBPROVIDER - IRF	1,171,472	59,325	42,993	137,246	1,411,036	41.00
43.00	04300	NURSERY	411,257	3,291	12,108	66,272	492,928	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,952,289	84,147	308,214	248,136	2,592,786	50.00
51.00	05100	RECOVERY ROOM	1,026,213	55,069	1,131	206,071	1,288,484	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,080,301	0	2,824	213,133	1,296,258	52.00
53.00	05300	ANESTHESIOLOGY	235,256	2,966	100,672	19,445	358,339	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,038,891	84,107	321,832	282,055	2,726,885	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1,880,531	152,188	175,653	205,285	2,413,657	55.00
56.00	05600	RADIOISOTOPE	346,529	9,816	75,229	23,505	455,079	56.00
57.00	05700	CT SCAN	555,521	4,525	8,291	64,081	632,418	57.00
58.00	05800	MRI	261,721	6,676	12,110	20,014	300,521	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,078,823	28,832	13,632	119,149	1,240,436	59.00
60.00	06000	LABORATORY	3,069,462	47,444	289,303	266,015	3,672,224	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	543,836	1,068	528	19,145	564,577	62.00
64.00	06400	INTRAVENOUS THERAPY	233,352	40,381	60,728	46,695	381,156	64.00
65.00	06500	RESPIRATORY THERAPY	1,056,513	22,282	36,865	174,180	1,289,840	65.00
66.00	06600	PHYSICAL THERAPY	1,042,188	30,414	1,813	81,525	1,155,940	66.00
67.00	06700	OCCUPATIONAL THERAPY	301,941	1,558	0	12,985	316,484	67.00
68.00	06800	SPEECH PATHOLOGY	93,217	506	0	35,909	129,632	68.00
69.00	06900	ELECTROCARDIOLOGY	102,459	0	62,986	13,528	178,973	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	174,675	5,679	13,501	40,131	233,986	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,943,067	0	0	0	7,943,067	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,102,448	0	0	0	2,102,448	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,425,623	0	0	383,420	4,809,043	73.00
74.00	07400	RENAL DIALYSIS	96,297	0	0	0	96,297	74.00
76.00	03950	DIABETES CENTER	46,051	0	255	9,503	55,809	76.00
76.97	07697	CARDIAC REHABILITATION	192,306	20,938	13,918	38,289	265,451	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	104,705	2,784	0	21,480	128,969	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	659,690	0	10,116	79,483	749,289	88.00
88.01	08801	RURAL HEALTH CLINIC II	755,651	0	39,472	124,506	919,629	88.01
88.02	08802	RURAL HEALTH CLINIC III	783,335	45,380	0	137,929	966,644	88.02
88.03	08803	RURAL HEALTH CLINIC IV	880,590	0	63,103	148,179	1,091,872	88.03
88.04	08804	RURAL HEALTH CLINIC V	847,920	0	0	147,181	995,101	88.04
91.00	09100	EMERGENCY	2,847,840	232,261	38,384	469,695	3,588,180	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,073,063	23,730	3,999	201,754	1,302,546	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	101,840,176	2,114,499	4,632,716	8,985,525	98,751,953	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	11,593,509	548,574	189,382	2,089,726	14,421,191	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	1,400	0	0	0	1,400	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	758,025	90,103	4,837	144,940	997,905	194.01
194.02	07952	HWY 61 BUILDING	0	20,661	0	0	20,661	194.02
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)	114,193,110	2,773,837	4,826,935	11,220,191	114,193,110	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/25/2017 1:17 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	29,760,876					5.00
6.00	00600	MAINTENANCE & REPAIRS	172,792	663,006				6.00
7.00	00700	OPERATION OF PLANT	1,116,064	36,958	4,319,324			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	108,686	2,135	14,731	433,896		8.00
9.00	00900	HOUSEKEEPING	533,272	2,231	15,393	0	2,063,803	9.00
10.00	01000	DIETARY	415,184	7,137	49,243	0	23,694	10.00
11.00	01100	CAFETERIA	5,250	4,517	31,168	0	14,997	11.00
13.00	01300	NURSING ADMINISTRATION	432,308	1,243	8,574	0	4,125	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	111,875	3,272	22,577	0	10,863	14.00
15.00	01500	PHARMACY	340,390	4,028	27,791	0	13,372	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	519,680	12,197	84,151	0	40,490	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,766,674	82,555	569,575	156,872	274,058	30.00
31.00	03100	INTENSIVE CARE UNIT	825,344	13,963	96,333	21,322	46,352	31.00
41.00	04100	SUBPROVIDER - IRF	497,365	17,993	124,141	16,288	59,732	41.00
43.00	04300	NURSERY	173,748	998	6,886	0	3,313	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	913,910	25,521	176,081	65,058	84,724	50.00
51.00	05100	RECOVERY ROOM	454,167	16,702	115,236	13,381	55,447	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	456,908	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	126,308	900	6,207	0	2,987	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	961,178	25,509	175,999	33,267	84,684	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	850,771	46,158	318,463	7,005	153,232	55.00
56.00	05600	RADIOISOTOPE	160,407	2,977	20,541	0	9,884	56.00
57.00	05700	CT SCAN	222,916	1,372	9,468	0	4,556	57.00
58.00	05800	MRI	105,928	2,025	13,970	0	6,722	58.00
59.00	05900	CARDIAC CATHETERIZATION	437,231	8,745	60,332	4,753	29,030	59.00
60.00	06000	LABORATORY	1,294,393	14,390	99,280	0	47,770	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	199,003	324	2,235	0	1,075	62.00
64.00	06400	INTRAVENOUS THERAPY	134,351	12,247	84,499	5,760	40,658	64.00
65.00	06500	RESPIRATORY THERAPY	454,645	6,758	46,627	0	22,435	65.00
66.00	06600	PHYSICAL THERAPY	407,448	9,224	63,643	1,496	30,623	66.00
67.00	06700	OCCUPATIONAL THERAPY	111,555	473	3,261	0	1,569	67.00
68.00	06800	SPEECH PATHOLOGY	45,693	154	1,059	0	510	68.00
69.00	06900	ELECTROCARDIOLOGY	63,085	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	82,476	1,723	11,884	1,553	5,718	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,799,788	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	741,075	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,695,101	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	33,943	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	19,672	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	93,567	6,350	43,813	0	21,081	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	45,459	844	5,826	0	2,803	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	264,111	0	0	79	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	324,153	0	0	196	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	340,725	13,764	94,959	461	45,691	88.02
88.03	08803	RURAL HEALTH CLINIC IV	384,865	0	0	821	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	350,755	0	0	821	0	88.04
91.00	09100	EMERGENCY	1,264,769	70,444	486,020	104,753	233,855	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	459,124	7,197	49,656	0	23,893	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,318,112	463,028	2,939,622	433,886	1,399,943	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	5,083,244	166,384	1,147,923	10	552,336	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	493	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	351,744	27,328	188,545	0	90,721	194.01
194.02	07952	HWY 61 BUILDING	7,283	6,266	43,234	0	20,803	194.02
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)	29,760,876	663,006	4,319,324	433,896	2,063,803	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/25/2017 1:17 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	1,673,146					10.00
11.00	01100	CAFETERIA	1,188,539	1,259,366				11.00
13.00	01300	NURSING ADMINISTRATION	0	27,972	1,700,691			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,458	0	477,437		14.00
15.00	01500	PHARMACY	0	55,203	0	0	1,406,478	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	378,256	270,520	719,609	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	57,361	71,717	213,570	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	48,990	31,819	92,486	0	0	41.00
43.00	04300	NURSERY	0	14,124	42,058	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	56,495	160,250	0	0	50.00
51.00	05100	RECOVERY ROOM	0	40,475	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	35,859	106,813	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	24,455	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	47,784	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	23,961	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	3,902	0	0	0	56.00
57.00	05700	CT SCAN	0	11,870	0	0	0	57.00
58.00	05800	MRI	0	3,517	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	18,767	0	0	0	59.00
60.00	06000	LABORATORY	0	83,643	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	3,710	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	10,332	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	37,919	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	27,423	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,973	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,435	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,858	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,144	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	377,514	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	99,923	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,406,478	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	0	1,704	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	6,540	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	3,792	11,250	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	121,754	265,472	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	89,183	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,673,146	1,065,125	1,700,691	477,437	1,406,478	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	194,241	0	0	0	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	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
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)	1,673,146	1,259,366	1,700,691	477,437	1,406,478	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/25/2017 1:17 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	2,130,862					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,283,347	14,350,588	79,912	14,430,500		30.00
31.00	03100	INTENSIVE CARE UNIT	277,011	3,964,495	-35,890	3,928,605		31.00
41.00	04100	SUBPROVIDER - IRF	144,316	2,444,166	0	2,444,166		41.00
43.00	04300	NURSERY	106,566	840,621	0	840,621		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,074,825	0	4,074,825		50.00
51.00	05100	RECOVERY ROOM	0	1,983,892	0	1,983,892		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,895,838	0	1,895,838		52.00
53.00	05300	ANESTHESIOLOGY	0	519,196	0	519,196		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,055,306	0	4,055,306		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	3,813,247	0	3,813,247		55.00
56.00	05600	RADIOISOTOPE	0	652,790	0	652,790		56.00
57.00	05700	CT SCAN	0	882,600	0	882,600		57.00
58.00	05800	MRI	0	432,683	0	432,683		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,799,294	0	1,799,294		59.00
60.00	06000	LABORATORY	0	5,211,700	0	5,211,700		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	770,924	0	770,924		62.00
64.00	06400	INTRAVENOUS THERAPY	0	669,003	-44,022	624,981		64.00
65.00	06500	RESPIRATORY THERAPY	0	1,858,224	0	1,858,224		65.00
66.00	06600	PHYSICAL THERAPY	0	1,695,797	0	1,695,797		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	438,315	0	438,315		67.00
68.00	06800	SPEECH PATHOLOGY	0	180,483	0	180,483		68.00
69.00	06900	ELECTROCARDIOLOGY	0	244,916	0	244,916		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	344,484	0	344,484		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,120,369	0	11,120,369		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,943,446	0	2,943,446		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,910,622	0	7,910,622		73.00
74.00	07400	RENAL DIALYSIS	0	130,240	0	130,240		74.00
76.00	03950	DIABETES CENTER	0	77,185	0	77,185		76.00
76.97	07697	CARDIAC REHABILITATION	0	436,802	0	436,802		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	198,943	0	198,943		76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,013,479	0	1,013,479		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,243,978	0	1,243,978		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,462,244	0	1,462,244		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	1,477,558	0	1,477,558		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	1,346,677	0	1,346,677		88.04
91.00	09100	EMERGENCY	319,622	6,454,869	0	6,454,869		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,931,599	0	1,931,599		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,130,862	90,871,398	0	90,871,398		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	21,565,329	0	21,565,329		192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	1,893	0	1,893		194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	1,656,243	0	1,656,243		194.01
194.02	07952	HWY 61 BUILDING	0	98,247	0	98,247		194.02
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	2,130,862	114,193,110	0	114,193,110		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/25/2017 1:17 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	1,843	32,510	20,247	54,600	54,600	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	97,976	555,338	2,466,240	3,119,554	12,291	5.00
6.00	00600	MAINTENANCE & REPAIRS	454	0	770	1,224	402	6.00
7.00	00700	OPERATION OF PLANT	57,589	121,853	80,803	260,245	792	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	270	7,040	47	7,357	35	8.00
9.00	00900	HOUSEKEEPING	5,907	7,356	671	13,934	696	9.00
10.00	01000	DIETARY	3,286	23,532	13,017	39,835	910	10.00
11.00	01100	CAFETERIA	0	14,895	0	14,895	0	11.00
13.00	01300	NURSING ADMINISTRATION	-27,059	4,097	181,992	159,030	754	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,123	10,789	0	11,912	169	14.00
15.00	01500	PHARMACY	156,933	13,281	93,957	264,171	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,016	40,214	87	54,317	892	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	69,654	272,191	43,916	385,761	5,234	30.00
31.00	03100	INTENSIVE CARE UNIT	16,277	46,036	21,309	83,622	1,817	31.00
41.00	04100	SUBPROVIDER - IRF	13,053	59,325	42,993	115,371	668	41.00
43.00	04300	NURSERY	2,719	3,291	12,108	18,118	322	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	157,402	84,147	308,214	549,763	1,207	50.00
51.00	05100	RECOVERY ROOM	2,107	55,069	1,131	58,307	1,003	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,078	0	2,824	5,902	1,037	52.00
53.00	05300	ANESTHESIOLOGY	1,140	2,966	100,672	104,778	95	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	149,435	84,107	321,832	555,374	1,372	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	410,868	152,188	175,653	738,709	999	55.00
56.00	05600	RADIOISOTOPE	123,787	9,816	75,229	208,832	114	56.00
57.00	05700	CT SCAN	89,439	4,525	8,291	102,255	312	57.00
58.00	05800	MRI	155,691	6,676	12,110	174,477	97	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,206	28,832	13,632	45,670	580	59.00
60.00	06000	LABORATORY	29,091	47,444	289,303	365,838	1,294	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,068	528	1,596	93	62.00
64.00	06400	INTRAVENOUS THERAPY	3,001	40,381	60,728	104,110	227	64.00
65.00	06500	RESPIRATORY THERAPY	54,738	22,282	36,865	113,885	848	65.00
66.00	06600	PHYSICAL THERAPY	1,375	30,414	1,813	33,602	397	66.00
67.00	06700	OCCUPATIONAL THERAPY	40	1,558	0	1,598	63	67.00
68.00	06800	SPEECH PATHOLOGY	1,568	506	0	2,074	175	68.00
69.00	06900	ELECTROCARDIOLOGY	2,270	0	62,986	65,256	66	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	981	5,679	13,501	20,161	195	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	1,866	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	0	0	255	255	46	76.00
76.97	07697	CARDIAC REHABILITATION	739	20,938	13,918	35,595	186	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	2,188	2,784	0	4,972	105	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	14,996	0	10,116	25,112	387	88.00
88.01	08801	RURAL HEALTH CLINIC II	82,072	0	39,472	121,544	606	88.01
88.02	08802	RURAL HEALTH CLINIC III	971	45,380	0	46,351	671	88.02
88.03	08803	RURAL HEALTH CLINIC IV	55,064	0	63,103	118,167	721	88.03
88.04	08804	RURAL HEALTH CLINIC V	29,845	0	0	29,845	716	88.04
91.00	09100	EMERGENCY	15,684	232,261	38,384	286,329	2,285	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	5,617	23,730	3,999	33,346	982	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,810,434	2,114,499	4,632,716	8,557,649	43,727	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	121,921	548,574	189,382	859,877	10,168	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	1,400	0	0	1,400	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	1,914	90,103	4,837	96,854	705	194.01
194.02	07952	HWY 61 BUILDING	0	20,661	0	20,661	0	194.02
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)	1,935,669	2,773,837	4,826,935	9,536,441	54,600	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/25/2017 1:17 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	3,131,845					5.00
6.00	00600	MAINTENANCE & REPAIRS	18,184	19,810				6.00
7.00	00700	OPERATION OF PLANT	117,448	1,104	379,589			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,437	64	1,295	20,188		8.00
9.00	00900	HOUSEKEEPING	56,118	67	1,353	0	72,168	9.00
10.00	01000	DIETARY	43,691	213	4,328	0	829	10.00
11.00	01100	CAFETERIA	553	135	2,739	0	524	11.00
13.00	01300	NURSING ADMINISTRATION	45,493	37	753	0	144	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,773	98	1,984	0	380	14.00
15.00	01500	PHARMACY	35,820	120	2,442	0	468	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	54,688	364	7,395	0	1,416	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	291,147	2,467	50,055	7,299	9,583	30.00
31.00	03100	INTENSIVE CARE UNIT	86,854	417	8,466	992	1,621	31.00
41.00	04100	SUBPROVIDER - IRF	52,340	538	10,910	758	2,089	41.00
43.00	04300	NURSERY	18,284	30	605	0	116	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	96,174	763	15,474	3,027	2,963	50.00
51.00	05100	RECOVERY ROOM	47,794	499	10,127	623	1,939	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	48,082	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	13,292	27	545	0	104	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	101,148	762	15,467	1,548	2,961	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	89,530	1,379	27,987	326	5,358	55.00
56.00	05600	RADIOISOTOPE	16,880	89	1,805	0	346	56.00
57.00	05700	CT SCAN	23,458	41	832	0	159	57.00
58.00	05800	MRI	11,147	60	1,228	0	235	58.00
59.00	05900	CARDIAC CATHETERIZATION	46,011	261	5,302	221	1,015	59.00
60.00	06000	LABORATORY	136,214	430	8,725	0	1,670	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	20,942	10	196	0	38	62.00
64.00	06400	INTRAVENOUS THERAPY	14,138	366	7,426	268	1,422	64.00
65.00	06500	RESPIRATORY THERAPY	47,844	202	4,098	0	785	65.00
66.00	06600	PHYSICAL THERAPY	42,877	276	5,593	70	1,071	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,739	14	287	0	55	67.00
68.00	06800	SPEECH PATHOLOGY	4,808	5	93	0	18	68.00
69.00	06900	ELECTROCARDIOLOGY	6,639	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,679	51	1,044	72	200	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	294,632	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	77,986	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	178,382	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	3,572	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	2,070	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	9,846	190	3,850	0	737	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	4,784	25	512	0	98	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	27,793	0	0	4	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	34,112	0	0	9	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	35,856	411	8,345	21	1,598	88.02
88.03	08803	RURAL HEALTH CLINIC IV	40,501	0	0	38	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	36,911	0	0	38	0	88.04
91.00	09100	EMERGENCY	133,096	2,105	42,712	4,874	8,178	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	48,315	215	4,364	0	835	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,559,082	13,835	258,337	20,188	48,955	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	534,930	4,971	100,883	0	19,314	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	52	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	37,015	817	16,570	0	3,172	194.01
194.02	07952	HWY 61 BUILDING	766	187	3,799	0	727	194.02
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)	3,131,845	19,810	379,589	20,188	72,168	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/25/2017 1:17 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	89,806					10.00
11.00	01100	CAFETERIA	63,794	82,640				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,836	208,047			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	752	0	27,068		14.00
15.00	01500	PHARMACY	0	3,622	0	0	306,643	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,303	17,750	88,031	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,079	4,706	26,126	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	2,630	2,088	11,314	0	0	41.00
43.00	04300	NURSERY	0	927	5,145	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,707	19,604	0	0	50.00
51.00	05100	RECOVERY ROOM	0	2,656	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,353	13,066	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,605	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,136	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	1,572	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	256	0	0	0	56.00
57.00	05700	CT SCAN	0	779	0	0	0	57.00
58.00	05800	MRI	0	231	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,232	0	0	0	59.00
60.00	06000	LABORATORY	0	5,489	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	243	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	678	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,488	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,800	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	326	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	225	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	188	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	469	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	21,402	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,666	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	306,643	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	0	112	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	429	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	249	1,376	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	7,990	32,475	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	10,910	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	89,806	69,894	208,047	27,068	306,643	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	12,746	0	0	0	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	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
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)	89,806	82,640	208,047	27,068	306,643	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/25/2017 1:17 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	119,072					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	71,714	949,344	0	949,344		30.00
31.00	03100	INTENSIVE CARE UNIT	15,479	233,179	0	233,179		31.00
41.00	04100	SUBPROVIDER - IRF	8,064	206,770	0	206,770		41.00
43.00	04300	NURSERY	5,955	49,502	0	49,502		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	692,682	0	692,682		50.00
51.00	05100	RECOVERY ROOM	0	122,948	0	122,948		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	70,440	0	70,440		52.00
53.00	05300	ANESTHESIOLOGY	0	120,446	0	120,446		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	681,768	0	681,768		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	865,860	0	865,860		55.00
56.00	05600	RADIOISOTOPE	0	228,322	0	228,322		56.00
57.00	05700	CT SCAN	0	127,836	0	127,836		57.00
58.00	05800	MRI	0	187,475	0	187,475		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	100,292	0	100,292		59.00
60.00	06000	LABORATORY	0	519,660	0	519,660		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	23,118	0	23,118		62.00
64.00	06400	INTRAVENOUS THERAPY	0	128,635	0	128,635		64.00
65.00	06500	RESPIRATORY THERAPY	0	170,150	0	170,150		65.00
66.00	06600	PHYSICAL THERAPY	0	85,686	0	85,686		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	14,082	0	14,082		67.00
68.00	06800	SPEECH PATHOLOGY	0	7,398	0	7,398		68.00
69.00	06900	ELECTROCARDIOLOGY	0	72,149	0	72,149		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	30,871	0	30,871		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	316,034	0	316,034		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	83,652	0	83,652		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	486,891	0	486,891		73.00
74.00	07400	RENAL DIALYSIS	0	3,572	0	3,572		74.00
76.00	03950	DIABETES CENTER	0	2,483	0	2,483		76.00
76.97	07697	CARDIAC REHABILITATION	0	50,833	0	50,833		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	12,121	0	12,121		76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	53,296	0	53,296		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	156,271	0	156,271		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	93,253	0	93,253		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	159,427	0	159,427		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	67,510	0	67,510		88.04
91.00	09100	EMERGENCY	17,860	537,904	0	537,904		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	98,967	0	98,967		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	119,072	7,810,827	0	7,810,827		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	1,542,889	0	1,542,889		192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	1,452	0	1,452		194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	155,133	0	155,133		194.01
194.02	07952	HWY 61 BUILDING	0	26,140	0	26,140		194.02
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	119,072	9,536,441	0	9,536,441		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/25/2017 1:17 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	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	350,675					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,704,072				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,110	15,537	47,391,832			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	70,207	1,892,533	10,663,820	-29,760,876	84,432,234	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	591	349,264	0	490,214	6.00
7.00	00700	OPERATION OF PLANT	15,405	62,006	687,934	0	3,166,302	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	890	36	30,253	0	308,344	8.00
9.00	00900	HOUSEKEEPING	930	515	603,978	0	1,512,907	9.00
10.00	01000	DIETARY	2,975	9,989	789,762	0	1,177,888	10.00
11.00	01100	CAFETERIA	1,883	0	0	0	14,895	11.00
13.00	01300	NURSING ADMINISTRATION	518	139,656	654,896	0	1,226,469	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,364	0	146,456	0	317,392	14.00
15.00	01500	PHARMACY	1,679	72,100	0	0	965,694	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,084	67	774,611	0	1,474,344	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,411	33,700	4,543,621	0	7,849,122	30.00
31.00	03100	INTENSIVE CARE UNIT	5,820	16,352	1,577,087	0	2,341,522	31.00
41.00	04100	SUBPROVIDER - IRF	7,500	32,992	579,697	0	1,411,036	41.00
43.00	04300	NURSERY	416	9,291	279,918	0	492,928	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,638	236,516	1,048,074	0	2,592,786	50.00
51.00	05100	RECOVERY ROOM	6,962	868	870,402	0	1,288,484	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,167	900,228	0	1,296,258	52.00
53.00	05300	ANESTHESIOLOGY	375	77,253	82,130	0	358,339	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,633	246,966	1,191,343	0	2,726,885	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	19,240	134,792	867,082	0	2,413,657	55.00
56.00	05600	RADIOISOTOPE	1,241	57,729	99,281	0	455,079	56.00
57.00	05700	CT SCAN	572	6,362	270,666	0	632,418	57.00
58.00	05800	MRI	844	9,293	84,536	0	300,521	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,645	10,461	503,259	0	1,240,436	59.00
60.00	06000	LABORATORY	5,998	222,004	1,123,594	0	3,672,224	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	135	405	80,865	0	564,577	62.00
64.00	06400	INTRAVENOUS THERAPY	5,105	46,601	197,232	0	381,156	64.00
65.00	06500	RESPIRATORY THERAPY	2,817	28,289	735,700	0	1,289,840	65.00
66.00	06600	PHYSICAL THERAPY	3,845	1,391	344,346	0	1,155,940	66.00
67.00	06700	OCCUPATIONAL THERAPY	197	0	54,844	0	316,484	67.00
68.00	06800	SPEECH PATHOLOGY	64	0	151,674	0	129,632	68.00
69.00	06900	ELECTROCARDIOLOGY	0	48,334	57,139	0	178,973	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	718	10,360	169,505	0	233,986	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	7,943,067	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,102,448	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,619,485	0	4,809,043	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	96,297	74.00
76.00	03950	DIABETES CENTER	0	196	40,139	0	55,809	76.00
76.97	07697	CARDIAC REHABILITATION	2,647	10,680	161,725	0	265,451	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	352	0	90,728	0	128,969	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	7,763	335,720	0	749,289	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	30,290	525,887	0	919,629	88.01
88.02	08802	RURAL HEALTH CLINIC III	5,737	0	582,582	0	966,644	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	48,424	625,879	0	1,091,872	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	621,662	0	995,101	88.04
91.00	09100	EMERGENCY	29,363	29,455	1,983,895	0	3,588,180	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,000	3,069	852,166	0	1,302,546	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	267,320	3,555,033	37,953,065	-29,760,876	68,991,077	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	69,352	145,327	8,826,569	0	14,421,191	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0	1,400	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	11,391	3,712	612,198	0	997,905	194.01
194.02	07952	HWY 61 BUILDING	2,612	0	0	0	20,661	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/25/2017 1:17 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	2,773,837	4,826,935	11,220,191		29,760,876	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.909994	1.303143	0.236754		0.352482	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			54,600		3,131,845	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001152		0.037093	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/25/2017 1:17 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	276,358					6.00
7.00	00700	OPERATION OF PLANT	15,405	260,953				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	890	890	466,219			8.00
9.00	00900	HOUSEKEEPING	930	930	0	259,133		9.00
10.00	01000	DIETARY	2,975	2,975	0	2,975	255,840	10.00
11.00	01100	CAFETERIA	1,883	1,883	0	1,883	181,739	11.00
13.00	01300	NURSING ADMINISTRATION	518	518	0	518	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	5,084	5,084	0	5,084	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,411	34,411	168,558	34,411	57,839	30.00
31.00	03100	INTENSIVE CARE UNIT	5,820	5,820	22,910	5,820	8,771	31.00
41.00	04100	SUBPROVIDER - IRF	7,500	7,500	17,501	7,500	7,491	41.00
43.00	04300	NURSERY	416	416	0	416	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,638	10,638	69,905	10,638	0	50.00
51.00	05100	RECOVERY ROOM	6,962	6,962	14,378	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	10,633	10,633	35,745	10,633	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	19,240	19,240	7,527	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	5,107	3,645	0	59.00
60.00	06000	LABORATORY	5,998	5,998	0	5,998	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	6,189	5,105	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,817	2,817	0	2,817	0	65.00
66.00	06600	PHYSICAL THERAPY	3,845	3,845	1,607	3,845	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	197	197	0	197	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	1,669	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	03950	DIABETES CENTER	0	0	0	0	0	76.00
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	85	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	211	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	5,737	5,737	495	5,737	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	882	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	882	0	0	88.04
91.00	09100	EMERGENCY	29,363	29,363	112,557	29,363	0	91.00
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)	193,003	177,598	466,208	175,778	255,840	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	69,352	69,352	11	69,352	0	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	11,391	11,391	0	11,391	0	194.01
194.02	07952	HWY 61 BUILDING	2,612	2,612	0	2,612	0	194.02
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)	663,006	4,319,324	433,896	2,063,803	1,673,146	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.399084	16.552115	0.930670	7.964262	6.539814	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/25/2017 1:17 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	
204.00		Cost to be allocated (per Wkst. B, Part II)	19,810	379,589	20,188	72,168	89,806	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.071682	1.454626	0.043302	0.278498	0.351024	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/25/2017 1:17 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	45,832					11.00
13.00	01300	NURSING ADMINISTRATION	1,018	434,007				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	417	0	10,045,515			14.00
15.00	01500	PHARMACY	2,009	0	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	28,054	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,845	183,640	0	0	16,896	30.00
31.00	03100	INTENSIVE CARE UNIT	2,610	54,502	0	0	3,647	31.00
41.00	04100	SUBPROVIDER - IRF	1,158	23,602	0	0	1,900	41.00
43.00	04300	NURSERY	514	10,733	0	0	1,403	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,056	40,895	0	0	0	50.00
51.00	05100	RECOVERY ROOM	1,473	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,305	27,258	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	890	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,739	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	872	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	142	0	0	0	0	56.00
57.00	05700	CT SCAN	432	0	0	0	0	57.00
58.00	05800	MRI	128	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	683	0	0	0	0	59.00
60.00	06000	LABORATORY	3,044	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	135	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	376	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,380	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	998	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	181	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	125	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	104	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	260	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	7,943,067	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,102,448	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	03950	DIABETES CENTER	62	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	238	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	138	2,871	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	4,431	67,747	0	0	4,208	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	22,759	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	38,763	434,007	10,045,515	100	28,054	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	7,069	0	0	0	0	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	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
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,259,366	1,700,691	477,437	1,406,478	2,130,862	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.477876	3.918580	0.047527	14,064.780000	75.955728	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/25/2017 1:17 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	
204.00		Cost to be allocated (per Wkst. B, Part II)	82,640	208,047	27,068	306,643	119,072	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.803107	0.479363	0.002695	3,066.430000	4.244386	205.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-2 | Date/Time Prepared: 2/25/2017 1:17 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&P	1	30.00	44,022	7.00
8.00		IV THERAPY OBSERVATION COSTS TO A&P	1	64.00	-44,022	8.00
9.00		ICU OBSERVATION COSTS TO A&P	1	30.00	35,890	9.00
10.00		ICU OBSERVATION COSTS TO A&P	1	31.00	-35,890	10.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/25/2017 1:17 pm

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		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	14,430,500		14,430,500	526	14,431,026	30.00
31.00	03100	INTENSIVE CARE UNIT	3,928,605		3,928,605	0	3,928,605	31.00
41.00	04100	SUBPROVIDER - IRF	2,444,166		2,444,166	0	2,444,166	41.00
43.00	04300	NURSERY	840,621		840,621	0	840,621	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,074,825		4,074,825	0	4,074,825	50.00
51.00	05100	RECOVERY ROOM	1,983,892		1,983,892	0	1,983,892	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,895,838		1,895,838	0	1,895,838	52.00
53.00	05300	ANESTHESIOLOGY	519,196		519,196	39,824	559,020	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,055,306		4,055,306	0	4,055,306	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	3,813,247		3,813,247	0	3,813,247	55.00
56.00	05600	RADIOISOTOPE	652,790		652,790	0	652,790	56.00
57.00	05700	CT SCAN	882,600		882,600	0	882,600	57.00
58.00	05800	MRI	432,683		432,683	0	432,683	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,799,294		1,799,294	0	1,799,294	59.00
60.00	06000	LABORATORY	5,211,700		5,211,700	43,692	5,255,392	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	770,924		770,924	0	770,924	62.00
64.00	06400	INTRAVENOUS THERAPY	624,981		624,981	0	624,981	64.00
65.00	06500	RESPIRATORY THERAPY	1,858,224	0	1,858,224	0	1,858,224	65.00
66.00	06600	PHYSICAL THERAPY	1,695,797	0	1,695,797	0	1,695,797	66.00
67.00	06700	OCCUPATIONAL THERAPY	438,315	0	438,315	0	438,315	67.00
68.00	06800	SPEECH PATHOLOGY	180,483	0	180,483	0	180,483	68.00
69.00	06900	ELECTROCARDIOLOGY	244,916		244,916	0	244,916	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	344,484		344,484	0	344,484	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,120,369		11,120,369	0	11,120,369	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,943,446		2,943,446	0	2,943,446	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,910,622		7,910,622	0	7,910,622	73.00
74.00	07400	RENAL DIALYSIS	130,240		130,240	0	130,240	74.00
76.00	03950	DIABETES CENTER	77,185		77,185	0	77,185	76.00
76.97	07697	CARDIAC REHABILITATION	436,802		436,802	0	436,802	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	198,943		198,943	0	198,943	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,013,479		1,013,479	0	1,013,479	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,243,978		1,243,978	0	1,243,978	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,462,244		1,462,244	0	1,462,244	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,477,558		1,477,558	0	1,477,558	88.03
88.04	08804	RURAL HEALTH CLINIC V	1,346,677		1,346,677	0	1,346,677	88.04
91.00	09100	EMERGENCY	6,454,869		6,454,869	153,176	6,608,045	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,137,944		1,137,944		1,137,944	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,931,599		1,931,599		1,931,599	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	92,009,342	0	92,009,342	237,218	92,246,560	200.00
201.00		Less Observation Beds	1,137,944		1,137,944		1,137,944	201.00
202.00		Total (see instructions)	90,871,398	0	90,871,398	237,218	91,108,616	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/25/2017 1:17 pm

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		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	5,282,777		5,282,777			30.00
31.00	03100	INTENSIVE CARE UNIT	1,586,122		1,586,122			31.00
41.00	04100	SUBPROVIDER - IRF	1,368,985		1,368,985			41.00
43.00	04300	NURSERY	305,093		305,093			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,187,160	11,470,306	23,657,466	0.172243	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,760,189	2,886,237	4,646,426	0.426972	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	753,812	144,730	898,542	2.109905	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	3,959,885	3,245,941	7,205,826	0.072052	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,541,671	6,657,305	9,198,976	0.440843	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	58,410	5,780,692	5,839,102	0.653054	0.000000	55.00
56.00	05600	RADIOISOTOPE	452,524	1,918,481	2,371,005	0.275322	0.000000	56.00
57.00	05700	CT SCAN	4,255,683	12,190,017	16,445,700	0.053668	0.000000	57.00
58.00	05800	MRI	629,799	4,541,122	5,170,921	0.083676	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,560,315	3,716,328	6,276,643	0.286665	0.000000	59.00
60.00	06000	LABORATORY	11,313,756	24,072,884	35,386,640	0.147279	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	647,812	535,704	1,183,516	0.651385	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	103,027	1,601,472	1,704,499	0.366666	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	297,539	421,060	718,599	2.585898	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,217,725	449,137	1,666,862	1.017359	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	713,750	9,429	723,179	0.606095	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	96,042	62,882	158,924	1.135656	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	547,945	1,288,403	1,836,348	0.133371	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	26,310	604,362	630,672	0.546217	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	59,651,410	33,996,268	93,647,678	0.118747	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	995,252	4,952,801	5,948,053	0.494859	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,492,109	23,859,775	52,351,884	0.151105	0.000000	73.00
74.00	07400	RENAL DIALYSIS	70,500	0	70,500	1.847376	0.000000	74.00
76.00	03950	DIABETES CENTER	16	20,626	20,642	3.739221	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	3,280	357,271	360,551	1.211485	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	232	20,981	21,213	9.378353	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	545,071	545,071			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	565,200	565,200			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,229,295	1,229,295			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	930,259	930,259			88.03
88.04	08804	RURAL HEALTH CLINIC V	0	930,259	930,259			88.04
91.00	09100	EMERGENCY	547,427	2,006,057	2,553,484	2.527867	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	292,560	1,146,456	1,439,016	0.790779	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,237,683	1,237,683			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	142,719,117	153,394,494	296,113,611			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	142,719,117	153,394,494	296,113,611			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/25/2017 1:17 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
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.172243	50.00
51.00	05100	RECOVERY ROOM	0.426972	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.109905	52.00
53.00	05300	ANESTHESIOLOGY	0.077579	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.440843	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.653054	55.00
56.00	05600	RADIOISOTOPE	0.275322	56.00
57.00	05700	CT SCAN	0.053668	57.00
58.00	05800	MRI	0.083676	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.286665	59.00
60.00	06000	LABORATORY	0.148513	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.651385	62.00
64.00	06400	INTRAVENOUS THERAPY	0.366666	64.00
65.00	06500	RESPIRATORY THERAPY	2.585898	65.00
66.00	06600	PHYSICAL THERAPY	1.017359	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.606095	67.00
68.00	06800	SPEECH PATHOLOGY	1.135656	68.00
69.00	06900	ELECTROCARDIOLOGY	0.133371	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.546217	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.118747	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.494859	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.151105	73.00
74.00	07400	RENAL DIALYSIS	1.847376	74.00
76.00	03950	DIABETES CENTER	3.739221	76.00
76.97	07697	CARDIAC REHABILITATION	1.211485	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	9.378353	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	2.587854	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.790779	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: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/25/2017 1:17 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	14,430,500		14,430,500	526	14,431,026	30.00
31.00	03100	INTENSIVE CARE UNIT	3,928,605		3,928,605	0	3,928,605	31.00
41.00	04100	SUBPROVIDER - IRF	2,444,166		2,444,166	0	2,444,166	41.00
43.00	04300	NURSERY	840,621		840,621	0	840,621	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,074,825		4,074,825	0	4,074,825	50.00
51.00	05100	RECOVERY ROOM	1,983,892		1,983,892	0	1,983,892	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,895,838		1,895,838	0	1,895,838	52.00
53.00	05300	ANESTHESIOLOGY	519,196		519,196	39,824	559,020	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,055,306		4,055,306	0	4,055,306	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	3,813,247		3,813,247	0	3,813,247	55.00
56.00	05600	RADIOISOTOPE	652,790		652,790	0	652,790	56.00
57.00	05700	CT SCAN	882,600		882,600	0	882,600	57.00
58.00	05800	MRI	432,683		432,683	0	432,683	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,799,294		1,799,294	0	1,799,294	59.00
60.00	06000	LABORATORY	5,211,700		5,211,700	43,692	5,255,392	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	770,924		770,924	0	770,924	62.00
64.00	06400	INTRAVENOUS THERAPY	624,981		624,981	0	624,981	64.00
65.00	06500	RESPIRATORY THERAPY	1,858,224	0	1,858,224	0	1,858,224	65.00
66.00	06600	PHYSICAL THERAPY	1,695,797	0	1,695,797	0	1,695,797	66.00
67.00	06700	OCCUPATIONAL THERAPY	438,315	0	438,315	0	438,315	67.00
68.00	06800	SPEECH PATHOLOGY	180,483	0	180,483	0	180,483	68.00
69.00	06900	ELECTROCARDIOLOGY	244,916		244,916	0	244,916	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	344,484		344,484	0	344,484	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,120,369		11,120,369	0	11,120,369	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,943,446		2,943,446	0	2,943,446	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,910,622		7,910,622	0	7,910,622	73.00
74.00	07400	RENAL DIALYSIS	130,240		130,240	0	130,240	74.00
76.00	03950	DIABETES CENTER	77,185		77,185	0	77,185	76.00
76.97	07697	CARDIAC REHABILITATION	436,802		436,802	0	436,802	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	198,943		198,943	0	198,943	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,013,479		1,013,479	0	1,013,479	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,243,978		1,243,978	0	1,243,978	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,462,244		1,462,244	0	1,462,244	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,477,558		1,477,558	0	1,477,558	88.03
88.04	08804	RURAL HEALTH CLINIC V	1,346,677		1,346,677	0	1,346,677	88.04
91.00	09100	EMERGENCY	6,454,869		6,454,869	153,176	6,608,045	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,137,944		1,137,944		1,137,944	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,931,599		1,931,599		1,931,599	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	92,009,342	0	92,009,342	237,218	92,246,560	200.00
201.00		Less Observation Beds	1,137,944		1,137,944		1,137,944	201.00
202.00		Total (see instructions)	90,871,398	0	90,871,398	237,218	91,108,616	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/25/2017 1:17 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	5,282,777		5,282,777			30.00
31.00	03100	INTENSIVE CARE UNIT	1,586,122		1,586,122			31.00
41.00	04100	SUBPROVIDER - IRF	1,368,985		1,368,985			41.00
43.00	04300	NURSERY	305,093		305,093			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,187,160	11,470,306	23,657,466	0.172243	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,760,189	2,886,237	4,646,426	0.426972	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	753,812	144,730	898,542	2.109905	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	3,959,885	3,245,941	7,205,826	0.072052	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,541,671	6,657,305	9,198,976	0.440843	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	58,410	5,780,692	5,839,102	0.653054	0.000000	55.00
56.00	05600	RADIOISOTOPE	452,524	1,918,481	2,371,005	0.275322	0.000000	56.00
57.00	05700	CT SCAN	4,255,683	12,190,017	16,445,700	0.053668	0.000000	57.00
58.00	05800	MRI	629,799	4,541,122	5,170,921	0.083676	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,560,315	3,716,328	6,276,643	0.286665	0.000000	59.00
60.00	06000	LABORATORY	11,313,756	24,072,884	35,386,640	0.147279	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	647,812	535,704	1,183,516	0.651385	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	103,027	1,601,472	1,704,499	0.366666	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	297,539	421,060	718,599	2.585898	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,217,725	449,137	1,666,862	1.017359	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	713,750	9,429	723,179	0.606095	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	96,042	62,882	158,924	1.135656	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	547,945	1,288,403	1,836,348	0.133371	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	26,310	604,362	630,672	0.546217	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	59,651,410	33,996,268	93,647,678	0.118747	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	995,252	4,952,801	5,948,053	0.494859	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,492,109	23,859,775	52,351,884	0.151105	0.000000	73.00
74.00	07400	RENAL DIALYSIS	70,500	0	70,500	1.847376	0.000000	74.00
76.00	03950	DIABETES CENTER	16	20,626	20,642	3.739221	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	3,280	357,271	360,551	1.211485	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	232	20,981	21,213	9.378353	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	545,071	545,071	1.859352	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	565,200	565,200	2.200952	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,229,295	1,229,295	1.189498	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	930,259	930,259	1.588330	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	930,259	930,259	1.447637	0.000000	88.04
91.00	09100	EMERGENCY	547,427	2,006,057	2,553,484	2.527867	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	292,560	1,146,456	1,439,016	0.790779	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,237,683	1,237,683			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	142,719,117	153,394,494	296,113,611			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	142,719,117	153,394,494	296,113,611			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/25/2017 1:17 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
41.00	04100	SUBPROVIDER - IRF			41.00
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	03950	DIABETES CENTER	0.000000		76.00
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
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: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part I Date/Time Prepared: 2/25/2017 1:17 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	949,344	0	949,344	13,227	71.77	30.00
31.00	INTENSIVE CARE UNIT	233,179		233,179	1,888	123.51	31.00
41.00	SUBPROVIDER - IRF	206,770	0	206,770	1,700	121.63	41.00
43.00	NURSERY	49,502		49,502	1,164	42.53	43.00
200.00	Total (lines 30-199)	1,438,795		1,438,795	17,979		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	7,610	546,170	30.00
31.00	INTENSIVE CARE UNIT	1,165	143,889	31.00
41.00	SUBPROVIDER - IRF	1,276	155,200	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	10,051	845,259	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part II Date/Time Prepared: 2/25/2017 1:17 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	692,682	23,657,466	0.029280	7,202,069	210,877	50.00
51.00	05100	RECOVERY ROOM	122,948	4,646,426	0.026461	896,009	23,709	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	70,440	898,542	0.078394	90,403	7,087	52.00
53.00	05300	ANESTHESIOLOGY	120,446	7,205,826	0.016715	2,170,664	36,283	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	681,768	9,198,976	0.074113	1,573,573	116,622	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	865,860	5,839,102	0.148287	23,261	3,449	55.00
56.00	05600	RADIOISOTOPE	228,322	2,371,005	0.096298	284,049	27,353	56.00
57.00	05700	CT SCAN	127,836	16,445,700	0.007773	2,570,568	19,981	57.00
58.00	05800	MRI	187,475	5,170,921	0.036256	416,705	15,108	58.00
59.00	05900	CARDIAC CATHETERIZATION	100,292	6,276,643	0.015979	1,198,703	19,154	59.00
60.00	06000	LABORATORY	519,660	35,386,640	0.014685	6,883,480	101,084	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	23,118	1,183,516	0.019533	386,426	7,548	62.00
64.00	06400	INTRAVENOUS THERAPY	128,635	1,704,499	0.075468	79,847	6,026	64.00
65.00	06500	RESPIRATORY THERAPY	170,150	718,599	0.236780	159,276	37,713	65.00
66.00	06600	PHYSICAL THERAPY	85,686	1,666,862	0.051406	565,481	29,069	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,082	723,179	0.019472	231,591	4,510	67.00
68.00	06800	SPEECH PATHOLOGY	7,398	158,924	0.046551	26,101	1,215	68.00
69.00	06900	ELECTROCARDIOLOGY	72,149	1,836,348	0.039289	351,776	13,821	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	30,871	630,672	0.048949	16,341	800	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	316,034	93,647,678	0.003375	31,406,245	105,996	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	83,652	5,948,053	0.014064	637,626	8,968	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	486,891	52,351,884	0.009300	14,700,691	136,716	73.00
74.00	07400	RENAL DIALYSIS	3,572	70,500	0.050667	56,000	2,837	74.00
76.00	03950	DIABETES CENTER	2,483	20,642	0.120289	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	50,833	360,551	0.140987	357	50	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	12,121	21,213	0.571395	9	5	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	53,296	545,071	0.097778	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	156,271	565,200	0.276488	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	93,253	1,229,295	0.075859	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	159,427	930,259	0.171379	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	67,510	930,259	0.072571	0	0	88.04
91.00	09100	EMERGENCY	537,904	2,553,484	0.210655	330,261	69,571	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	74,860	1,439,016	0.052022	175,950	9,153	92.00
200.00		Total (lines 50-199)	6,347,925	286,332,951		72,433,462	1,014,705	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part III Date/Time Prepared: 2/25/2017 1:17 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
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
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	13,227	0.00	7,610	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,888	0.00	1,165	0		31.00
41.00	04100	SUBPROVIDER - IRF	1,700	0.00	1,276	0		41.00
43.00	04300	NURSERY	1,164	0.00	0	0		43.00
200.00		Total (lines 30-199)	17,979		10,051	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/25/2017 1:17 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	03950	DIABETES CENTER	0	0	0	0	0	76.00
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
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: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 2/25/2017 1:17 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	23,657,466	0.000000	0.000000	7,202,069	50.00
51.00	05100	RECOVERY ROOM	0	4,646,426	0.000000	0.000000	896,009	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	898,542	0.000000	0.000000	90,403	52.00
53.00	05300	ANESTHESIOLOGY	0	7,205,826	0.000000	0.000000	2,170,664	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,198,976	0.000000	0.000000	1,573,573	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	5,839,102	0.000000	0.000000	23,261	55.00
56.00	05600	RADIOISOTOPE	0	2,371,005	0.000000	0.000000	284,049	56.00
57.00	05700	CT SCAN	0	16,445,700	0.000000	0.000000	2,570,568	57.00
58.00	05800	MRI	0	5,170,921	0.000000	0.000000	416,705	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	6,276,643	0.000000	0.000000	1,198,703	59.00
60.00	06000	LABORATORY	0	35,386,640	0.000000	0.000000	6,883,480	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,183,516	0.000000	0.000000	386,426	62.00
64.00	06400	INTRAVENOUS THERAPY	0	1,704,499	0.000000	0.000000	79,847	64.00
65.00	06500	RESPIRATORY THERAPY	0	718,599	0.000000	0.000000	159,276	65.00
66.00	06600	PHYSICAL THERAPY	0	1,666,862	0.000000	0.000000	565,481	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	723,179	0.000000	0.000000	231,591	67.00
68.00	06800	SPEECH PATHOLOGY	0	158,924	0.000000	0.000000	26,101	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,836,348	0.000000	0.000000	351,776	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	630,672	0.000000	0.000000	16,341	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	93,647,678	0.000000	0.000000	31,406,245	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,948,053	0.000000	0.000000	637,626	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	52,351,884	0.000000	0.000000	14,700,691	73.00
74.00	07400	RENAL DIALYSIS	0	70,500	0.000000	0.000000	56,000	74.00
76.00	03950	DIABETES CENTER	0	20,642	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	360,551	0.000000	0.000000	357	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	21,213	0.000000	0.000000	9	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	545,071	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	565,200	0.000000	0.000000	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,229,295	0.000000	0.000000	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	930,259	0.000000	0.000000	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	930,259	0.000000	0.000000	0	88.04
91.00	09100	EMERGENCY	0	2,553,484	0.000000	0.000000	330,261	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,439,016	0.000000	0.000000	175,950	92.00
200.00		Total (lines 50-199)	0	286,332,951			72,433,462	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 2/25/2017 1:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	3,925,135	0		50.00
51.00	05100	RECOVERY ROOM	0	1,111,072	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	25,895	0		52.00
53.00	05300	ANESTHESIOLOGY	0	955,818	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,889,084	0		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	2,547,165	0		55.00
56.00	05600	RADIOISOTOPE	0	954,302	0		56.00
57.00	05700	CT SCAN	0	3,996,142	0		57.00
58.00	05800	MRI	0	1,693,358	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,743,235	0		59.00
60.00	06000	LABORATORY	0	5,017,940	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	205,629	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	603,558	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	233,135	0		65.00
66.00	06600	PHYSICAL THERAPY	0	2,361	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	702	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	185	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	505,207	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	222,635	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	10,121,574	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,197,178	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,562,933	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03950	DIABETES CENTER	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	226,465	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	5,565	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	516,665	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	537,175	0		92.00
200.00		Total (lines 50-199)	0	47,800,113	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/25/2017 1:17 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	0.172243	3,925,135	0	0	676,077	50.00
51.00	05100	RECOVERY ROOM	0.426972	1,111,072	0	0	474,397	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.109905	25,895	0	0	54,636	52.00
53.00	05300	ANESTHESIOLOGY	0.072052	955,818	0	0	68,869	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.440843	1,889,084	0	0	832,789	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.653054	2,547,165	0	0	1,663,436	55.00
56.00	05600	RADIOISOTOPE	0.275322	954,302	0	0	262,740	56.00
57.00	05700	CT SCAN	0.053668	3,996,142	0	0	214,465	57.00
58.00	05800	MRI	0.083676	1,693,358	0	0	141,693	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.286665	1,743,235	0	0	499,724	59.00
60.00	06000	LABORATORY	0.147279	5,017,940	532	0	739,037	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.651385	205,629	10	0	133,944	62.00
64.00	06400	INTRAVENOUS THERAPY	0.366666	603,558	0	0	221,304	64.00
65.00	06500	RESPIRATORY THERAPY	2.585898	233,135	0	0	602,863	65.00
66.00	06600	PHYSICAL THERAPY	1.017359	2,361	0	0	2,402	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.606095	702	0	0	425	67.00
68.00	06800	SPEECH PATHOLOGY	1.135656	185	0	0	210	68.00
69.00	06900	ELECTROCARDIOLOGY	0.133371	505,207	0	0	67,380	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.546217	222,635	0	0	121,607	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.118747	10,121,574	0	0	1,201,907	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.494859	3,197,178	0	0	1,582,152	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.151105	7,562,933	60	1,610	1,142,797	73.00
74.00	07400	RENAL DIALYSIS	1.847376	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	3.739221	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.211485	226,465	0	0	274,359	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	9.378353	5,565	0	0	52,191	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	2.527867	516,665	0	0	1,306,060	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.790779	537,175	0	0	424,787	92.00
200.00		Subtotal (see instructions)		47,800,113	602	1,610	12,762,251	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		47,800,113	602	1,610	12,762,251	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/25/2017 1:17 pm

Title XVIII | Hospital | PPS

		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	0	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	0	0		59.00
60.00	06000	LABORATORY	78	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	7	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	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9	243		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	DIABETES CENTER	0	0		76.00
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
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	94	243		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	94	243		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 26-0025 | Component CCN: 26-T025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part II Date/Time Prepared: 2/25/2017 1:17 pm

Title XVIII | Subprovider - IRF | 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	692,682	23,657,466	0.029280	69	2	50.00
51.00	05100	RECOVERY ROOM	122,948	4,646,426	0.026461	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	70,440	898,542	0.078394	30	2	52.00
53.00	05300	ANESTHESIOLOGY	120,446	7,205,826	0.016715	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	681,768	9,198,976	0.074113	28,082	2,081	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	865,860	5,839,102	0.148287	0	0	55.00
56.00	05600	RADIOISOTOPE	228,322	2,371,005	0.096298	0	0	56.00
57.00	05700	CT SCAN	127,836	16,445,700	0.007773	34,589	269	57.00
58.00	05800	MRI	187,475	5,170,921	0.036256	7,980	289	58.00
59.00	05900	CARDIAC CATHETERIZATION	100,292	6,276,643	0.015979	19,208	307	59.00
60.00	06000	LABORATORY	519,660	35,386,640	0.014685	137,149	2,014	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	23,118	1,183,516	0.019533	6,578	128	62.00
64.00	06400	INTRAVENOUS THERAPY	128,635	1,704,499	0.075468	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	170,150	718,599	0.236780	3,263	773	65.00
66.00	06600	PHYSICAL THERAPY	85,686	1,666,862	0.051406	310,971	15,986	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,082	723,179	0.019472	310,971	6,055	67.00
68.00	06800	SPEECH PATHOLOGY	7,398	158,924	0.046551	23,885	1,112	68.00
69.00	06900	ELECTROCARDIOLOGY	72,149	1,836,348	0.039289	5,633	221	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	30,871	630,672	0.048949	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	316,034	93,647,678	0.003375	107,860	364	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	83,652	5,948,053	0.014064	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	486,891	52,351,884	0.009300	138,672	1,290	73.00
74.00	07400	RENAL DIALYSIS	3,572	70,500	0.050667	2,800	142	74.00
76.00	03950	DIABETES CENTER	2,483	20,642	0.120289	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	50,833	360,551	0.140987	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	12,121	21,213	0.571395	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	53,296	545,071	0.097778	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	156,271	565,200	0.276488	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	93,253	1,229,295	0.075859	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	159,427	930,259	0.171379	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	67,510	930,259	0.072571	0	0	88.04
91.00	09100	EMERGENCY	537,904	2,553,484	0.210655	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,439,016	0.000000	0	0	92.00
200.00		Total (lines 50-199)	6,273,065	286,332,951		1,137,740	31,035	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0025 | Component CCN: 26-T025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 2/25/2017 1:17 pm

Title XVIII | Subprovider - IRF | 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	03950	DIABETES CENTER	0	0	0	0	0	76.00
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
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: 26-0025 | Component CCN: 26-T025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/25/2017 1:17 pm

Title XVIII | Subprovider - IRF | 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	23,657,466	0.000000	0.000000	69	50.00
51.00	05100	RECOVERY ROOM	0	4,646,426	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	898,542	0.000000	0.000000	30	52.00
53.00	05300	ANESTHESIOLOGY	0	7,205,826	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,198,976	0.000000	0.000000	28,082	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	5,839,102	0.000000	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0	2,371,005	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	16,445,700	0.000000	0.000000	34,589	57.00
58.00	05800	MRI	0	5,170,921	0.000000	0.000000	7,980	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	6,276,643	0.000000	0.000000	19,208	59.00
60.00	06000	LABORATORY	0	35,386,640	0.000000	0.000000	137,149	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,183,516	0.000000	0.000000	6,578	62.00
64.00	06400	INTRAVENOUS THERAPY	0	1,704,499	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	718,599	0.000000	0.000000	3,263	65.00
66.00	06600	PHYSICAL THERAPY	0	1,666,862	0.000000	0.000000	310,971	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	723,179	0.000000	0.000000	310,971	67.00
68.00	06800	SPEECH PATHOLOGY	0	158,924	0.000000	0.000000	23,885	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,836,348	0.000000	0.000000	5,633	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	630,672	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	93,647,678	0.000000	0.000000	107,860	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,948,053	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	52,351,884	0.000000	0.000000	138,672	73.00
74.00	07400	RENAL DIALYSIS	0	70,500	0.000000	0.000000	2,800	74.00
76.00	03950	DIABETES CENTER	0	20,642	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	360,551	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	21,213	0.000000	0.000000	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	545,071	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	565,200	0.000000	0.000000	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,229,295	0.000000	0.000000	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	930,259	0.000000	0.000000	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	930,259	0.000000	0.000000	0	88.04
91.00	09100	EMERGENCY	0	2,553,484	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,439,016	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	286,332,951			1,137,740	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0025 | Component CCN: 26-T025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 2/25/2017 1:17 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03950	DIABETES CENTER	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	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	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/25/2017 1:17 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	0.172243	0	317,830	0	0	50.00
51.00	05100	RECOVERY ROOM	0.426972	0	279,899	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.109905	0	4,140	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.072052	0	106,993	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.440843	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.653054	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.275322	0	0	0	0	56.00
57.00	05700	CT SCAN	0.053668	0	0	0	0	57.00
58.00	05800	MRI	0.083676	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.286665	0	0	0	0	59.00
60.00	06000	LABORATORY	0.147279	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.651385	0	8,572	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.366666	0	380,500	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2.585898	0	16,827	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1.017359	0	11,797	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.606095	0	8,727	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.135656	0	15,765	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.133371	0	114,212	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.546217	0	54,603	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.118747	0	2,676,214	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.494859	0	103,378	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.151105	0	1,268,328	0	0	73.00
74.00	07400	RENAL DIALYSIS	1.847376	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	3.739221	0	152	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.211485	0	5,117	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	9.378353	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1.859352				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2.200952				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1.189498				0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1.588330				0	88.03
88.04	08804	RURAL HEALTH CLINIC V	1.447637				0	88.04
91.00	09100	EMERGENCY	2.527867	0	74,680	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.790779	0	52,440	0	0	92.00
200.00		Subtotal (see instructions)		0	5,500,174	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	5,500,174	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/25/2017 1:17 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	54,744	0		50.00
51.00	05100	RECOVERY ROOM	119,509	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,735	0		52.00
53.00	05300	ANESTHESIOLOGY	7,709	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	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	5,584	0		62.00
64.00	06400	INTRAVENOUS THERAPY	139,516	0		64.00
65.00	06500	RESPIRATORY THERAPY	43,513	0		65.00
66.00	06600	PHYSICAL THERAPY	12,002	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,289	0		67.00
68.00	06800	SPEECH PATHOLOGY	17,904	0		68.00
69.00	06900	ELECTROCARDIOLOGY	15,233	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	29,825	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	317,792	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51,158	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	191,651	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	DIABETES CENTER	568	0		76.00
76.97	07697	CARDIAC REHABILITATION	6,199	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	188,781	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	41,468	0		92.00
200.00		Subtotal (see instructions)	1,257,180	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	1,257,180	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/25/2017 1:17 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)	13,227	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,227	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)	12,184	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)	7,610	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)	14,431,026	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)	14,431,026	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)	14,431,026	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)	1,091.03	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	8,302,738	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	8,302,738	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/25/2017 1:17 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,928,605	1,888	2,080.83	1,165	2,424,167	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)	13,166,112	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	23,893,017	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)	690,059	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,014,705	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,704,764	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	22,188,253	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)	1,043	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,091.03	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,137,944	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/25/2017 1:17 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	949,344	14,431,026	0.065785	1,137,944	74,860	90.00
91.00	Nursing School cost	0	14,431,026	0.000000	1,137,944	0	91.00
92.00	Allied health cost	0	14,431,026	0.000000	1,137,944	0	92.00
93.00	All other Medical Education	0	14,431,026	0.000000	1,137,944	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 26-0025 Component CCN: 26-T025	Period: From 10/01/2015 To 09/30/2016	Worksheet D-1 Date/Time Prepared: 2/25/2017 1:17 pm
	Title XVIII	Subprovider - IRF	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)	1,700	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,700	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)	1,700	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)	1,276	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)	2,444,166	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)	2,444,166	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)	2,444,166	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)	1,437.74	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,834,556	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)	1,834,556	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-0025 | Component CCN: 26-T025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/25/2017 1:17 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	625,234	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,459,790	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)	155,200	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	31,035	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	186,235	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,273,555	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1

Component CCN: 26-T025 | Date/Time Prepared: 2/25/2017 1:17 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	206,770	2,444,166	0.084597	0	0	90.00
91.00	Nursing School cost	0	2,444,166	0.000000	0	0	91.00
92.00	Allied health cost	0	2,444,166	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,444,166	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/25/2017 1:17 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)	13,227	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,227	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)	12,184	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)	611	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)	1,164	15.00
16.00	Nursery days (title V or XIX only)	117	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)	14,430,500	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)	14,430,500	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)	14,430,500	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)	1,090.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	666,595	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)	666,595	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/25/2017 1:17 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)	840,621	1,164	722.18	117	84,495	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,928,605	1,888	2,080.83	190	395,358	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)	713,831	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,860,279	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)	1,043	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,090.99	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,137,903	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/25/2017 1:17 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	949,344	14,430,500	0.065787	1,137,903	74,859	90.00
91.00	Nursing School cost	0	14,430,500	0.000000	1,137,903	0	91.00
92.00	Allied health cost	0	14,430,500	0.000000	1,137,903	0	92.00
93.00	All other Medical Education	0	14,430,500	0.000000	1,137,903	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 2/25/2017 1:17 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		3,528,670		30.00
31.00	03100	INTENSIVE CARE UNIT		978,737		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.172243	7,202,069	1,240,506	50.00
51.00	05100	RECOVERY ROOM	0.426972	896,009	382,571	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.109905	90,403	190,742	52.00
53.00	05300	ANESTHESIOLOGY	0.077579	2,170,664	168,398	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.440843	1,573,573	693,699	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.653054	23,261	15,191	55.00
56.00	05600	RADIOISOTOPE	0.275322	284,049	78,205	56.00
57.00	05700	CT SCAN	0.053668	2,570,568	137,957	57.00
58.00	05800	MRI	0.083676	416,705	34,868	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.286665	1,198,703	343,626	59.00
60.00	06000	LABORATORY	0.148513	6,883,480	1,022,286	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.651385	386,426	251,712	62.00
64.00	06400	INTRAVENOUS THERAPY	0.366666	79,847	29,277	64.00
65.00	06500	RESPIRATORY THERAPY	2.585898	159,276	411,871	65.00
66.00	06600	PHYSICAL THERAPY	1.017359	565,481	575,297	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.606095	231,591	140,366	67.00
68.00	06800	SPEECH PATHOLOGY	1.135656	26,101	29,642	68.00
69.00	06900	ELECTROCARDIOLOGY	0.133371	351,776	46,917	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.546217	16,341	8,926	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.118747	31,406,245	3,729,397	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.494859	637,626	315,535	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.151105	14,700,691	2,221,348	73.00
74.00	07400	RENAL DIALYSIS	1.847376	56,000	103,453	74.00
76.00	03950	DIABETES CENTER	3.739221	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.211485	357	433	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	9.378353	9	84	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	2.587854	330,261	854,667	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.790779	175,950	139,138	92.00
200.00		Total (sum of lines 50-94 and 96-98)		72,433,462	13,166,112	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)		72,433,462		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 26-0025 | Component CCN: 26-T025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 2/25/2017 1:17 pm

Title XVIII | Subprovider - IRF | 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		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		994,950		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.172243	69	12	50.00
51.00	05100	RECOVERY ROOM	0.426972	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.109905	30	63	52.00
53.00	05300	ANESTHESIOLOGY	0.077579	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.440843	28,082	12,380	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.653054	0	0	55.00
56.00	05600	RADIOISOTOPE	0.275322	0	0	56.00
57.00	05700	CT SCAN	0.053668	34,589	1,856	57.00
58.00	05800	MRI	0.083676	7,980	668	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.286665	19,208	5,506	59.00
60.00	06000	LABORATORY	0.148513	137,149	20,368	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.651385	6,578	4,285	62.00
64.00	06400	INTRAVENOUS THERAPY	0.366666	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2.585898	3,263	8,438	65.00
66.00	06600	PHYSICAL THERAPY	1.017359	310,971	316,369	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.606095	310,971	188,478	67.00
68.00	06800	SPEECH PATHOLOGY	1.135656	23,885	27,125	68.00
69.00	06900	ELECTROCARDIOLOGY	0.133371	5,633	751	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.546217	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.118747	107,860	12,808	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.494859	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.151105	138,672	20,954	73.00
74.00	07400	RENAL DIALYSIS	1.847376	2,800	5,173	74.00
76.00	03950	DIABETES CENTER	3.739221	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.211485	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	9.378353	0	0	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	2.587854	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.790779	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,137,740	625,234	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,137,740		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 2/25/2017 1:17 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		157,375		30.00
31.00	03100	INTENSIVE CARE UNIT		118,874		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		23,085		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.172243	50,461	8,692	50.00
51.00	05100	RECOVERY ROOM	0.426972	36,604	15,629	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.109905	17,120	36,122	52.00
53.00	05300	ANESTHESIOLOGY	0.072052	38,101	2,745	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.440843	152,494	67,226	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.653054	0	0	55.00
56.00	05600	RADIOISOTOPE	0.275322	308	85	56.00
57.00	05700	CT SCAN	0.053668	245,320	13,166	57.00
58.00	05800	MRI	0.083676	21,761	1,821	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.286665	42,788	12,266	59.00
60.00	06000	LABORATORY	0.147279	636,474	93,739	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.651385	8,660	5,641	62.00
64.00	06400	INTRAVENOUS THERAPY	0.366666	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2.585898	9,813	25,375	65.00
66.00	06600	PHYSICAL THERAPY	1.017359	19,388	19,725	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.606095	3,675	2,227	67.00
68.00	06800	SPEECH PATHOLOGY	1.135656	5,572	6,328	68.00
69.00	06900	ELECTROCARDIOLOGY	0.133371	69,331	9,247	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.546217	1,576	861	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.118747	1,300,923	154,481	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.494859	43,782	21,666	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.151105	1,383,342	209,030	73.00
74.00	07400	RENAL DIALYSIS	1.847376	4,200	7,759	74.00
76.00	03950	DIABETES CENTER	3.739221	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.211485	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	9.378353	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.859352	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2.200952	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1.189498	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1.588330	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	1.447637	0	0	88.04
91.00	09100	EMERGENCY	2.527867	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.790779	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		4,091,693	713,831	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)		4,091,693		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 26-0025	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part A Date/Time Prepared: 2/25/2017 1:17 pm
	Title XVIII	Hospital	PPS

		1.00	
	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)	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	16,590,195	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)	671,457	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	1,402,142	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	83.15	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
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)	4.42	30.00
31.00	Percentage of Medicaid patient days (see instructions)	14.95	31.00
32.00	Sum of lines 30 and 31	19.37	32.00
33.00	Allowable disproportionate share percentage (see instructions)	5.35	33.00
34.00	Disproportionate share adjustment (see instructions)	221,894	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 26-0025	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part A Date/Time Prepared: 2/25/2017 1:17 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	6,406,145,534	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000081593	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	522,697	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	522,697	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	522,697		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
		Before 1/1	On/After 1/1	
		1.00	1.01	
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)	18,006,243		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	22,064,109		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		22,064,109	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,385,873	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
54.01	Islet isolation add-on payment			54.01
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)		23,449,982	59.00
60.00	Primary payer payments		4,607	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		23,445,375	61.00
62.00	Deductibles billed to program beneficiaries		2,072,812	62.00
63.00	Coinsurance billed to program beneficiaries		43,022	63.00
64.00	Allowable bad debts (see instructions)		609,058	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		395,888	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		463,881	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		21,725,429	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 ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	RURAL DEMONSTRATION PROJECT		0	70.50
70.88	SCH or MDH volume decrease adjustment		0	70.88
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)		154,211	70.93
70.94	HRR adjustment amount (see instructions)		-94,565	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E Part A Date/Time Prepared: 2/25/2017 1:17 pm

Title XVIII | Hospital | PPS

		FFY (yyyy)	Amount	
		0	1.00	
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)		21,785,075	71.00
71.01	Sequestration adjustment (see instructions)		435,702	71.01
72.00	Interim payments		21,694,482	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)		-345,109	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

		Prior to 10/1	On/After 10/1	
		1.00	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)		0.0000000000	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: 26-0025	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part B Date/Time Prepared: 2/25/2017 1:17 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	337	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	12,762,251	2.00
3.00	PPS payments	9,008,456	3.00
4.00	Outlier payment (see instructions)	482,052	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	11,256,305	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	84.31	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)	337	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	2,212	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)	2,212	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)	2,212	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,875	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)	337	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)	9,490,508	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)	1,727,333	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)	7,763,512	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)	7,763,512	30.00
31.00	Primary payer payments	252	31.00
32.00	Subtotal (line 30 minus line 31)	7,763,260	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)	202,174	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	131,413	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	74,871	36.00
37.00	Subtotal (see instructions)	7,894,673	37.00
38.00	MSP-LCC reconciliation amount from PS&R	318	38.00
39.00	OTHER ADJUSTMENTS PER PS&R	55,852	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)	7,950,207	40.00
40.01	Sequestration adjustment (see instructions)	159,004	40.01
41.00	Interim payments	7,775,492	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	15,711	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: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 2/25/2017 1:17 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		21,694,482		7,775,492	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)		21,694,482		7,775,492	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		15,711	6.01
6.02	SETTLEMENT TO PROGRAM		345,109		0	6.02
7.00	Total Medicare program liability (see instructions)		21,349,373		7,791,203	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 26-0025 | Component CCN: 26-T025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 2/25/2017 1:17 pm

Title XVIII | Subprovider - IRF | 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		1,683,678		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,683,678		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,683,678		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 26-0025	Period: From 10/01/2015 To 09/30/2016	Worksheet E-1 Part II Date/Time Prepared: 2/25/2017 1:17 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	4,080	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	8,775	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	811	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	14,072	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	296,113,611	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	8,676,632	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)	453,749	8.00
9.00	Sequestration adjustment amount (see instructions)	9,075	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	444,674	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)	444,674	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 26-0025 Component CCN: 26-T025	Period: From 10/01/2015 To 09/30/2016	Worksheet E-3 Part III Date/Time Prepared: 2/25/2017 1:17 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	1,727,968	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0000	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	0	3.00
4.00	Outlier Payments	1,600	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	4.644809	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	1,729,568	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	1,729,568	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	1,729,568	19.00
20.00	Deductibles	7,728	20.00
21.00	Subtotal (line 19 minus line 20)	1,721,840	21.00
22.00	Coinsurance	3,801	22.00
23.00	Subtotal (line 21 minus line 22)	1,718,039	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	1,718,039	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	1,718,039	32.00
32.01	Sequestration adjustment (see instructions)	34,361	32.01
33.00	Interim payments	1,683,678	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)	0	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	1,600	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-3 Part VII Date/Time Prepared: 2/25/2017 1:17 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	1,860,279		1.00
2.00	Medical and other services		1,257,180	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	1,860,279	1,257,180	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)	1,860,279	1,257,180	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	302,761		8.00
9.00	Ancillary service charges	4,091,693	5,500,174	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)	4,394,454	5,500,174	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)	4,394,454	5,500,174	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	2,534,175	4,242,994	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)	1,860,279	1,257,180	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)	1,860,279	1,257,180	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)	1,860,279	1,257,180	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)	1,860,279	1,257,180	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	1,860,279	1,257,180	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)	1,860,279	1,257,180	40.00
41.00	Interim payments	1,047,868	1,876,109	41.00
42.00	Balance due provider/program (line 40 minus line 41)	812,411	-618,929	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: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G | Date/Time Prepared: 2/25/2017 1:17 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	19,759,597	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	15,051,045	0	0	0	4.00
5.00	Other receivable	1,313,654	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,523,994	0	0	0	7.00
8.00	Prepaid expenses	832,787	0	0	0	8.00
9.00	Other current assets	470,636	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)	39,951,713	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,479,295	0	0	0	12.00
13.00	Land improvements	7,112,479	0	0	0	13.00
14.00	Accumulated depreciation	-5,933,627	0	0	0	14.00
15.00	Buildings	43,662,581	0	0	0	15.00
16.00	Accumulated depreciation	-27,404,803	0	0	0	16.00
17.00	Leasehold improvements	21,287,367	0	0	0	17.00
18.00	Accumulated depreciation	-11,434,370	0	0	0	18.00
19.00	Fixed equipment	1,330,764	0	0	0	19.00
20.00	Accumulated depreciation	-176,766	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	69,055,086	0	0	0	23.00
24.00	Accumulated depreciation	-56,621,495	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	1,592,751	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	44,949,262	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	55,750,709	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	3,158,755	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	58,909,464	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	143,810,439	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	5,916,849	0	0	0	37.00
38.00	Salaries, wages, and fees payable	6,498,749	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,652,094	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	7,864,266	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)	22,931,958	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,862,146	0	0	0	47.00
48.00	Unsecured loans	3,602,078	0	0	0	48.00
49.00	Other long term liabilities	6,323,653	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	17,787,877	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	40,719,835	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	103,090,604				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)	103,090,604	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	143,810,439	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-1 | Date/Time Prepared: 2/25/2017 1:17 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		93,538,827		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		8,760,593				2.00
3.00	Total (sum of line 1 and line 2)		102,299,420		0		3.00
4.00	TRANSFER FROM FOUNDATION	512,334		0		0	4.00
5.00	UNREALIZED GAINS ON INVESTMENTS	2,087,376		0		0	5.00
6.00	FOUNDATION CONSOLIDATION	120,608		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)		2,720,318		0		10.00
11.00	Subtotal (line 3 plus line 10)		105,019,738		0		11.00
12.00	CHANGE IN MINIMUM PENSION LIABILITY	1,897,197		0		0	12.00
13.00	ASSETS RELEASED FROM RESTRICTION	31,937		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)		1,929,134		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		103,090,604		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	TRANSFER FROM FOUNDATION		0			4.00
5.00	UNREALIZED GAINS ON INVESTMENTS		0			5.00
6.00	FOUNDATION CONSOLIDATION		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 MINIMUM PENSION LIABILITY		0			12.00
13.00	ASSETS RELEASED FROM RESTRICTION		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: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/25/2017 1:17 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,587,870		5,587,870	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	1,368,985		1,368,985	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)	6,956,855		6,956,855	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,586,122		1,586,122	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)	1,586,122		1,586,122	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8,542,977		8,542,977	17.00
18.00	Ancillary services	133,336,153	144,804,214	278,140,367	18.00
19.00	Outpatient services	839,987	3,152,513	3,992,500	19.00
20.00	RURAL HEALTH CLINIC	0	545,071	545,071	20.00
20.01	RURAL HEALTH CLINIC II	0	565,200	565,200	20.01
20.02	RURAL HEALTH CLINIC III	0	1,229,295	1,229,295	20.02
20.03	RURAL HEALTH CLINIC IV	0	930,259	930,259	20.03
20.04	RURAL HEALTH CLINIC V	0	930,259	930,259	20.04
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,237,683	1,237,683	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	3,681,846	6,719,444	10,401,290	27.00
27.01	PHYSICIAN REVENUE - NRCC	0	12,692,690	12,692,690	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	146,400,963	172,806,628	319,207,591	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		122,066,026		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)		122,066,026		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 26-0025	Period: From 10/01/2015 To 09/30/2016	Worksheet G-3 Date/Time Prepared: 2/25/2017 1:17 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	319,207,591	1.00
2.00	Less contractual allowances and discounts on patients' accounts	194,777,766	2.00
3.00	Net patient revenues (line 1 minus line 2)	124,429,825	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	122,066,026	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,363,799	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	2,626,793	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	588,945	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	1,166	17.00
18.00	Revenue from sale of medical records and abstracts	39,001	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	307,327	22.00
23.00	Governmental appropriations	0	23.00
24.00	DAYCARE INCOME	730,696	24.00
24.01	CONTRACTED SERVICES	259,044	24.01
24.02	OTHER OPERATING REVENUE	305,939	24.02
24.03	EHR MEANINGFUL USE	1,269,556	24.03
24.04	GAIN ON SALE OF ASSETS	268,327	24.04
25.00	Total other income (sum of lines 6-24)	6,396,794	25.00
26.00	Total (line 5 plus line 25)	8,760,593	26.00
27.00		0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	8,760,593	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 26-0025 | HHA CCN: 26-7282 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H | Date/Time Prepared: 2/25/2017 1:17 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		2,382	2,382	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	1,125	1,125	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	167,199	21,770	0	0	98,541	287,510	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	413,585	53,850	0	0	4,609	472,044	6.00
7.00	Physical Therapy	189,948	24,732	0	1,238	0	215,918	7.00
8.00	Occupational Therapy	6,188	806	0	0	691	7,685	8.00
9.00	Speech Pathology	23,626	3,076	0	0	871	27,573	9.00
10.00	Medical Social Services	2,401	313	0	0	0	2,714	10.00
11.00	Home Health Aide	49,219	6,408	0	0	0	55,627	11.00
12.00	Supplies (see instructions)	0	0	0	0	485	485	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
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	852,166	110,955	0	1,238	108,704	1,073,063	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	2,382	0	2,382			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	1,125	0	1,125			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	287,510	0	287,510			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	472,044	0	472,044			6.00
7.00	Physical Therapy	0	215,918	0	215,918			7.00
8.00	Occupational Therapy	0	7,685	0	7,685			8.00
9.00	Speech Pathology	0	27,573	0	27,573			9.00
10.00	Medical Social Services	0	2,714	0	2,714			10.00
11.00	Home Health Aide	0	55,627	0	55,627			11.00
12.00	Supplies (see instructions)	0	485	0	485			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
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	0	1,073,063	0	1,073,063			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: 26-0025 | HHA CCN: 26-7282 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-1 Part I | Date/Time Prepared: 2/25/2017 1:17 pm

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	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	2,382	2,382				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	1,125	0	0	1,125		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	287,510	2,382	0	1,125	0	291,017	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	472,044	0	0	0	0	472,044	6.00
7.00	Physical Therapy	215,918	0	0	0	0	215,918	7.00
8.00	Occupational Therapy	7,685	0	0	0	0	7,685	8.00
9.00	Speech Pathology	27,573	0	0	0	0	27,573	9.00
10.00	Medical Social Services	2,714	0	0	0	0	2,714	10.00
11.00	Home Health Aide	55,627	0	0	0	0	55,627	11.00
12.00	Supplies (see instructions)	485	0	0	0	0	485	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
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,073,063	2,382	0	1,125	0	1,073,063	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	291,017			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	175,658	647,702		6.00
7.00	Physical Therapy	80,348	296,266		7.00
8.00	Occupational Therapy	2,860	10,545		8.00
9.00	Speech Pathology	10,261	37,834		9.00
10.00	Medical Social Services	1,010	3,724		10.00
11.00	Home Health Aide	20,700	76,327		11.00
12.00	Supplies (see instructions)	180	665		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
23.50	Telemedicine	0	0		23.50
24.00	Total (sum of lines 1-23)		1,073,063		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 26-0025 | HHA CCN: 26-7282 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-1 Part II Date/Time Prepared: 2/25/2017 1:17 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	-291,017	782,046	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	472,044	6.00
7.00	Physical Therapy	0	0	0	0	0	215,918	7.00
8.00	Occupational Therapy	0	0	0	0	0	7,685	8.00
9.00	Speech Pathology	0	0	0	0	0	27,573	9.00
10.00	Medical Social Services	0	0	0	0	0	2,714	10.00
11.00	Home Health Aide	0	0	0	0	0	55,627	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	485	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
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	650	0	650	0	-291,017	782,046	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	2,382	0	1,125	0		291,017	25.00
26.00	Unit Cost Multiplier	3.664615	0.000000	1.730769	0.000000		0.372123	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 26-0025 | HHA CCN: 26-7282 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-2 Part I | Date/Time Prepared: 2/25/2017 1:17 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	23,730	3,999	39,585	67,314	23,727	1.00
2.00	Skilled Nursing Care	647,702	0	0	97,918	745,620	262,818	2.00
3.00	Physical Therapy	296,266	0	0	44,971	341,237	120,280	3.00
4.00	Occupational Therapy	10,545	0	0	1,465	12,010	4,233	4.00
5.00	Speech Pathology	37,834	0	0	5,594	43,428	15,308	5.00
6.00	Medical Social Services	3,724	0	0	568	4,292	1,513	6.00
7.00	Home Health Aide	76,327	0	0	11,653	87,980	31,011	7.00
8.00	Supplies (see instructions)	665	0	0	0	665	234	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
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,073,063	23,730	3,999	201,754	1,302,546	459,124	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	7,197	49,656	0	23,893	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
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	7,197	49,656	0	23,893	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: 26-0025 HHA CCN: 26-7282 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-2 Part I Date/Time Prepared: 2/25/2017 1:17 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	89,183	0	0	0	260,970	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	1,008,438	0	2.00
3.00	Physical Therapy	0	0	0	0	461,517	0	3.00
4.00	Occupational Therapy	0	0	0	0	16,243	0	4.00
5.00	Speech Pathology	0	0	0	0	58,736	0	5.00
6.00	Medical Social Services	0	0	0	0	5,805	0	6.00
7.00	Home Health Aide	0	0	0	0	118,991	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	899	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
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	89,183	0	0	0	1,931,599	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	260,970						1.00
2.00	Skilled Nursing Care	1,008,438	157,529	1,165,967				2.00
3.00	Physical Therapy	461,517	72,094	533,611				3.00
4.00	Occupational Therapy	16,243	2,537	18,780				4.00
5.00	Speech Pathology	58,736	9,175	67,911				5.00
6.00	Medical Social Services	5,805	907	6,712				6.00
7.00	Home Health Aide	118,991	18,588	137,579				7.00
8.00	Supplies (see instructions)	899	140	1,039				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
19.50	Telemedicine	0	0	0				19.50
20.00	Total (sum of lines 1-19) (2)	1,931,599	260,970	1,931,599				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.		0.156211					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: 26-0025 | HHA CCN: 26-7282 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-2 Part II | Date/Time Prepared: 2/25/2017 1:17 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 SALARIES)	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	3,069	167,199	0	67,314	3,000	1.00
2.00	Skilled Nursing Care	0	0	413,585	0	745,620	0	2.00
3.00	Physical Therapy	0	0	189,948	0	341,237	0	3.00
4.00	Occupational Therapy	0	0	6,188	0	12,010	0	4.00
5.00	Speech Pathology	0	0	23,626	0	43,428	0	5.00
6.00	Medical Social Services	0	0	2,401	0	4,292	0	6.00
7.00	Home Health Aide	0	0	49,219	0	87,980	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	665	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
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	3,000	3,069	852,166		1,302,546	3,000	20.00
21.00	Total cost to be allocated	23,730	3,999	201,754		459,124	7,197	21.00
22.00	Unit cost multiplier	7.910000	1.303030	0.236754		0.352482	2.399000	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 NRS ING)	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	3,000	0	3,000	0	0	22,759	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
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	3,000	0	3,000	0	0	22,759	20.00
21.00	Total cost to be allocated	49,656	0	23,893	0	0	89,183	21.00
22.00	Unit cost multiplier	16.552000	0.000000	7.964333	0.000000	0.000000	3.918582	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 26-0025
HHA CCN: 26-7282

Period: From 10/01/2015 To 09/30/2016

Worksheet H-2 Part II
Date/Time Prepared: 2/25/2017 1:17 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
19.50	Telemedicine	0	0	0			19.50
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: 26-0025 | HHA CCN: 26-7282 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-3 Part I | Date/Time Prepared: 2/25/2017 1:17 pm

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	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	1,165,967		1,165,967	3,941	295.86	1.00
2.00	Physical Therapy	3.00	533,611	0	533,611	2,026	263.38	2.00
3.00	Occupational Therapy	4.00	18,780	0	18,780	66	284.55	3.00
4.00	Speech Pathology	5.00	67,911	0	67,911	252	269.49	4.00
5.00	Medical Social Services	6.00	6,712		6,712	22	305.09	5.00
6.00	Home Health Aide	7.00	137,579		137,579	234	587.94	6.00
7.00	Total (sum of lines 1-6)		1,930,560	0	1,930,560	6,541		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	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	1,333			8.00
8.01	Skilled Nursing Care		99914	0	260			8.01
8.02	Skilled Nursing Care		50089	0	487			8.02
9.00	Physical Therapy		99926	0	929			9.00
9.01	Physical Therapy		99914	0	204			9.01
9.02	Physical Therapy		50089	0	293			9.02
10.00	Occupational Therapy		99926	0	156			10.00
10.01	Occupational Therapy		99914	0	10			10.01
10.02	Occupational Therapy		50089	0	36			10.02
11.00	Speech Pathology		99926	0	28			11.00
11.01	Speech Pathology		99914	0	0			11.01
11.02	Speech Pathology		50089	0	10			11.02
12.00	Medical Social Services		99926	0	13			12.00
12.01	Medical Social Services		99914	0	0			12.01
12.02	Medical Social Services		50089	0	4			12.02
13.00	Home Health Aide		99926	0	155			13.00
13.01	Home Health Aide		99914	0	5			13.01
13.02	Home Health Aide		50089	0	45			13.02
14.00	Total (sum of lines 8-13)			0	3,968			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 Records)	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	1,039	4,818	5,857	40,574	0.144354	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	2,080		0	615,389		1.00
2.00	Physical Therapy	0	1,426		0	375,580		2.00
3.00	Occupational Therapy	0	202		0	57,479		3.00
4.00	Speech Pathology	0	38		0	10,241		4.00
5.00	Medical Social Services	0	17		0	5,187		5.00
6.00	Home Health Aide	0	205		0	120,528		6.00
7.00	Total (sum of lines 1-6)	0	3,968		0	1,184,404		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 26-0025 | HHA CCN: 26-7282 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-3 Part I | Date/Time Prepared: 2/25/2017 1:17 pm

Title XVIII | Home Health Agency I | PPS

	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

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		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	25,404	0	0	3,667	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	615,389						1.00
2.00	Physical Therapy	375,580						2.00
3.00	Occupational Therapy	57,479						3.00
4.00	Speech Pathology	10,241						4.00
5.00	Medical Social Services	5,187						5.00
6.00	Home Health Aide	120,528						6.00
7.00	Total (sum of lines 1-6)	1,184,404						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: 26-0025 | HHA CCN: 26-7282 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-3 Part II | Date/Time Prepared: 2/25/2017 1:17 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	1.017359	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.606095	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	1.135656	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.118747	40,574	4,818	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.151105	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 26-0025 | HHA CCN: 26-7282 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-4 Part I-II | Date/Time Prepared: 2/25/2017 1:17 pm

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	703,317	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	4,948	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	16,524	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	4,063	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	2,248	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	731,100	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	731,100	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	731,100	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	731,100	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	731,100	31.00
31.01	Sequestration adjustment (see instructions)	0	14,623	31.01
32.00	Interim payments (see instructions)	0	716,477	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 HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 26-0025 | HHA CCN: 26-7282 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-5 | Date/Time Prepared: 2/25/2017 1:17 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		716,477	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		716,477	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		716,477	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: 26-0025	Period: From 10/01/2015 To 09/30/2016	Worksheet L Parts I-III Date/Time Prepared: 2/25/2017 1:17 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,320,689	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	65,184	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)	38.94	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)	1,385,873	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

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 26-0025 Component CCN: 26-T025	Period: From 10/01/2015 To 09/30/2016	Worksheet L Parts I-III Date/Time Prepared: 2/25/2017 1:17 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	0	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	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)	0.00	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)	0	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 RHC/FQHC COSTS

Provider CCN: 26-0025 | Component CCN: 26-8512 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-1 | Date/Time Prepared: 2/25/2017 1:17 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	110,754	0	110,754	0	110,754	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	110,149	0	110,149	0	110,149	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)	220,903	0	220,903	0	220,903	10.00
11.00	Physician Services Under Agreement	0	161,629	161,629	0	161,629	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	12,079	12,079	0	12,079	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	173,708	173,708	0	173,708	14.00
15.00	Medical Supplies	0	8,474	8,474	0	8,474	15.00
16.00	Transportation (Health Care Staff)	0	195	195	0	195	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	8,669	8,669	0	8,669	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	220,903	182,377	403,280	0	403,280	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	15,166	15,166	0	15,166	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	15,166	15,166	0	15,166	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	7,368	7,368	0	7,368	29.00
30.00	Administrative Costs	114,817	119,059	233,876	0	233,876	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	114,817	126,427	241,244	0	241,244	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	335,720	323,970	659,690	0	659,690	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-1

Component CCN: 26-8512 | Date/Time Prepared: 2/25/2017 1:17 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	110,754		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	110,149		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	220,903		10.00
11.00	Physician Services Under Agreement	0	161,629		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	12,079		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	173,708		14.00
15.00	Medical Supplies	0	8,474		15.00
16.00	Transportation (Health Care Staff)	0	195		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	8,669		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	403,280		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	15,166		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	15,166		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	7,368		29.00
30.00	Administrative Costs	0	233,876		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	241,244		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	659,690		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Component CCN: 26-3984 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-1 | Date/Time Prepared: 2/25/2017 1:17 pm

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	185,142	0	185,142	0	185,142	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	139,503	0	139,503	0	139,503	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	95,756	0	95,756	0	95,756	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)	420,401	0	420,401	0	420,401	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	18,954	18,954	0	18,954	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	18,954	18,954	0	18,954	14.00
15.00	Medical Supplies	0	5,027	5,027	0	5,027	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						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	5,027	5,027	0	5,027	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	420,401	23,981	444,382	0	444,382	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	11,328	11,328	0	11,328	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	11,328	11,328	0	11,328	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	9,708	9,708	0	9,708	29.00
30.00	Administrative Costs	105,486	159,347	264,833	25,400	290,233	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	105,486	169,055	274,541	25,400	299,941	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	525,887	204,364	730,251	25,400	755,651	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-1

Component CCN: 26-3984 | Date/Time Prepared: 2/25/2017 1:17 pm

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	185,142		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	139,503		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	95,756		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	420,401		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	18,954		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	18,954		14.00
15.00	Medical Supplies	0	5,027		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				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	5,027		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	444,382		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	11,328		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	11,328		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	9,708		29.00
30.00	Administrative Costs	0	290,233		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	299,941		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	755,651		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Component CCN: 26-8513 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-1 | Date/Time Prepared: 2/25/2017 1:17 pm

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	234,823	0	234,823	0	234,823	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	109,355	0	109,355	0	109,355	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	109,277	0	109,277	0	109,277	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)	453,455	0	453,455	0	453,455	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	143	143	0	143	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	143	143	0	143	14.00
15.00	Medical Supplies	0	8,622	8,622	0	8,622	15.00
16.00	Transportation (Health Care Staff)	0	195	195	0	195	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	8,817	8,817	0	8,817	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	453,455	8,960	462,415	0	462,415	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	61,547	61,547	0	61,547	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	61,547	61,547	0	61,547	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	187	187	0	187	29.00
30.00	Administrative Costs	129,127	130,109	259,236	0	259,236	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	129,127	130,296	259,423	0	259,423	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	582,582	200,803	783,385	0	783,385	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-1

Component CCN: 26-8513 | Date/Time Prepared: 2/25/2017 1:17 pm

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	234,823		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	109,355		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	109,277		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	453,455		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	143		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	143		14.00
15.00	Medical Supplies	0	8,622		15.00
16.00	Transportation (Health Care Staff)	0	195		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	8,817		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	462,415		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	61,547		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	61,547		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	187		29.00
30.00	Administrative Costs	-50	259,186		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-50	259,373		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-50	783,335		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Component CCN: 26-8723 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-1 | Date/Time Prepared: 2/25/2017 1:17 pm

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	526,087	0	526,087	-263,044	263,043	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	40,000	0	40,000	76,701	116,701	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	108,451	0	108,451	0	108,451	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)	674,538	0	674,538	-186,343	488,195	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	29,973	29,973	0	29,973	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	29,973	29,973	0	29,973	14.00
15.00	Medical Supplies	0	24,049	24,049	0	24,049	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						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	24,049	24,049	0	24,049	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	674,538	54,022	728,560	-186,343	542,217	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	58,071	58,071	0	58,071	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	58,071	58,071	0	58,071	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	4,644	4,644	0	4,644	29.00
30.00	Administrative Costs	132,343	202,665	335,008	-59,350	275,658	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	132,343	207,309	339,652	-59,350	280,302	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	806,881	319,402	1,126,283	-245,693	880,590	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-1

Component CCN: 26-8723 | Date/Time Prepared: 2/25/2017 1:17 pm

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	263,043		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	116,701		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	108,451		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	488,195		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	29,973		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	29,973		14.00
15.00	Medical Supplies	0	24,049		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				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	24,049		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	542,217		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	58,071		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	58,071		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	4,644		29.00
30.00	Administrative Costs	0	275,658		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	280,302		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	880,590		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Component CCN: 26-8724 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-1 | Date/Time Prepared: 2/25/2017 1:17 pm

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	263,044	263,044	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	193,402	0	193,402	-76,701	116,701	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	88,899	0	88,899	0	88,899	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)	282,301	0	282,301	186,343	468,644	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	27,040	27,040	0	27,040	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	27,040	27,040	0	27,040	14.00
15.00	Medical Supplies	0	4,564	4,564	0	4,564	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						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	4,564	4,564	0	4,564	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	282,301	31,604	313,905	186,343	500,248	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	609	609	0	609	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	609	609	0	609	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	5,474	5,474	0	5,474	29.00
30.00	Administrative Costs	158,359	123,880	282,239	59,350	341,589	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	158,359	129,354	287,713	59,350	347,063	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	440,660	161,567	602,227	245,693	847,920	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-1

Component CCN: 26-8724 | Date/Time Prepared: 2/25/2017 1:17 pm

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	263,044		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	116,701		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	88,899		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	468,644		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	27,040		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	27,040		14.00
15.00	Medical Supplies	0	4,564		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				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	4,564		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	500,248		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	609		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	609		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	5,474		29.00
30.00	Administrative Costs	0	341,589		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	347,063		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	847,920		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025 | Component CCN: 26-8512 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-2 | Date/Time Prepared: 2/25/2017 1:17 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.68	1,805	4,200	2,856		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.93	1,853	2,100	1,953		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.61	3,658		4,809	4,809	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)	1.61	3,658			4,809	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					403,280	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					15,166	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					418,446	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.963756	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					241,244	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					353,789	15.00
16.00	Total overhead (sum of lines 14 and 15)					595,033	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					595,033	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					573,467	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					976,747	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025 | Component CCN: 26-3984 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-2 | Date/Time Prepared: 2/25/2017 1:17 pm

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	0.73	745	4,200	3,066		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.86	2,302	2,100	1,806		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.59	3,047		4,872	4,872	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)	1.59	3,047			4,872	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					444,382	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					11,328	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					455,710	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.975142	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					299,941	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					488,327	15.00
16.00	Total overhead (sum of lines 14 and 15)					788,268	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					788,268	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					768,673	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,213,055	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025 | Component CCN: 26-8513 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-2 | Date/Time Prepared: 2/25/2017 1:17 pm

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	0.86	3,118	4,200	3,612		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.86	2,360	2,100	1,806		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.72	5,478		5,418	5,478	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)	1.72	5,478			5,478	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					462,415	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					61,547	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					523,962	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.882535	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					259,373	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					678,909	15.00
16.00	Total overhead (sum of lines 14 and 15)					938,282	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					938,282	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					828,067	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,290,482	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025 | Component CCN: 26-8723 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-2 | Date/Time Prepared: 2/25/2017 1:17 pm

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	0.85	3,263	4,200	3,570		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.91	3,583	2,100	1,911		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.76	6,846		5,481	6,846	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)	1.76	6,846			6,846	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					542,217	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					58,071	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					600,288	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.903261	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					280,302	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					596,968	15.00
16.00	Total overhead (sum of lines 14 and 15)					877,270	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					877,270	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					792,404	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,334,621	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025 | Component CCN: 26-8724 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-2 | Date/Time Prepared: 2/25/2017 1:17 pm

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	0.85	3,475	4,200	3,570		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.91	3,165	2,100	1,911		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.76	6,640		5,481	6,640	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)	1.76	6,640			6,640	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					500,248	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					609	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					500,857	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.998784	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					347,063	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					498,757	15.00
16.00	Total overhead (sum of lines 14 and 15)					845,820	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					845,820	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					844,791	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,345,039	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 26-0025 Component CCN: 26-8512	Period: From 10/01/2015 To 09/30/2016	Worksheet M-3 Date/Time Prepared: 2/25/2017 1:17 pm
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			976,747	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			12,480	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			964,267	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,809	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)			4,809	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			200.51	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)	80.44	81.32		8.00
9.00	Rate for Program covered visits (see instructions)	80.44	81.32		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	712		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	57,900		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)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	57,900		16.00
16.01	Total program charges (see instructions)(from contractor's records)		76,947		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		390		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		293		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.)		34,648		16.04
16.05	Total program cost (see instructions)	0	34,941		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		14,297		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		12,454		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		34,941		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		7,477		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		42,418		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)		42,418		26.00
26.01	Sequestration adjustment (see instructions)		848		26.01
27.00	Interim payments		33,371		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)		8,199		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 HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 26-0025 Component CCN: 26-3984	Period: From 10/01/2015 To 09/30/2016	Worksheet M-3 Date/Time Prepared: 2/25/2017 1:17 pm
	Title XVIII	RHC II	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,213,055	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			15,751	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,197,304	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,872	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)			4,872	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			245.75	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)	80.44	81.32		8.00
9.00	Rate for Program covered visits (see instructions)	80.44	81.32		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	840		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	68,309		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)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	68,309		16.00
16.01	Total program charges (see instructions)(from contractor's records)		102,776		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		125		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		83		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.)		41,933		16.04
16.05	Total program cost (see instructions)	0	42,016		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		15,810		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		17,368		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		42,016		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		8,496		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		50,512		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)		50,512		26.00
26.01	Sequestration adjustment (see instructions)		1,010		26.01
27.00	Interim payments		40,140		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)		9,362		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 HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 26-0025 Component CCN: 26-8513	Period: From 10/01/2015 To 09/30/2016	Worksheet M-3 Date/Time Prepared: 2/25/2017 1:17 pm
	Title XVIII	RHC III	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,290,482	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			53,786	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,236,696	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			5,478	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)			5,478	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			225.76	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)	80.44	81.32		8.00
9.00	Rate for Program covered visits (see instructions)	80.44	81.32		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,689		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	137,349		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)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	137,349		16.00
16.01	Total program charges (see instructions)(from contractor's records)		227,097		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,351		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		817		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.)		88,775		16.04
16.05	Total program cost (see instructions)	0	89,592		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		25,563		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		40,045		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		89,592		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		33,073		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		122,665		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)		122,665		26.00
26.01	Sequestration adjustment (see instructions)		2,453		26.01
27.00	Interim payments		85,649		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)		34,563		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 HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 26-0025 Component CCN: 26-8723	Period: From 10/01/2015 To 09/30/2016	Worksheet M-3 Date/Time Prepared: 2/25/2017 1:17 pm
	Title XVIII	RHC IV	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,334,621	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		29,355	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,305,266	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		6,846	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)		6,846	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		190.66	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)	80.44	81.32	8.00
9.00	Rate for Program covered visits (see instructions)	80.44	81.32	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,055	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	167,113	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)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	167,113	16.00
16.01	Total program charges (see instructions)(from contractor's records)		228,905	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		90	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		66	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.)		109,435	16.04
16.05	Total program cost (see instructions)	0	109,501	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		30,253	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		39,712	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		109,501	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		20,408	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		129,909	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)		129,909	26.00
26.01	Sequestration adjustment (see instructions)		2,598	26.01
27.00	Interim payments		105,279	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)		22,032	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 HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 26-0025 Component CCN: 26-8724	Period: From 10/01/2015 To 09/30/2016	Worksheet M-3 Date/Time Prepared: 2/25/2017 1:17 pm
	Title XVIII	RHC V	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,345,039	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			30,176	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,314,863	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			6,640	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)			6,640	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			198.02	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)	80.44	81.32		8.00
9.00	Rate for Program covered visits (see instructions)	80.44	81.32		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,670		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	135,804		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)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	135,804		16.00
16.01	Total program charges (see instructions)(from contractor's records)		189,461		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		500		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		358		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.)		87,742		16.04
16.05	Total program cost (see instructions)	0	88,100		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		25,769		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		32,658		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		88,100		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		16,273		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		104,373		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)		104,373		26.00
26.01	Sequestration adjustment (see instructions)		2,087		26.01
27.00	Interim payments		84,643		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)		17,643		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 26-0025 Component CCN: 26-8512	Period: From 10/01/2015 To 09/30/2016	Worksheet M-4 Date/Time Prepared: 2/25/2017 1:17 pm
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	220,903	220,903	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000199	0.007864	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	44	1,737	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	625	2,747	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	669	4,484	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	403,280	403,280	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	573,467	573,467	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001659	0.011119	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	951	6,376	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,620	10,860	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	4	158	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	405.00	68.73	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	2	97	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	810	6,667	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)		12,480	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		7,477	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 26-0025 | Component CCN: 26-3984 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-4 | Date/Time Prepared: 2/25/2017 1:17 pm

Title XVIII | RHC II | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	420,401	420,401	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000202	0.007160	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	85	3,010	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	313	2,362	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	398	5,372	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	444,382	444,382	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	768,673	768,673	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000896	0.012089	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	689	9,292	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,087	14,664	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	4	142	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	271.75	103.27	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	2	77	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	544	7,952	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)		15,751	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)		8,496	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 26-0025 Component CCN: 26-8513	Period: From 10/01/2015 To 09/30/2016	Worksheet M-4 Date/Time Prepared: 2/25/2017 1:17 pm
	Title XVIII	RHC III	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	453,455	453,455	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001817	0.015190	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	824	6,888	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	6,095	5,466	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	6,919	12,354	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	462,415	462,415	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	828,067	828,067	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.014963	0.026716	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	12,390	22,123	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	19,309	34,477	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	39	326	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	495.10	105.76	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	26	191	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	12,873	20,200	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)		53,786	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)		33,073	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 26-0025 Component CCN: 26-8723	Period: From 10/01/2015 To 09/30/2016	Worksheet M-4 Date/Time Prepared: 2/25/2017 1:17 pm
	Title XVIII	RHC IV	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	488,195	488,195	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000410	0.011974	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	200	5,846	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,406	4,474	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,606	10,320	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	542,217	542,217	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	792,404	792,404	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002962	0.019033	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	2,347	15,082	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	3,953	25,402	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	9	263	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	439.22	96.59	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	6	184	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	2,635	17,773	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)		29,355	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)		20,408	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 26-0025 Component CCN: 26-8724	Period: From 10/01/2015 To 09/30/2016	Worksheet M-4 Date/Time Prepared: 2/25/2017 1:17 pm
	Title XVIII	RHC V	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	468,644	468,644	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000846	0.010053	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	396	4,711	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	2,657	3,459	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	3,053	8,170	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	500,248	500,248	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	844,791	844,791	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.006103	0.016332	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	5,156	13,797	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	8,209	21,967	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	17	202	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	482.88	108.75	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	6	123	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	2,897	13,376	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		30,176	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)		16,273	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 26-0025 Component CCN: 26-8512	Period: From 10/01/2015 To 09/30/2016	Worksheet M-5 Date/Time Prepared: 2/25/2017 1:17 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		33,371	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)		33,371	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		8,199	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		41,570	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: 26-0025 Component CCN: 26-3984	Period: From 10/01/2015 To 09/30/2016	Worksheet M-5 Date/Time Prepared: 2/25/2017 1:17 pm
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		40,140	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)		40,140	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		9,362	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		49,502	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: 26-0025 Component CCN: 26-8513	Period: From 10/01/2015 To 09/30/2016	Worksheet M-5 Date/Time Prepared: 2/25/2017 1:17 pm
		RHC III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		85,649	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)		85,649	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		34,563	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		120,212	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: 26-0025 Component CCN: 26-8723	Period: From 10/01/2015 To 09/30/2016	Worksheet M-5 Date/Time Prepared: 2/25/2017 1:17 pm
		RHC IV	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		105,279	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)		105,279	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		22,032	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		127,311	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: 26-0025 Component CCN: 26-8724	Period: From 10/01/2015 To 09/30/2016	Worksheet M-5 Date/Time Prepared: 2/25/2017 1:17 pm
		RHC V	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		84,643	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)		84,643	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		17,643	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		102,286	7.00

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