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 10/01/2016 To 09/30/2017	Worksheet S Parts I-III Date/Time Prepared: 2/27/2018 10:22 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/27/2018 Time: 10:22 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 CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HANNIBAL REGIONAL HOSPITAL (26-0025) for the cost reporting period beginning 10/01/2016 and ending 09/30/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-278,845	27,336	0	2,623,810	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		17,568		0	10.00
10.01	RURAL HEALTH CLINIC II	0		12,832		0	10.01
10.02	RURAL HEALTH CLINIC III	0		86,495		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		23,900		0	10.03
10.04	RURAL HEALTH CLINIC V	0		12,102		0	10.04
10.05	RURAL HEALTH CLINIC VI	0		0		0	10.05
10.06	RURAL HEALTH CLINIC VII	0		0		0	10.06
10.07	RURAL HEALTH CLINIC VIII	0		0		0	10.07
10.08	RURAL HEALTH CLINIC IX	0		3,669		0	10.08
200.00	Total	0	-278,845	183,902	0	2,623,810	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/27/2018 10:15 am

	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
15.05	Hospital-Based Health Clinic - RHC VI	HANNIBAL REG - LA PLATA	268756	99926		07/03/2017	N	O	O	15.05
15.06	Hospital-Based Health Clinic - RHC VII	HANNIBAL REG - LANCASTER	268757	99926		07/03/2017	N	O	O	15.06
15.07	Hospital-Based Health Clinic - RHC VIII	HANNIBAL REG - KIRKSVILLE	268758	99926		07/03/2017	N	O	O	15.07
15.08	Hospital-Based Health Clinic - RHC IX	HANNIBAL REG - HRMG 2ND FLOOR	268754	99926		07/24/2017	N	O	O	15.08
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)	10/01/2016	09/30/2017	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 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/27/2018 10:15 am

		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.	1,111	0	68	0	1,127	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		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.	10/01/2016	09/30/2017	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)(i) or (ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	Y	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2018 10:15 am

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				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. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2018 10:15 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 26-0025	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part I Date/Time Prepared: 2/27/2018 10:15 am

		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
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06
	Rural Providers			
105.00	Does this hospital qualify as a 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 Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/27/2018 10:15 am

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

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	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:	240,193	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/27/2018 10:15 am

	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

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

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2016	09/30/2017	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 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 2/27/2018 10:15 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	01/25/2018	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.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	01/29/2018	Y	01/29/2018	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 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II Date/Time Prepared: 2/27/2018 10:15 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		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 10/01/2016 To 09/30/2017	Worksheet S-2 Part II Date/Time Prepared: 2/27/2018 10:15 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 2/27/2018 10:15 am

	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	28,470	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	28,470	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		86	31,390	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	4,745		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
26.05	RURAL HEALTH CLINIC VI	88.05				0	26.05
26.06	RURAL HEALTH CLINIC VII	88.06				0	26.06
26.07	RURAL HEALTH CLINIC VIII	88.07				0	26.07
26.08	RURAL HEALTH CLINIC IX	88.08				0	26.08
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
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 2/27/2018 10:15 am

	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)	7,397	835	12,478			1.00
2.00	HMO and other (see instructions)	1,115	1,127				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)	7,397	835	12,478			7.00
8.00	INTENSIVE CARE UNIT	1,000	204	1,886			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		122	1,164			13.00
14.00	Total (see instructions)	8,397	1,161	15,528	0.00	816.72	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	1,696	0	2,156	0.00	11.85	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	4,631	371	9,241	0.00	15.05	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	753	110	3,629	0.00	6.97	26.00
26.01	RURAL HEALTH CLINIC II	910	280	3,330	0.00	6.96	26.01
26.02	RURAL HEALTH CLINIC III	1,613	193	4,847	0.00	7.80	26.02
26.03	RURAL HEALTH CLINIC IV	2,298	522	8,030	0.00	8.64	26.03
26.04	RURAL HEALTH CLINIC V	1,434	307	6,084	0.00	8.37	26.04
26.05	RURAL HEALTH CLINIC VI	0	30	309	0.00	0.81	26.05
26.06	RURAL HEALTH CLINIC VII	0	9	505	0.00	0.92	26.06
26.07	RURAL HEALTH CLINIC VIII	0	85	681	0.00	0.70	26.07
26.08	RURAL HEALTH CLINIC IX	415	193	3,416	0.00	6.23	26.08
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	891.02	27.00
28.00	Observation Bed Days		0	954			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	18	171			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 2/27/2018 10:15 am

	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	2,045	260	4,159	1.00
2.00	HMO and other (see instructions)			250	304		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	2,045	260	4,159	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	164	0	206	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
26.05	RURAL HEALTH CLINIC VI	0.00					26.05
26.06	RURAL HEALTH CLINIC VII	0.00					26.06
26.07	RURAL HEALTH CLINIC VIII	0.00					26.07
26.08	RURAL HEALTH CLINIC IX	0.00					26.08
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part II Date/Time Prepared: 2/27/2018 10:15 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. 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	64,732,626	0	64,732,626	1,853,315.90	34.93	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		346,721	0	346,721	2,011.00	172.41	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		6,126,998	0	6,126,998	36,786.00	166.56	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		1,334,486	0	1,334,486	88,063.00	15.15	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)		19,716,249	-1,107,870	18,608,379	334,267.95	55.67	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,610,462	0	2,610,462	32,270.96	80.89	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		404,471	0	404,471	2,754.40	146.85	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)		14,916,722	0	14,916,722			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		4,754,820	0	4,754,820			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		32,331	0	32,331			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		909,259	0	909,259			23.00
24.00	Wage-related costs (RHC/FQHC)		757,708	0	757,708			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	527,661	327,187	854,848	38,796.05	22.03	26.00
27.00	Administrative & General	5.00	11,808,230	89,284	11,897,514	386,523.00	30.78	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part II Date/Time Prepared: 2/27/2018 10:15 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. 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.)		486,741	0	486,741	2,410.84	201.90	28.00
29.00	Maintenance & Repairs	6.00	376,337	0	376,337	22,129.00	17.01	29.00
30.00	Operation of Plant	7.00	757,207	0	757,207	32,436.00	23.34	30.00
31.00	Laundry & Linen Service	8.00	30,019	0	30,019	3,041.00	9.87	31.00
32.00	Housekeeping	9.00	612,017	0	612,017	48,622.00	12.59	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	863,072	0	863,072	56,533.00	15.27	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	1,000,955	0	1,000,955	28,903.00	34.63	38.00
39.00	Central Services and Supply	14.00	151,816	0	151,816	9,103.00	16.68	39.00
40.00	Pharmacy	15.00	1,759,767	-1,759,767	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	914,641	0	914,641	45,892.00	19.93	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 10/01/2016 To 09/30/2017 | Worksheet S-3 Part III Date/Time Prepared: 2/27/2018 10:15 am

		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)		57,757,883	0	57,757,883	1,730,877.74	33.37	1.00
2.00	Excluded area salaries (see instructions)		19,716,249	-1,107,870	18,608,379	334,267.95	55.67	2.00
3.00	Subtotal salaries (line 1 minus line 2)		38,041,634	1,107,870	39,149,504	1,396,609.79	28.03	3.00
4.00	Subtotal other wages & related costs (see inst.)		3,014,933	0	3,014,933	35,025.36	86.08	4.00
5.00	Subtotal wage-related costs (see inst.)		14,949,053	0	14,949,053	0.00	38.18	5.00
6.00	Total (sum of lines 3 thru 5)		56,005,620	1,107,870	57,113,490	1,431,635.15	39.89	6.00
7.00	Total overhead cost (see instructions)		19,288,463	-1,343,296	17,945,167	674,388.89	26.61	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part IV Date/Time Prepared: 2/27/2018 10:15 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	2,535,871	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	1,662,016	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	554,798	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	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)	11,363,110	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	-829	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	86,821	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)	136,168	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	23,317	14.00
15.00	'Workers' Compensation Insurance	559,450	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	3,994,217	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	29,163	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))	307,985	21.00
22.00	Day Care Cost and Allowances	72,217	22.00
23.00	Tuition Reimbursement	46,537	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	21,370,841	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 10/01/2016 To 09/30/2017 | Worksheet S-3 Part V Date/Time Prepared: 2/27/2018 10:15 am

	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	2,610,462	21,370,841	1.00
2.00	Hospital	2,610,462	21,370,841	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	0	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
14.05	Hospital-Based Health Clinic RHC 5	0	0	14.05
14.06	Hospital-Based Health Clinic RHC 6	0	0	14.06
14.07	Hospital-Based Health Clinic RHC 7	0	0	14.07
14.08	Hospital-Based Health Clinic RHC 8	0	0	14.08
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 10/01/2016 To 09/30/2017 | Worksheet S-4 | Date/Time Prepared: 2/27/2018 10:15 am

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	2,337	66	1,239	3,642	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	302.00	46.00	301.00	649.00	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		4.00	0.00	4.00	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		2.00	0.00	2.00	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.		2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		99926			20.00
20.01			99914			20.01

		Full Episodes					
		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	1,900	79	48	52	2,079	21.00
22.00	Skilled Nursing Visit Charges	416,725	17,380	10,560	11,440	456,105	22.00
23.00	Physical Therapy Visits	1,412	52	9	21	1,494	23.00
24.00	Physical Therapy Visit Charges	316,920	11,700	2,025	4,725	335,370	24.00
25.00	Occupational Therapy Visits	579	45	2	19	645	25.00
26.00	Occupational Therapy Visit Charges	130,175	10,125	450	4,275	145,025	26.00
27.00	Speech Pathology Visits	80	0	0	0	80	27.00
28.00	Speech Pathology Visit Charges	17,980	0	0	0	17,980	28.00
29.00	Medical Social Service Visits	13	1	0	1	15	29.00
30.00	Medical Social Service Visit Charges	2,905	225	0	225	3,355	30.00
31.00	Home Health Aide Visits	278	33	1	6	318	31.00
32.00	Home Health Aide Visit Charges	33,360	3,960	120	720	38,160	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,262	210	60	99	4,631	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)	918,065	43,390	13,155	21,385	995,995	35.00
36.00	Total Number of Episodes (standard/non outlier)	292		21	8	321	36.00
37.00	Total Number of Outlier Episodes		5		0	5	37.00
38.00	Total Non-Routine Medical Supply Charges	16,530	3,944	895	477	21,846	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 26-0025 | Component CCN: 26-8512 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-8 | Date/Time Prepared: 2/27/2018 10:15 am

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 10/01/2016
To 09/30/2017

Worksheet S-8

Date/Time Prepared:
2/27/2018 10:15 am

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 10/01/2016 To 09/30/2017 | Worksheet S-8 | Date/Time Prepared: 2/27/2018 10:15 am

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 10/01/2016
To 09/30/2017

Worksheet S-8

Date/Time Prepared:
2/27/2018 10:15 am

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 10/01/2016 To 09/30/2017 | Worksheet S-8 | Date/Time Prepared: 2/27/2018 10:15 am

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 10/01/2016
To 09/30/2017

Worksheet S-8

Date/Time Prepared:
2/27/2018 10:15 am

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 10/01/2016 To 09/30/2017 | Worksheet S-8 | Date/Time Prepared: 2/27/2018 10:15 am

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
					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 10/01/2016
To 09/30/2017

Worksheet S-8

Date/Time Prepared:
2/27/2018 10:15 am

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 10/01/2016 To 09/30/2017 | Worksheet S-8 | Date/Time Prepared: 2/27/2018 10:15 am

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 10/01/2016
To 09/30/2017

Worksheet S-8

Date/Time Prepared:
2/27/2018 10:15 am

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-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 26-0025 | Component CCN: 26-8756 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-8 | Date/Time Prepared: 2/27/2018 10:15 am

RHC VI | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			29934 JULY ROAD		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	LA PLATA		MO	63549	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		MACON				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: 26-8756

Period:
From 10/01/2016
To 09/30/2017

Worksheet S-8

Date/Time Prepared:
2/27/2018 10:15 am

RHC VI

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: 26-8757 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-8 | Date/Time Prepared: 2/27/2018 10:15 am

RHC VII | Cost

					1.00	
	Clinic Address and Identification					
1.00	Street			1000 WEST WASHINGTON STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	LANCASTER		MO	63548	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		SCHUYLER				2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 26-0025 Component CCN: 26-8757	Period: From 10/01/2016 To 09/30/2017	Worksheet S-8 Date/Time Prepared: 2/27/2018 10:15 am
		RHC VII	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: 26-8758 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-8 | Date/Time Prepared: 2/27/2018 10:15 am

RHC VIII | Cost

					1.00	
	Clinic Address and Identification					
1.00	Street			1611 SOUTH BALTIMORE STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	KIRKSVILLE		MO	63501	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		ADAIR				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: 26-8758

Period:
From 10/01/2016
To 09/30/2017

Worksheet S-8

Date/Time Prepared:
2/27/2018 10:15 am

RHC VIII

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: 26-8754 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-8 | Date/Time Prepared: 2/27/2018 10:15 am

RHC IX | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			6500 HOSPITAL DRIVE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	HANNIBAL		MO	63401	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		RALLS				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: 26-8754

Period:
From 10/01/2016
To 09/30/2017

Worksheet S-8
Date/Time Prepared:
2/27/2018 10:15 am

RHC IX

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 10/01/2016 To 09/30/2017 | Worksheet S-10 | Date/Time Prepared: 2/27/2018 10:15 am

		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)	0.286376	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,407,077	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1,524,239	5.00
6.00	Medicaid charges	40,625,216	6.00
7.00	Medicaid cost (line 1 times line 6)	11,634,087	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)	4,702,771	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	4,702,771	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	6,787,107	2,212,195	8,999,302	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,943,665	2,212,195	4,155,860	21.00
22.00	Payments received from patients for amounts previously written off as charity care	26,430	109,126	135,556	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,917,235	2,103,069	4,020,304	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	9,876,627	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	479,877	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	738,272	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	9,138,355	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,875,401	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	6,895,705	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	11,598,476	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/27/2018 10:15 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,573,530	2,573,530	48,552	2,622,082	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		5,169,989	5,169,989	-1,098,307	4,071,682	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	527,661	13,409,104	13,936,765	399,404	14,336,169	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,808,230	8,852,857	20,661,087	9,644	20,670,731	5.00
6.00	00600	MAINTENANCE & REPAIRS	376,337	69,362	445,699	0	445,699	6.00
7.00	00700	OPERATION OF PLANT	757,207	2,706,391	3,463,598	-437,052	3,026,546	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	30,019	275,068	305,087	0	305,087	8.00
9.00	00900	HOUSEKEEPING	612,017	215,811	827,828	437,052	1,264,880	9.00
10.00	01000	DIETARY	863,072	795,012	1,658,084	0	1,658,084	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,000,955	184,426	1,185,381	148,898	1,334,279	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	151,816	142,214	294,030	-6,808	287,222	14.00
15.00	01500	PHARMACY	1,759,767	665,270	2,425,037	-1,759,767	665,270	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	914,641	561,322	1,475,963	0	1,475,963	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,186,879	3,861,753	10,048,632	-8,175	10,040,457	30.00
31.00	03100	INTENSIVE CARE UNIT	1,680,317	391,301	2,071,618	0	2,071,618	31.00
41.00	04100	SUBPROVIDER - IRF	723,671	874,179	1,597,850	0	1,597,850	41.00
43.00	04300	NURSERY	213,283	118,246	331,529	1,623	333,152	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,299,186	2,074,090	3,373,276	-276,630	3,096,646	50.00
51.00	05100	RECOVERY ROOM	966,778	162,452	1,129,230	0	1,129,230	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	940,349	194,373	1,134,722	5,185	1,139,907	52.00
53.00	05300	ANESTHESIOLOGY	2,223,851	230,193	2,454,044	0	2,454,044	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,148,175	770,945	1,919,120	240,421	2,159,541	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	898,364	605,565	1,503,929	346,852	1,850,781	55.00
56.00	05600	RADIOISOTOPE	133,279	132,314	265,593	121,456	387,049	56.00
57.00	05700	CT SCAN	315,327	162,549	477,876	65,700	543,576	57.00
58.00	05800	MRI	81,467	140,492	221,959	155,376	377,335	58.00
59.00	05900	CARDIAC CATHETERIZATION	604,292	2,125,534	2,729,826	-1,009,740	1,720,086	59.00
60.00	06000	LABORATORY	2,156,200	2,512,531	4,668,731	25,292	4,694,023	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	90,347	467,311	557,658	0	557,658	62.00
64.00	06400	INTRAVENOUS THERAPY	282,243	57,242	339,485	0	339,485	64.00
65.00	06500	RESPIRATORY THERAPY	858,405	261,447	1,119,852	0	1,119,852	65.00
66.00	06600	PHYSICAL THERAPY	369,145	733,600	1,102,745	0	1,102,745	66.00
67.00	06700	OCCUPATIONAL THERAPY	55,019	399,881	454,900	0	454,900	67.00
68.00	06800	SPEECH PATHOLOGY	201,533	68,241	269,774	0	269,774	68.00
69.00	06900	ELECTROCARDIOLOGY	62,277	46,610	108,887	0	108,887	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	163,283	28,395	191,678	0	191,678	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,907,508	9,907,508	-1,971,548	7,935,960	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,257,918	3,257,918	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,549,530	3,549,530	1,759,767	5,309,297	73.00
74.00	07400	RENAL DIALYSIS	0	84,998	84,998	0	84,998	74.00
76.00	03950	DIABETES CENTER	46,739	9,647	56,386	0	56,386	76.00
76.97	07697	CARDIAC REHABILITATION	142,255	24,781	167,036	0	167,036	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	82,165	13,025	95,190	0	95,190	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	354,116	155,666	509,782	0	509,782	88.00
88.01	08801	RURAL HEALTH CLINIC II	570,943	216,279	787,222	25,400	812,622	88.01
88.02	08802	RURAL HEALTH CLINIC III	572,179	219,252	791,431	0	791,431	88.02
88.03	08803	RURAL HEALTH CLINIC IV	800,331	325,058	1,125,389	-248,646	876,743	88.03
88.04	08804	RURAL HEALTH CLINIC V	432,358	156,524	588,882	248,646	837,528	88.04
88.05	08805	RURAL HEALTH CLINIC VI	41,992	8,611	50,603	0	50,603	88.05
88.06	08806	RURAL HEALTH CLINIC VII	59,559	18,831	78,390	0	78,390	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	60,241	14,383	74,624	0	74,624	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	0	0	831,842	831,842	88.08
91.00	09100	EMERGENCY	2,121,778	4,822,575	6,944,353	0	6,944,353	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,039,962	253,080	1,293,042	0	1,293,042	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		310,966	310,966	0	310,966	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	46,780,010	72,130,314	118,910,324	1,312,355	120,222,679	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	17,063,521	4,498,224	21,561,745	-912,951	20,648,794	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	889,095	196,242	1,085,337	-399,404	685,933	194.01
194.02	07952	HWY 61 BUILDING	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	64,732,626	76,824,780	141,557,406	0	141,557,406	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/27/2018 10:15 am

		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	-127,428	2,494,654		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-8,314	4,063,368		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	354,062	14,690,231		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,585,481	25,256,212		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	445,699		6.00
7.00	00700	OPERATION OF PLANT	-11,888	3,014,658		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	305,087		8.00
9.00	00900	HOUSEKEEPING	0	1,264,880		9.00
10.00	01000	DIETARY	-631,185	1,026,899		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,334,279		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	287,222		14.00
15.00	01500	PHARMACY	-14,005	651,265		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-64,869	1,411,094		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-3,029,063	7,011,394		30.00
31.00	03100	INTENSIVE CARE UNIT	-3,734	2,067,884		31.00
41.00	04100	SUBPROVIDER - IRF	-67,068	1,530,782		41.00
43.00	04300	NURSERY	-133	333,019		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-843,271	2,253,375		50.00
51.00	05100	RECOVERY ROOM	0	1,129,230		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-70	1,139,837		52.00
53.00	05300	ANESTHESIOLOGY	-2,198,560	255,484		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,048	2,158,493		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	1,850,781		55.00
56.00	05600	RADIOISOTOPE	0	387,049		56.00
57.00	05700	CT SCAN	0	543,576		57.00
58.00	05800	MRI	0	377,335		58.00
59.00	05900	CARDIAC CATHETERIZATION	-483,925	1,236,161		59.00
60.00	06000	LABORATORY	-842,843	3,851,180		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	557,658		62.00
64.00	06400	INTRAVENOUS THERAPY	0	339,485		64.00
65.00	06500	RESPIRATORY THERAPY	-290	1,119,562		65.00
66.00	06600	PHYSICAL THERAPY	-31,677	1,071,068		66.00
67.00	06700	OCCUPATIONAL THERAPY	-105,758	349,142		67.00
68.00	06800	SPEECH PATHOLOGY	-123,964	145,810		68.00
69.00	06900	ELECTROCARDIOLOGY	-5,569	103,318		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	191,678		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,935,960		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,257,918		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,309,297		73.00
74.00	07400	RENAL DIALYSIS	0	84,998		74.00
76.00	03950	DIABETES CENTER	0	56,386		76.00
76.97	07697	CARDIAC REHABILITATION	0	167,036		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	95,190		76.98
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	509,782		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	812,622		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	791,431		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	876,743		88.03
88.04	08804	RURAL HEALTH CLINIC V	-90	837,438		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	50,603		88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	78,390		88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	74,624		88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	831,842		88.08
91.00	09100	EMERGENCY	-4,212,197	2,732,156		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	1,293,042		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-310,966	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,178,372	112,044,307		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	20,648,794		192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0		194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	685,933		194.01
194.02	07952	HWY 61 BUILDING	0	0		194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-8,178,372	133,379,034		200.00

RECLASSIFICATIONS | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/27/2018 10:15 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - ADMISSION KITS				
1.00	NURSERY	43.00	0	1,623	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	5,185	2.00
	0		0	6,808	
	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	240,421	3.00
4.00	RADIOLOGY - THERAPEUTIC	55.00	0	346,852	4.00
5.00	RADIOISOTOPE	56.00	0	121,456	5.00
6.00	CT SCAN	57.00	0	65,700	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	1,142,599	
	D - PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	92,844	1.00
	0		0	92,844	
	E - IMPLANTS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,257,918	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	3,257,918	
	F - HRMG 2ND FLOOR RHC				
1.00	RURAL HEALTH CLINIC IX	88.08	699,574	132,268	1.00
	TOTALS		699,574	132,268	
	G - CHILDREN'S CENTER				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	327,187	72,217	1.00
	0		327,187	72,217	
	H - LOUISIANA CLINIC				
1.00	RURAL HEALTH CLINIC V	88.04	395,523	109,238	1.00
	0		395,523	109,238	
	I - BOWLING GREEN CLINIC				
1.00	RURAL HEALTH CLINIC IV	88.03	213,748	42,367	1.00
	0		213,748	42,367	
	J - OUTSIDE CLEANING SERVICE				
1.00	HOUSEKEEPING	9.00	0	437,052	1.00
	0		0	437,052	
	K - PHARMACY SALARIES				
1.00	DRUGS CHARGED TO PATIENTS	73.00	1,759,767	0	1.00
	0		1,759,767	0	
	L - MEDICAL DIRECTORSHIPS				
1.00	ADMINISTRATIVE & GENERAL	5.00	89,284	0	1.00
2.00		0.00	0	0	2.00
	TOTALS		89,284	0	
500.00	Grand Total: Increases		3,485,083	5,293,311	500.00

RECLASSIFICATIONS | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/27/2018 10:15 am

		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	6,808	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	6,808			
	C - CAPITAL LEASE EXP						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,142,599	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	1,142,599			
	D - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	92,844	5		1.00
	0		0	92,844			
	E - IMPLANTS						
1.00	OPERATING ROOM	50.00	0	276,630	0		1.00
2.00	CARDIAC CATHETERIZATION	59.00	0	1,009,740	0		2.00
3.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,971,548	0		3.00
	0		0	3,257,918			
	F - HRMG 2ND FLOOR RHC						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	699,574	132,268	0		1.00
	TOTALS		699,574	132,268			
	G - CHILDREN'S CENTER						
1.00	CHILD DEVELOPMENT CENTER	194.01	327,187	72,217	0		1.00
	0		327,187	72,217			
	H - LOUISIANA CLINIC						
1.00	RURAL HEALTH CLINIC IV	88.03	395,523	109,238	0		1.00
	0		395,523	109,238			
	I - BOWLING GREEN CLINIC						
1.00	RURAL HEALTH CLINIC V	88.04	213,748	42,367	0		1.00
	0		213,748	42,367			
	J - OUTSIDE CLEANING SERVICE						
1.00	OPERATION OF PLANT	7.00	0	437,052	0		1.00
	0		0	437,052			
	K - PHARMACY SALARIES						
1.00	PHARMACY	15.00	1,759,767	0	0		1.00
	0		1,759,767	0			
	L - MEDICAL DIRECTORSHIPS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	81,109	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	8,175	0	0		2.00
	TOTALS		89,284	0			
500.00	Grand Total: Decreases		3,485,083	5,293,311			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 2/27/2018 10:15 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,479,295	0	0	0	0	1.00
2.00	Land Improvements	7,112,479	78,385	0	78,385	100,729	2.00
3.00	Buildings and Fixtures	43,662,581	0	0	0	0	3.00
4.00	Building Improvements	21,287,367	806,112	0	806,112	426,268	4.00
5.00	Fixed Equipment	1,330,764	185,237	0	185,237	0	5.00
6.00	Movable Equipment	69,055,086	7,061,423	0	7,061,423	518,693	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	144,927,572	8,131,157	0	8,131,157	1,045,690	8.00
9.00	Reconciling Items	-1,592,751	-4,550,869	0	-4,550,869	-2,176,894	9.00
10.00	Total (line 8 minus line 9)	146,520,323	12,682,026	0	12,682,026	3,222,584	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	7,090,135	0	2.00
3.00	Buildings and Fixtures	43,662,581	0	3.00
4.00	Building Improvements	21,667,211	0	4.00
5.00	Fixed Equipment	1,516,001	0	5.00
6.00	Movable Equipment	75,597,816	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	152,013,039	0	8.00
9.00	Reconciling Items	-3,966,726	0	9.00
10.00	Total (line 8 minus line 9)	155,979,765	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 2/27/2018 10:15 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,551,271	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,169,989	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	7,721,260	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	22,259	2,573,530		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,169,989		2.00
3.00	Total (sum of lines 1-2)	22,259	7,743,519		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part III | Date/Time Prepared: 2/27/2018 10:15 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	74,899,222	0	74,899,222	0.522947	48,552	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	77,113,817	8,787,824	68,325,993	0.477053	44,292	2.00
3.00	Total (sum of lines 1-2)	152,013,039	8,787,824	143,225,215	1.000000	92,844	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	48,552	2,423,843	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	44,292	4,019,076	0	2.00
3.00	Total (sum of lines 1-2)	0	0	92,844	6,442,919	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	48,552	0	22,259	2,494,654	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	44,292	0	0	4,063,368	2.00
3.00	Total (sum of lines 1-2)	0	92,844	0	22,259	6,558,022	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/27/2018 10:15 am

	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	-310,966	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	-8,411	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	-11,719,188			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	-631,185	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	-39,276	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		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	-129,004	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/27/2018 10:15 am

	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	
33.01	MISC INCOME - A&P	B	-12,770	ADULTS & PEDIATRICS	30.00	0	33.01
33.02	MISC INCOME - EKG	B	-5,569	ELECTROCARDIOLOGY	69.00	0	33.02
33.03	MISC INCOME - ICU	B	-3,734	INTENSIVE CARE UNIT	31.00	0	33.03
33.04	MISC INCOME - LAB	B	-700	LABORATORY	60.00	0	33.04
33.05	MISC INCOME - PHARMACY	B	-14,005	PHARMACY	15.00	0	33.05
33.06	MISC INCOME - RADIOLOGY	B	-1,048	RADIOLOGY-DIAGNOSTIC	54.00	0	33.06
33.07	MISC INCOME - L&D	B	-70	DELIVERY ROOM & LABOR ROOM	52.00	0	33.07
33.08	MISC INCOME - PLANT OPS	B	-3,477	OPERATION OF PLANT	7.00	0	33.08
33.09	MISC INCOME - ER	B	-1,628	EMERGENCY	91.00	0	33.09
33.10	MISC INCOME - RHC V (BOWLING GREEN)	B	-90	RURAL HEALTH CLINIC V	88.04	0	33.10
33.11	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.11
33.12	MISC INCOME - PT	B	-1,000	PHYSICAL THERAPY	66.00	0	33.12
34.00	NON ALLOWED ADVERTISING COSTS	A	-1,112,354	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	ADVERTISING EMPLOYEE BENEFITS	A	-57,787	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.01
35.00	LOBBYING EXPENSE	A	-17,403	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	ALCOHOLIC BEVERAGE EXPENSE	A	-2,042	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	DEVELOPMENT SALARIES	A	-125,180	ADMINISTRATIVE & GENERAL	5.00	0	37.00
37.01	DEVELOPMENT EXPENSE	A	-128,060	ADMINISTRATIVE & GENERAL	5.00	0	37.01
37.02	FOUNDATION EMPLOYEE BENEFITS	A	-28,368	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.02
38.00	DEFINED BENEFIT PENSION PLAN	A	1,662,016	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
39.00	CONTRIBUTIONS	A	-50,427	ADMINISTRATIVE & GENERAL	5.00	0	39.00
39.01	RECRUITMENT FEES	A	-503,519	ADMINISTRATIVE & GENERAL	5.00	0	39.01
39.02	RECRUITMENT FEES	A	-790	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.02
39.03	PATIENT PHONE	A	-30,874	ADMINISTRATIVE & GENERAL	5.00	0	39.03
39.04	PATIENT PHONE	A	-8,314	CAP REL COSTS-MVBLE EQUIP	2.00	9	39.04
39.05	DAYCARE REVENUE	B	-271,500	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.05
40.00	MEDICAID/FRA	A	6,902,742	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	EMPLOYED PHYSICIAN BENEFITS	A	-949,509	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	41.00
45.00	STAFF DEVELOPMENT	B	-20,617	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	NURSERY PHOTOS	B	-133	NURSERY	43.00	0	45.01
45.02	SPEECH CONTRACT SERVICE	B	-123,964	SPEECH PATHOLOGY	68.00	0	45.02
45.03	BUILDING RENTAL INCOME	B	-144,443	CAP REL COSTS-BLDG & FIXT	1.00	9	45.03
45.04	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.04
45.05	PT CONTRACT SERVICE	B	-30,677	PHYSICAL THERAPY	66.00	0	45.05
45.06	MEDICAL RECORDS REVENUE	B	-25,593	MEDICAL RECORDS & LIBRARY	16.00	0	45.06
45.07	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.07
45.08	R/T CONTRACT SERVICE	B	-290	RESPIRATORY THERAPY	65.00	0	45.08
45.09	O/T CONTRACT SERVICE	B	-105,758	OCCUPATIONAL THERAPY	67.00	0	45.09
45.10	PHYSICIAN PENSION EXPENSE	A	-1,258	ADMINISTRATIVE & GENERAL	5.00	0	45.10
45.11	PHYSICIAN PENSION EXPENSE	A	-35,625	ADULTS & PEDIATRICS	30.00	0	45.11
45.12	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.12
45.13	PHYSICIAN PENSION EXPENSE	A	-1,615	SUBPROVIDER - IRF	41.00	0	45.13
45.14	PHYSICIAN PENSION EXPENSE	A	-78,018	ANESTHESIOLOGY	53.00	0	45.14
45.15	PHYSICIAN PENSION EXPENSE	A	-1,908	CARDIAC CATHETERIZATION	59.00	0	45.15
45.16	PHYSICIAN PENSION EXPENSE	A	-21,998	LABORATORY	60.00	0	45.16
45.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.17
45.18	PALMYRA CLINIC DEPRECIATION	A	17,015	CAP REL COSTS-BLDG & FIXT	1.00	9	45.18
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,178,372				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 10/01/2016 To 09/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 2/27/2018 10:15 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	557,038	63,283	493,755	211,500	3,541	1.00
2.00	30.00	ADULTS & PEDIATRICS	2,980,668	2,980,668	0	0	0	2.00
3.00	41.00	SUBPROVIDER - IRF	65,453	65,453	0	0	0	3.00
4.00	50.00	OPERATING ROOM	843,271	843,271	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	2,178,993	2,075,744	103,249	239,400	502	5.00
6.00	59.00	CARDIAC CATHETERIZATION	482,017	482,017	0	0	0	6.00
7.00	60.00	LABORATORY	901,659	768,414	133,245	260,300	635	7.00
8.00	91.00	EMERGENCY	4,219,543	4,198,600	20,943	211,500	88	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			12,228,642	11,477,450	751,192		4,766	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	360,058	18,003	516	457	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	14,680	0	0	2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	57,778	2,889	14,209	673	0	5.00
6.00	59.00	CARDIAC CATHETERIZATION	0	0	2,000	0	0	6.00
7.00	60.00	LABORATORY	79,466	3,973	13,858	2,048	0	7.00
8.00	91.00	EMERGENCY	8,948	447	5,206	26	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			506,250	25,312	50,469	3,204	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	360,515	133,240	196,523		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,980,668		2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	65,453		3.00
4.00	50.00	OPERATING ROOM	0	0	0	843,271		4.00
5.00	53.00	ANESTHESIOLOGY	0	58,451	44,798	2,120,542		5.00
6.00	59.00	CARDIAC CATHETERIZATION	0	0	0	482,017		6.00
7.00	60.00	LABORATORY	0	81,514	51,731	820,145		7.00
8.00	91.00	EMERGENCY	0	8,974	11,969	4,210,569		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	509,454	241,738	11,719,188		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/27/2018 10:15 am

		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	2,494,654	2,494,654				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,063,368		4,063,368			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	14,690,231	39,708	5,541	14,735,480		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	25,256,212	475,340	1,671,083	2,850,133	30,252,768	5.00
6.00	00600	MAINTENANCE & REPAIRS	445,699	0	1,443	93,781	540,923	6.00
7.00	00700	OPERATION OF PLANT	3,014,658	107,241	74,435	188,691	3,385,025	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	305,087	6,196	27	7,481	318,791	8.00
9.00	00900	HOUSEKEEPING	1,264,880	6,474	3,475	152,511	1,427,340	9.00
10.00	01000	DIETARY	1,026,899	33,819	9,514	215,072	1,285,304	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,334,279	3,606	167,790	249,432	1,755,107	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	287,222	9,495	7,227	37,832	341,776	14.00
15.00	01500	PHARMACY	651,265	11,688	10,702	0	673,655	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,411,094	33,283	96	227,923	1,672,396	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,011,394	239,550	48,332	1,252,662	8,551,938	30.00
31.00	03100	INTENSIVE CARE UNIT	2,067,884	40,515	60,053	418,725	2,587,177	31.00
41.00	04100	SUBPROVIDER - IRF	1,530,782	52,211	15,328	165,519	1,763,840	41.00
43.00	04300	NURSERY	333,019	2,896	10,729	53,149	399,793	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,253,375	61,532	734,106	312,208	3,361,221	50.00
51.00	05100	RECOVERY ROOM	1,129,230	48,465	1,030	240,915	1,419,640	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,139,837	0	2,062	234,329	1,376,228	52.00
53.00	05300	ANESTHESIOLOGY	255,484	2,611	71,821	25,744	355,660	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,158,493	74,021	252,317	286,118	2,770,949	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1,850,781	133,938	211,973	223,867	2,420,559	55.00
56.00	05600	RADIOISOTOPE	387,049	8,639	82,715	33,212	511,615	56.00
57.00	05700	CT SCAN	543,576	3,982	63,840	78,578	689,976	57.00
58.00	05800	MRI	377,335	5,875	12,881	20,301	416,392	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,236,161	25,374	16,307	150,586	1,428,428	59.00
60.00	06000	LABORATORY	3,851,180	41,755	187,703	335,180	4,415,818	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	557,658	940	483	22,514	581,595	62.00
64.00	06400	INTRAVENOUS THERAPY	339,485	48,521	39,973	70,333	498,312	64.00
65.00	06500	RESPIRATORY THERAPY	1,119,562	18,072	32,455	187,778	1,357,867	65.00
66.00	06600	PHYSICAL THERAPY	1,071,068	26,036	893	91,989	1,189,986	66.00
67.00	06700	OCCUPATIONAL THERAPY	349,142	1,225	0	13,710	364,077	67.00
68.00	06800	SPEECH PATHOLOGY	145,810	446	0	50,221	196,477	68.00
69.00	06900	ELECTROCARDIOLOGY	103,318	0	41,775	15,519	160,612	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	191,678	4,998	15,701	40,689	253,066	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,935,960	0	0	0	7,935,960	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,257,918	0	0	0	3,257,918	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,309,297	0	0	438,523	5,747,820	73.00
74.00	07400	RENAL DIALYSIS	84,998	0	0	0	84,998	74.00
76.00	03950	DIABETES CENTER	56,386	0	0	11,647	68,033	76.00
76.97	07697	CARDIAC REHABILITATION	167,036	18,427	14,858	35,449	235,770	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	95,190	0	0	20,475	115,665	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	509,782	0	7,419	88,244	605,445	88.00
88.01	08801	RURAL HEALTH CLINIC II	812,622	0	42,218	142,276	997,116	88.01
88.02	08802	RURAL HEALTH CLINIC III	791,431	39,938	0	142,584	973,953	88.02
88.03	08803	RURAL HEALTH CLINIC IV	876,743	0	315	154,140	1,031,198	88.03
88.04	08804	RURAL HEALTH CLINIC V	837,438	0	0	153,038	990,476	88.04
88.05	08805	RURAL HEALTH CLINIC VI	50,603	2,061	0	10,464	63,128	88.05
88.06	08806	RURAL HEALTH CLINIC VII	78,390	5,931	0	14,842	99,163	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	74,624	1,309	0	15,012	90,945	88.07
88.08	08808	RURAL HEALTH CLINIC IX	831,842	14,041	0	174,330	1,020,213	88.08
91.00	09100	EMERGENCY	2,732,156	204,408	31,810	530,971	3,499,345	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,293,042	20,884	4,988	259,152	1,578,066	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	112,044,307	1,875,451	3,955,418	10,537,849	107,119,523	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,648,794	532,819	105,282	4,057,607	25,344,502	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	685,933	68,201	2,668	140,024	896,826	194.01
194.02	07952	HWY 61 BUILDING	0	18,183	0	0	18,183	194.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/27/2018 10:15 am

	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	
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 through 201)	133,379,034	2,494,654	4,063,368	14,735,480	133,379,034	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/27/2018 10:15 am

		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	30,252,768					5.00
6.00	00600	MAINTENANCE & REPAIRS	158,684	699,607				6.00
7.00	00700	OPERATION OF PLANT	993,021	37,900	4,415,946			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	93,520	2,190	14,612	429,113		8.00
9.00	00900	HOUSEKEEPING	418,720	2,288	15,269	0	1,863,617	9.00
10.00	01000	DIETARY	377,053	11,952	79,761	0	33,890	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	514,873	1,274	8,505	0	3,614	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	100,262	3,356	22,395	0	9,515	14.00
15.00	01500	PHARMACY	197,621	4,131	27,567	0	11,713	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	490,609	11,762	78,496	0	33,353	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,508,771	84,659	564,974	158,966	240,055	30.00
31.00	03100	INTENSIVE CARE UNIT	758,966	14,318	95,555	20,965	40,601	31.00
41.00	04100	SUBPROVIDER - IRF	517,435	18,452	123,138	20,312	52,321	41.00
43.00	04300	NURSERY	117,282	1,023	6,830	0	2,902	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	986,038	21,746	145,122	58,135	61,662	50.00
51.00	05100	RECOVERY ROOM	416,461	17,128	114,305	17,346	48,568	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	403,726	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	104,335	923	6,157	0	2,616	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	812,877	26,159	174,577	32,006	74,177	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	710,088	47,335	315,890	6,263	134,220	55.00
56.00	05600	RADIOISOTOPE	150,086	3,053	20,375	0	8,657	56.00
57.00	05700	CT SCAN	202,409	1,407	9,391	0	3,990	57.00
58.00	05800	MRI	122,152	2,076	13,857	0	5,888	58.00
59.00	05900	CARDIAC CATHETERIZATION	419,039	8,967	59,845	5,445	25,428	59.00
60.00	06000	LABORATORY	1,295,411	14,756	98,478	1,199	41,843	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	170,615	332	2,216	0	942	62.00
64.00	06400	INTRAVENOUS THERAPY	146,183	17,148	114,436	4,509	48,623	64.00
65.00	06500	RESPIRATORY THERAPY	398,340	6,387	42,622	0	18,110	65.00
66.00	06600	PHYSICAL THERAPY	349,091	9,201	61,405	1,524	26,091	66.00
67.00	06700	OCCUPATIONAL THERAPY	106,805	433	2,890	0	1,228	67.00
68.00	06800	SPEECH PATHOLOGY	57,638	157	1,051	0	446	68.00
69.00	06900	ELECTROCARDIOLOGY	47,117	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	74,239	1,766	11,788	1,464	5,009	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,328,069	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	955,733	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,686,163	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	24,935	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	19,958	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	69,165	6,512	43,460	0	18,466	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	33,931	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	177,612	0	0	1,400	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	292,511	0	0	251	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	285,716	14,114	94,192	400	40,022	88.02
88.03	08803	RURAL HEALTH CLINIC IV	302,509	0	0	370	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	290,563	0	0	370	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	18,519	728	4,860	0	2,065	88.05
88.06	08806	RURAL HEALTH CLINIC VII	29,090	2,096	13,988	0	5,944	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	26,679	463	3,087	0	1,312	88.07
88.08	08808	RURAL HEALTH CLINIC IX	299,287	4,962	33,116	0	14,071	88.08
91.00	09100	EMERGENCY	1,026,557	72,239	482,094	98,173	204,839	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	462,937	7,381	49,255	0	20,928	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,549,401	480,774	2,955,559	429,098	1,243,109	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,434,943	188,304	1,256,651	15	533,941	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	263,090	24,103	160,851	0	68,345	194.01
194.02	07952	HWY 61 BUILDING	5,334	6,426	42,885	0	18,222	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 through 201)	30,252,768	699,607	4,415,946	429,113	1,863,617	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/27/2018 10:15 am

		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	1,787,960					10.00
11.00	01100	CAFETERIA	1,286,939	1,286,939				11.00
13.00	01300	NURSING ADMINISTRATION	0	36,944	2,320,317			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,641	0	488,945		14.00
15.00	01500	PHARMACY	0	65,648	0	0	980,335	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	382,593	255,491	986,995	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	56,612	68,917	278,703	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	61,816	31,495	127,366	0	0	41.00
43.00	04300	NURSERY	0	10,047	40,588	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	58,153	235,154	0	0	50.00
51.00	05100	RECOVERY ROOM	0	40,718	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	33,462	135,308	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	24,213	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	47,469	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	25,223	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	5,821	0	0	0	56.00
57.00	05700	CT SCAN	0	12,784	0	0	0	57.00
58.00	05800	MRI	0	3,003	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	14,299	0	0	0	59.00
60.00	06000	LABORATORY	0	88,984	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	4,625	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	12,811	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	37,900	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	8,877	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,472	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,870	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,950	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,336	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	346,639	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	142,306	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	980,335	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	0	1,914	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	5,369	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	2,977	12,060	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
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	0	0	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	0	0	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	16,558	0	0	0	88.08
91.00	09100	EMERGENCY	0	97,409	354,263	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	149,880	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,787,960	1,038,380	2,320,317	488,945	980,335	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	248,559	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 through 201)	1,787,960	1,286,939	2,320,317	488,945	980,335	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/27/2018 10:15 am

		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	2,286,616					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,302,844	15,037,286	77,451	15,114,737		30.00
31.00	03100	INTENSIVE CARE UNIT	91,498	4,013,312	-77,451	3,935,861		31.00
41.00	04100	SUBPROVIDER - IRF	274,912	2,991,087	0	2,991,087		41.00
43.00	04300	NURSERY	274,411	852,876	0	852,876		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,927,231	0	4,927,231		50.00
51.00	05100	RECOVERY ROOM	0	2,074,166	0	2,074,166		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,948,724	0	1,948,724		52.00
53.00	05300	ANESTHESIOLOGY	0	493,904	0	493,904		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,938,214	0	3,938,214		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	3,659,578	0	3,659,578		55.00
56.00	05600	RADIOISOTOPE	0	699,607	0	699,607		56.00
57.00	05700	CT SCAN	0	919,957	0	919,957		57.00
58.00	05800	MRI	0	563,368	0	563,368		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,961,451	0	1,961,451		59.00
60.00	06000	LABORATORY	0	5,956,489	0	5,956,489		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	760,325	0	760,325		62.00
64.00	06400	INTRAVENOUS THERAPY	0	842,022	0	842,022		64.00
65.00	06500	RESPIRATORY THERAPY	0	1,861,226	0	1,861,226		65.00
66.00	06600	PHYSICAL THERAPY	0	1,646,175	0	1,646,175		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	477,905	0	477,905		67.00
68.00	06800	SPEECH PATHOLOGY	0	258,639	0	258,639		68.00
69.00	06900	ELECTROCARDIOLOGY	0	210,679	0	210,679		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	354,668	0	354,668		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	10,610,668	0	10,610,668		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,355,957	0	4,355,957		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,414,318	0	8,414,318		73.00
74.00	07400	RENAL DIALYSIS	0	109,933	0	109,933		74.00
76.00	03950	DIABETES CENTER	0	89,905	0	89,905		76.00
76.97	07697	CARDIAC REHABILITATION	0	378,742	0	378,742		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	164,633	0	164,633		76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	784,457	0	784,457		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,289,878	0	1,289,878		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,408,397	0	1,408,397		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	1,334,077	0	1,334,077		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	1,281,409	0	1,281,409		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	89,300	0	89,300		88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	150,281	0	150,281		88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	122,486	0	122,486		88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	1,388,207	0	1,388,207		88.08
91.00	09100	EMERGENCY	342,951	6,177,870	0	6,177,870		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	2,268,447	0	2,268,447		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,286,616	96,867,854	0	96,867,854		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	35,006,915	0	35,006,915		192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0		194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	1,413,215	0	1,413,215		194.01
194.02	07952	HWY 61 BUILDING	0	91,050	0	91,050		194.02
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/27/2018 10:15 am

	Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		16.00	24.00	25.00	26.00		
202.00	TOTAL (sum lines 118 through 201)	2,286,616	133,379,034	0	133,379,034		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/27/2018 10:15 am

		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	978	39,708	5,541	46,227	46,227	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	193,521	475,340	1,671,083	2,339,944	8,944	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,383	0	1,443	3,826	294	6.00
7.00	00700	OPERATION OF PLANT	83,193	107,241	74,435	264,869	592	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,494	6,196	27	7,717	23	8.00
9.00	00900	HOUSEKEEPING	10,166	6,474	3,475	20,115	479	9.00
10.00	01000	DIETARY	3,712	33,819	9,514	47,045	675	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	6,784	3,606	167,790	178,180	783	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	209	9,495	7,227	16,931	119	14.00
15.00	01500	PHARMACY	151,441	11,688	10,702	173,831	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,654	33,283	96	40,033	715	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,682	239,550	48,332	322,564	3,931	30.00
31.00	03100	INTENSIVE CARE UNIT	5,320	40,515	60,053	105,888	1,314	31.00
41.00	04100	SUBPROVIDER - IRF	1,956	52,211	15,328	69,495	519	41.00
43.00	04300	NURSERY	1,601	2,896	10,729	15,226	167	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	181,801	61,532	734,106	977,439	980	50.00
51.00	05100	RECOVERY ROOM	7,494	48,465	1,030	56,989	756	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,314	0	2,062	3,376	735	52.00
53.00	05300	ANESTHESIOLOGY	1,278	2,611	71,821	75,710	81	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	256,242	74,021	252,317	582,580	898	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	349,402	133,938	211,973	695,313	703	55.00
56.00	05600	RADIOISOTOPE	121,566	8,639	82,715	212,920	104	56.00
57.00	05700	CT SCAN	101,222	3,982	63,840	169,044	247	57.00
58.00	05800	MRI	156,605	5,875	12,881	175,361	64	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,481	25,374	16,307	46,162	473	59.00
60.00	06000	LABORATORY	35,636	41,755	187,703	265,094	1,052	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	7	940	483	1,430	71	62.00
64.00	06400	INTRAVENOUS THERAPY	4,518	48,521	39,973	93,012	221	64.00
65.00	06500	RESPIRATORY THERAPY	62,847	18,072	32,455	113,374	589	65.00
66.00	06600	PHYSICAL THERAPY	1,374	26,036	893	28,303	289	66.00
67.00	06700	OCCUPATIONAL THERAPY	179	1,225	0	1,404	43	67.00
68.00	06800	SPEECH PATHOLOGY	1,274	446	0	1,720	158	68.00
69.00	06900	ELECTROCARDIOLOGY	1,226	0	41,775	43,001	49	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,471	4,998	15,701	22,170	128	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	1,376	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	0	0	0	0	37	76.00
76.97	07697	CARDIAC REHABILITATION	-311	18,427	14,858	32,974	111	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	64	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	15,178	0	7,419	22,597	277	88.00
88.01	08801	RURAL HEALTH CLINIC II	76,341	0	42,218	118,559	446	88.01
88.02	08802	RURAL HEALTH CLINIC III	7,340	39,938	0	47,278	447	88.02
88.03	08803	RURAL HEALTH CLINIC IV	63,657	0	315	63,972	484	88.03
88.04	08804	RURAL HEALTH CLINIC V	28,296	0	0	28,296	480	88.04
88.05	08805	RURAL HEALTH CLINIC VI	3,198	2,061	0	5,259	33	88.05
88.06	08806	RURAL HEALTH CLINIC VII	6,080	5,931	0	12,011	47	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	1,309	0	1,309	47	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	14,041	0	14,041	547	88.08
91.00	09100	EMERGENCY	6,117	204,408	31,810	242,335	1,666	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	7,030	20,884	4,988	32,902	813	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,006,957	1,875,451	3,955,418	7,837,826	33,071	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	185,014	532,819	105,282	823,115	12,717	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	1,939	68,201	2,668	72,808	439	194.01
194.02	07952	HWY 61 BUILDING	0	18,183	0	18,183	0	194.02
200.00		Cross Foot Adjustments				0		200.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/27/2018 10:15 am

	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	
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2,193,910	2,494,654	4,063,368	8,751,932	46,227	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/27/2018 10:15 am

		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	2,348,888					5.00
6.00	00600	MAINTENANCE & REPAIRS	12,321	16,441				6.00
7.00	00700	OPERATION OF PLANT	77,101	891	343,453			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,261	51	1,136	16,188		8.00
9.00	00900	HOUSEKEEPING	32,511	54	1,188	0	54,347	9.00
10.00	01000	DIETARY	29,275	281	6,203	0	988	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	39,976	30	661	0	105	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,785	79	1,742	0	277	14.00
15.00	01500	PHARMACY	15,344	97	2,144	0	342	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	38,092	276	6,105	0	973	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	194,787	1,990	43,941	5,999	7,001	30.00
31.00	03100	INTENSIVE CARE UNIT	58,928	336	7,432	791	1,184	31.00
41.00	04100	SUBPROVIDER - IRF	40,175	434	9,577	766	1,526	41.00
43.00	04300	NURSERY	9,106	24	531	0	85	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	76,559	511	11,287	2,193	1,798	50.00
51.00	05100	RECOVERY ROOM	32,335	403	8,890	654	1,416	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	31,346	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	8,101	22	479	0	76	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	63,114	615	13,578	1,207	2,163	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	55,133	1,112	24,569	236	3,914	55.00
56.00	05600	RADIOISOTOPE	11,653	72	1,585	0	252	56.00
57.00	05700	CT SCAN	15,716	33	730	0	116	57.00
58.00	05800	MRI	9,484	49	1,078	0	172	58.00
59.00	05900	CARDIAC CATHETERIZATION	32,535	211	4,654	205	742	59.00
60.00	06000	LABORATORY	100,579	347	7,659	45	1,220	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	13,247	8	172	0	27	62.00
64.00	06400	INTRAVENOUS THERAPY	11,350	403	8,900	170	1,418	64.00
65.00	06500	RESPIRATORY THERAPY	30,928	150	3,315	0	528	65.00
66.00	06600	PHYSICAL THERAPY	27,104	216	4,776	57	761	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,293	10	225	0	36	67.00
68.00	06800	SPEECH PATHOLOGY	4,475	4	82	0	13	68.00
69.00	06900	ELECTROCARDIOLOGY	3,658	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,764	42	917	55	146	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	180,757	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	74,206	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	130,918	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,936	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	1,550	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	5,370	153	3,380	0	539	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	2,635	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	13,790	0	0	53	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	22,711	0	0	9	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	22,184	332	7,326	15	1,167	88.02
88.03	08803	RURAL HEALTH CLINIC IV	23,488	0	0	14	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	22,560	0	0	14	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	1,438	17	378	0	60	88.05
88.06	08806	RURAL HEALTH CLINIC VII	2,259	49	1,088	0	173	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	2,071	11	240	0	38	88.07
88.08	08808	RURAL HEALTH CLINIC IX	23,237	117	2,576	0	410	88.08
91.00	09100	EMERGENCY	79,705	1,698	37,495	3,704	5,974	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	35,944	173	3,831	0	610	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,750,795	11,301	229,870	16,187	36,250	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	577,252	4,423	97,738	1	15,573	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	20,427	566	12,510	0	1,993	194.01
194.02	07952	HWY 61 BUILDING	414	151	3,335	0	531	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 through 201)	2,348,888	16,441	343,453	16,188	54,347	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/27/2018 10:15 am

		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	84,467					10.00
11.00	01100	CAFETERIA	60,798	60,798				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,745	221,480			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	550	0	27,483		14.00
15.00	01500	PHARMACY	0	3,101	0	0	194,859	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	18,075	12,068	94,213	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,674	3,256	26,603	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	2,920	1,488	12,157	0	0	41.00
43.00	04300	NURSERY	0	475	3,874	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,747	22,446	0	0	50.00
51.00	05100	RECOVERY ROOM	0	1,924	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,581	12,915	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,144	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,243	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	1,192	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	275	0	0	0	56.00
57.00	05700	CT SCAN	0	604	0	0	0	57.00
58.00	05800	MRI	0	142	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	676	0	0	0	59.00
60.00	06000	LABORATORY	0	4,204	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	218	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	605	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,791	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	419	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	117	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	136	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	139	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	347	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	19,485	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,998	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	194,859	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	0	90	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	254	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	141	1,151	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
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	0	0	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	0	0	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	782	0	0	0	88.08
91.00	09100	EMERGENCY	0	4,602	33,815	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	14,306	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	84,467	49,056	221,480	27,483	194,859	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11,742	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 through 201)	84,467	60,798	221,480	27,483	194,859	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/27/2018 10:15 am

		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	86,194					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	49,110	753,679	0	753,679		30.00
31.00	03100	INTENSIVE CARE UNIT	3,449	211,855	0	211,855		31.00
41.00	04100	SUBPROVIDER - IRF	10,363	149,420	0	149,420		41.00
43.00	04300	NURSERY	10,344	39,832	0	39,832		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,095,960	0	1,095,960		50.00
51.00	05100	RECOVERY ROOM	0	103,367	0	103,367		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	49,953	0	49,953		52.00
53.00	05300	ANESTHESIOLOGY	0	85,613	0	85,613		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	666,398	0	666,398		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	782,172	0	782,172		55.00
56.00	05600	RADIOISOTOPE	0	226,861	0	226,861		56.00
57.00	05700	CT SCAN	0	186,490	0	186,490		57.00
58.00	05800	MRI	0	186,350	0	186,350		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	85,658	0	85,658		59.00
60.00	06000	LABORATORY	0	380,200	0	380,200		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	15,173	0	15,173		62.00
64.00	06400	INTRAVENOUS THERAPY	0	116,079	0	116,079		64.00
65.00	06500	RESPIRATORY THERAPY	0	150,675	0	150,675		65.00
66.00	06600	PHYSICAL THERAPY	0	61,925	0	61,925		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	10,128	0	10,128		67.00
68.00	06800	SPEECH PATHOLOGY	0	6,588	0	6,588		68.00
69.00	06900	ELECTROCARDIOLOGY	0	46,847	0	46,847		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	29,569	0	29,569		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	200,242	0	200,242		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	82,204	0	82,204		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	327,153	0	327,153		73.00
74.00	07400	RENAL DIALYSIS	0	1,936	0	1,936		74.00
76.00	03950	DIABETES CENTER	0	1,677	0	1,677		76.00
76.97	07697	CARDIAC REHABILITATION	0	42,781	0	42,781		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	3,991	0	3,991		76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	36,717	0	36,717		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	141,725	0	141,725		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	78,749	0	78,749		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	87,958	0	87,958		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	51,350	0	51,350		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	7,185	0	7,185		88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	15,627	0	15,627		88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	3,716	0	3,716		88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	41,710	0	41,710		88.08
91.00	09100	EMERGENCY	12,928	423,922	0	423,922		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	88,579	0	88,579		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	86,194	7,078,014	0	7,078,014		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,542,561	0	1,542,561		192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0		194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	108,743	0	108,743		194.01
194.02	07952	HWY 61 BUILDING	0	22,614	0	22,614		194.02
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/27/2018 10:15 am

	Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		16.00	24.00	25.00	26.00		
202.00	TOTAL (sum lines 118 through 201)	86,194	8,751,932	0	8,751,932		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/27/2018 10:15 am

		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	358,354					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,835,937				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,704	3,867	59,132,480			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	68,282	1,166,297	11,437,406	-30,252,768	103,126,266	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,007	376,337	0	540,923	6.00
7.00	00700	OPERATION OF PLANT	15,405	51,950	757,207	0	3,385,025	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	890	19	30,019	0	318,791	8.00
9.00	00900	HOUSEKEEPING	930	2,425	612,017	0	1,427,340	9.00
10.00	01000	DIETARY	4,858	6,640	863,072	0	1,285,304	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	518	117,105	1,000,955	0	1,755,107	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,364	5,044	151,816	0	341,776	14.00
15.00	01500	PHARMACY	1,679	7,469	0	0	673,655	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,781	67	914,641	0	1,672,396	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,411	33,732	5,026,854	0	8,551,938	30.00
31.00	03100	INTENSIVE CARE UNIT	5,820	41,913	1,680,317	0	2,587,177	31.00
41.00	04100	SUBPROVIDER - IRF	7,500	10,698	664,218	0	1,763,840	41.00
43.00	04300	NURSERY	416	7,488	213,283	0	399,793	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,839	512,353	1,252,873	0	3,361,221	50.00
51.00	05100	RECOVERY ROOM	6,962	719	966,778	0	1,419,640	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,439	940,349	0	1,376,228	52.00
53.00	05300	ANESTHESIOLOGY	375	50,126	103,310	0	355,660	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,633	176,099	1,148,175	0	2,770,949	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	19,240	147,942	898,364	0	2,420,559	55.00
56.00	05600	RADIOISOTOPE	1,241	57,729	133,279	0	511,615	56.00
57.00	05700	CT SCAN	572	44,556	315,327	0	689,976	57.00
58.00	05800	MRI	844	8,990	81,467	0	416,392	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,645	11,381	604,292	0	1,428,428	59.00
60.00	06000	LABORATORY	5,998	131,003	1,345,056	0	4,415,818	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	135	337	90,347	0	581,595	62.00
64.00	06400	INTRAVENOUS THERAPY	6,970	27,898	282,243	0	498,312	64.00
65.00	06500	RESPIRATORY THERAPY	2,596	22,651	753,542	0	1,357,867	65.00
66.00	06600	PHYSICAL THERAPY	3,740	623	369,145	0	1,189,986	66.00
67.00	06700	OCCUPATIONAL THERAPY	176	0	55,019	0	364,077	67.00
68.00	06800	SPEECH PATHOLOGY	64	0	201,533	0	196,477	68.00
69.00	06900	ELECTROCARDIOLOGY	0	29,156	62,277	0	160,612	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	718	10,958	163,283	0	253,066	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	7,935,960	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,257,918	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,759,767	0	5,747,820	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	84,998	74.00
76.00	03950	DIABETES CENTER	0	0	46,739	0	68,033	76.00
76.97	07697	CARDIAC REHABILITATION	2,647	10,370	142,255	0	235,770	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	82,165	0	115,665	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,178	354,116	0	605,445	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	29,465	570,943	0	997,116	88.01
88.02	08802	RURAL HEALTH CLINIC III	5,737	0	572,179	0	973,953	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	220	618,556	0	1,031,198	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	614,133	0	990,476	88.04
88.05	08805	RURAL HEALTH CLINIC VI	296	0	41,992	0	63,128	88.05
88.06	08806	RURAL HEALTH CLINIC VII	852	0	59,559	0	99,163	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	188	0	60,241	0	90,945	88.07
88.08	08808	RURAL HEALTH CLINIC IX	2,017	0	699,574	0	1,020,213	88.08
91.00	09100	EMERGENCY	29,363	22,201	2,130,752	0	3,499,345	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,000	3,481	1,039,962	0	1,578,066	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	269,406	2,760,596	42,287,734	-30,252,768	76,866,755	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	76,539	73,479	16,282,838	0	25,344,502	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	9,797	1,862	561,908	0	896,826	194.01
194.02	07952	HWY 61 BUILDING	2,612	0	0	0	18,183	194.02

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/27/2018 10:15 am

		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	
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,494,654	4,063,368	14,735,480		30,252,768	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.961424	1.432813	0.249194		0.293357	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			46,227		2,348,888	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000782		0.022777	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/27/2018 10:15 am

		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	284,368					6.00
7.00	00700	OPERATION OF PLANT	15,405	268,963				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	890	890	484,947			8.00
9.00	00900	HOUSEKEEPING	930	930	0	267,143		9.00
10.00	01000	DIETARY	4,858	4,858	0	4,858	275,559	10.00
11.00	01100	CAFETERIA	0	0	0	0	198,342	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	4,781	4,781	0	4,781	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,411	34,411	179,648	34,411	58,965	30.00
31.00	03100	INTENSIVE CARE UNIT	5,820	5,820	23,693	5,820	8,725	31.00
41.00	04100	SUBPROVIDER - IRF	7,500	7,500	22,955	7,500	9,527	41.00
43.00	04300	NURSERY	416	416	0	416	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,839	8,839	65,699	8,839	0	50.00
51.00	05100	RECOVERY ROOM	6,962	6,962	19,603	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	36,171	10,633	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	19,240	19,240	7,078	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	6,154	3,645	0	59.00
60.00	06000	LABORATORY	5,998	5,998	1,355	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	6,970	6,970	5,096	6,970	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,596	2,596	0	2,596	0	65.00
66.00	06600	PHYSICAL THERAPY	3,740	3,740	1,722	3,740	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	176	176	0	176	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	1,655	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	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	1,582	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	284	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	5,737	5,737	452	5,737	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	418	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	418	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	296	296	0	296	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	852	852	0	852	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	188	188	0	188	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	2,017	2,017	0	2,017	0	88.08
91.00	09100	EMERGENCY	29,363	29,363	110,947	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 through 117)	195,420	180,015	484,930	178,195	275,559	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	76,539	76,539	17	76,539	0	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	9,797	9,797	0	9,797	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

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/27/2018 10:15 am

	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	699,607	4,415,946	429,113	1,863,617	1,787,960	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	2.460217	16.418414	0.884866	6.976103	6.488483	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	16,441	343,453	16,188	54,347	84,467	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.057816	1.276953	0.033381	0.203438	0.306530	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/27/2018 10:15 am

		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	48,421					11.00
13.00	01300	NURSING ADMINISTRATION	1,390	449,048				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	438	0	11,193,878			14.00
15.00	01500	PHARMACY	2,470	0	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	27,390	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,613	191,012	0	0	15,606	30.00
31.00	03100	INTENSIVE CARE UNIT	2,593	53,937	0	0	1,096	31.00
41.00	04100	SUBPROVIDER - IRF	1,185	24,649	0	0	3,293	41.00
43.00	04300	NURSERY	378	7,855	0	0	3,287	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,188	45,509	0	0	0	50.00
51.00	05100	RECOVERY ROOM	1,532	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,259	26,186	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	911	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,786	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	949	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	219	0	0	0	0	56.00
57.00	05700	CT SCAN	481	0	0	0	0	57.00
58.00	05800	MRI	113	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	538	0	0	0	0	59.00
60.00	06000	LABORATORY	3,348	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	174	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	482	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,426	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	334	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	93	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	108	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	111	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	276	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	7,935,960	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	3,257,918	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	72	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	202	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	112	2,334	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
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	0	0	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	0	0	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	623	0	0	0	0	88.08
91.00	09100	EMERGENCY	3,665	68,560	0	0	4,108	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	29,006	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,069	449,048	11,193,878	100	27,390	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,352	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

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/27/2018 10:15 am

		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	
202.00		Cost to be allocated (per Wkst. B, Part I)	1,286,939	2,320,317	488,945	980,335	2,286,616	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.578117	5.167191	0.043680	9,803.350000	83.483607	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	60,798	221,480	27,483	194,859	86,194	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.255612	0.493221	0.002455	1,948.590000	3.146915	205.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-2 | Date/Time Prepared: 2/27/2018 10:15 am

		Description	Worksheet CODE	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		ICU OBSERVATION COSTS TO A&P	1	30.00	77,451	7.00
8.00		ICU OBSERVATION COSTS TO A&P	1	31.00	-77,451	8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/27/2018 10:15 am

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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	15,114,737		15,114,737	0	15,114,737	30.00
31.00	03100	INTENSIVE CARE UNIT	3,935,861		3,935,861	0	3,935,861	31.00
41.00	04100	SUBPROVIDER - IRF	2,991,087		2,991,087	0	2,991,087	41.00
43.00	04300	NURSERY	852,876		852,876	0	852,876	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,927,231		4,927,231	0	4,927,231	50.00
51.00	05100	RECOVERY ROOM	2,074,166		2,074,166	0	2,074,166	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,948,724		1,948,724	0	1,948,724	52.00
53.00	05300	ANESTHESIOLOGY	493,904		493,904	44,798	538,702	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,938,214		3,938,214	0	3,938,214	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	3,659,578		3,659,578	0	3,659,578	55.00
56.00	05600	RADIOISOTOPE	699,607		699,607	0	699,607	56.00
57.00	05700	CT SCAN	919,957		919,957	0	919,957	57.00
58.00	05800	MRI	563,368		563,368	0	563,368	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,961,451		1,961,451	0	1,961,451	59.00
60.00	06000	LABORATORY	5,956,489		5,956,489	51,731	6,008,220	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	760,325		760,325	0	760,325	62.00
64.00	06400	INTRAVENOUS THERAPY	842,022		842,022	0	842,022	64.00
65.00	06500	RESPIRATORY THERAPY	1,861,226	0	1,861,226	0	1,861,226	65.00
66.00	06600	PHYSICAL THERAPY	1,646,175	0	1,646,175	0	1,646,175	66.00
67.00	06700	OCCUPATIONAL THERAPY	477,905	0	477,905	0	477,905	67.00
68.00	06800	SPEECH PATHOLOGY	258,639	0	258,639	0	258,639	68.00
69.00	06900	ELECTROCARDIOLOGY	210,679		210,679	0	210,679	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	354,668		354,668	0	354,668	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,610,668		10,610,668	0	10,610,668	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,355,957		4,355,957	0	4,355,957	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,414,318		8,414,318	0	8,414,318	73.00
74.00	07400	RENAL DIALYSIS	109,933		109,933	0	109,933	74.00
76.00	03950	DIABETES CENTER	89,905		89,905	0	89,905	76.00
76.97	07697	CARDIAC REHABILITATION	378,742		378,742	0	378,742	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	164,633		164,633	0	164,633	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	784,457		784,457	0	784,457	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,289,878		1,289,878	0	1,289,878	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,408,397		1,408,397	0	1,408,397	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,334,077		1,334,077	0	1,334,077	88.03
88.04	08804	RURAL HEALTH CLINIC V	1,281,409		1,281,409	0	1,281,409	88.04
88.05	08805	RURAL HEALTH CLINIC VI	89,300		89,300	0	89,300	88.05
88.06	08806	RURAL HEALTH CLINIC VII	150,281		150,281	0	150,281	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	122,486		122,486	0	122,486	88.07
88.08	08808	RURAL HEALTH CLINIC IX	1,388,207		1,388,207	0	1,388,207	88.08
91.00	09100	EMERGENCY	6,177,870		6,177,870	11,969	6,189,839	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,073,517		1,073,517		1,073,517	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,268,447		2,268,447		2,268,447	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	97,941,371	0	97,941,371	108,498	98,049,869	200.00
201.00		Less Observation Beds	1,073,517		1,073,517		1,073,517	201.00
202.00		Total (see instructions)	96,867,854	0	96,867,854	108,498	96,976,352	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/27/2018 10:15 am

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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	5,711,471		5,711,471			30.00
31.00	03100	INTENSIVE CARE UNIT	1,542,821		1,542,821			31.00
41.00	04100	SUBPROVIDER - IRF	1,987,672		1,987,672			41.00
43.00	04300	NURSERY	241,971		241,971			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,080,210	16,657,454	28,737,664	0.171456	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,763,161	3,475,616	5,238,777	0.395926	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	457,895	150,510	608,405	3.203005	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	4,253,873	3,938,348	8,192,221	0.060289	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,324,715	7,538,472	9,863,187	0.399284	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	6,570	5,871,004	5,877,574	0.622634	0.000000	55.00
56.00	05600	RADIOISOTOPE	358,025	2,163,688	2,521,713	0.277433	0.000000	56.00
57.00	05700	CT SCAN	4,300,730	14,598,703	18,899,433	0.048676	0.000000	57.00
58.00	05800	MRI	539,160	4,937,602	5,476,762	0.102865	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,179,868	3,869,251	7,049,119	0.278255	0.000000	59.00
60.00	06000	LABORATORY	11,587,638	26,967,931	38,555,569	0.154491	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	559,794	655,150	1,214,944	0.625811	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	279,972	1,264,576	1,544,548	0.545158	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	293,700	504,222	797,922	2.332591	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,217,764	544,204	1,761,968	0.934282	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	878,930	8,716	887,646	0.538396	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	159,184	141,088	300,272	0.861349	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	550,036	1,389,125	1,939,161	0.108644	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	9,816	583,299	593,115	0.597975	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	64,642,817	42,307,881	106,950,698	0.099211	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,054,305	6,455,582	7,509,887	0.580030	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,530,358	30,052,316	62,582,674	0.134451	0.000000	73.00
74.00	07400	RENAL DIALYSIS	55,600	0	55,600	1.977212	0.000000	74.00
76.00	03950	DIABETES CENTER	0	23,342	23,342	3.851641	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	3,119	287,436	290,555	1.303512	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	70	15,346	15,416	10.679359	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	607,492	607,492			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	662,283	662,283			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,099,113	1,099,113			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	873,296	873,296			88.03
88.04	08804	RURAL HEALTH CLINIC V	0	873,296	873,296			88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	51,163	51,163			88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	143,904	143,904			88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	135,306	135,306			88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	638,977	638,977			88.08
91.00	09100	EMERGENCY	607,170	2,003,166	2,610,336	2.366695	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	269,790	1,296,396	1,566,186	0.685434	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	2,020,221	2,020,221			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	153,448,205	184,805,475	338,253,680			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	153,448,205	184,805,475	338,253,680			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/27/2018 10:15 am

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	0.171456		50.00
51.00	05100	RECOVERY ROOM	0.395926		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3.203005		52.00
53.00	05300	ANESTHESIOLOGY	0.065758		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.399284		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.622634		55.00
56.00	05600	RADIOISOTOPE	0.277433		56.00
57.00	05700	CT SCAN	0.048676		57.00
58.00	05800	MRI	0.102865		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.278255		59.00
60.00	06000	LABORATORY	0.155833		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.625811		62.00
64.00	06400	INTRAVENOUS THERAPY	0.545158		64.00
65.00	06500	RESPIRATORY THERAPY	2.332591		65.00
66.00	06600	PHYSICAL THERAPY	0.934282		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.538396		67.00
68.00	06800	SPEECH PATHOLOGY	0.861349		68.00
69.00	06900	ELECTROCARDIOLOGY	0.108644		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.597975		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.099211		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.580030		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.134451		73.00
74.00	07400	RENAL DIALYSIS	1.977212		74.00
76.00	03950	DIABETES CENTER	3.851641		76.00
76.97	07697	CARDIAC REHABILITATION	1.303512		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	10.679359		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
88.05	08805	RURAL HEALTH CLINIC VI			88.05
88.06	08806	RURAL HEALTH CLINIC VII			88.06
88.07	08807	RURAL HEALTH CLINIC VIII			88.07
88.08	08808	RURAL HEALTH CLINIC IX			88.08
91.00	09100	EMERGENCY	2.371281		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.685434		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 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/27/2018 10:15 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,114,737		15,114,737	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,935,861		3,935,861	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	2,991,087		2,991,087	0	0	41.00
43.00	04300	NURSERY	852,876		852,876	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,927,231		4,927,231	0	0	50.00
51.00	05100	RECOVERY ROOM	2,074,166		2,074,166	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,948,724		1,948,724	0	0	52.00
53.00	05300	ANESTHESIOLOGY	493,904		493,904	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,938,214		3,938,214	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	3,659,578		3,659,578	0	0	55.00
56.00	05600	RADIOISOTOPE	699,607		699,607	0	0	56.00
57.00	05700	CT SCAN	919,957		919,957	0	0	57.00
58.00	05800	MRI	563,368		563,368	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,961,451		1,961,451	0	0	59.00
60.00	06000	LABORATORY	5,956,489		5,956,489	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	760,325		760,325	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	842,022		842,022	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,861,226	0	1,861,226	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,646,175	0	1,646,175	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	477,905	0	477,905	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	258,639	0	258,639	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	210,679		210,679	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	354,668		354,668	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,610,668		10,610,668	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,355,957		4,355,957	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,414,318		8,414,318	0	0	73.00
74.00	07400	RENAL DIALYSIS	109,933		109,933	0	0	74.00
76.00	03950	DIABETES CENTER	89,905		89,905	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	378,742		378,742	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	164,633		164,633	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	784,457		784,457	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,289,878		1,289,878	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,408,397		1,408,397	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,334,077		1,334,077	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	1,281,409		1,281,409	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	89,300		89,300	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	150,281		150,281	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	122,486		122,486	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	1,388,207		1,388,207	0	0	88.08
91.00	09100	EMERGENCY	6,177,870		6,177,870	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,073,517		1,073,517		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,268,447		2,268,447		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	97,941,371	0	97,941,371	0	0	200.00
201.00		Less Observation Beds	1,073,517		1,073,517		0	201.00
202.00		Total (see instructions)	96,867,854	0	96,867,854	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/27/2018 10:15 am

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	5,711,471		5,711,471			30.00
31.00	03100	INTENSIVE CARE UNIT	1,542,821		1,542,821			31.00
41.00	04100	SUBPROVIDER - IRF	1,987,672		1,987,672			41.00
43.00	04300	NURSERY	241,971		241,971			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,080,210	16,657,454	28,737,664	0.171456	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,763,161	3,475,616	5,238,777	0.395926	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	457,895	150,510	608,405	3.203005	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	4,253,873	3,938,348	8,192,221	0.060289	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,324,715	7,538,472	9,863,187	0.399284	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	6,570	5,871,004	5,877,574	0.622634	0.000000	55.00
56.00	05600	RADIOISOTOPE	358,025	2,163,688	2,521,713	0.277433	0.000000	56.00
57.00	05700	CT SCAN	4,300,730	14,598,703	18,899,433	0.048676	0.000000	57.00
58.00	05800	MRI	539,160	4,937,602	5,476,762	0.102865	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,179,868	3,869,251	7,049,119	0.278255	0.000000	59.00
60.00	06000	LABORATORY	11,587,638	26,967,931	38,555,569	0.154491	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	559,794	655,150	1,214,944	0.625811	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	279,972	1,264,576	1,544,548	0.545158	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	293,700	504,222	797,922	2.332591	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,217,764	544,204	1,761,968	0.934282	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	878,930	8,716	887,646	0.538396	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	159,184	141,088	300,272	0.861349	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	550,036	1,389,125	1,939,161	0.108644	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	9,816	583,299	593,115	0.597975	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	64,642,817	42,307,881	106,950,698	0.099211	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,054,305	6,455,582	7,509,887	0.580030	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,530,358	30,052,316	62,582,674	0.134451	0.000000	73.00
74.00	07400	RENAL DIALYSIS	55,600	0	55,600	1.977212	0.000000	74.00
76.00	03950	DIABETES CENTER	0	23,342	23,342	3.851641	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	3,119	287,436	290,555	1.303512	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	70	15,346	15,416	10.679359	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	607,492	607,492	1.291304	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	662,283	662,283	1.947624	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,099,113	1,099,113	1.281394	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	873,296	873,296	1.527634	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	873,296	873,296	1.467325	0.000000	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	51,163	51,163	1.745402	0.000000	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	143,904	143,904	1.044314	0.000000	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	135,306	135,306	0.905252	0.000000	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	638,977	638,977	2.172546	0.000000	88.08
91.00	09100	EMERGENCY	607,170	2,003,166	2,610,336	2.366695	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	269,790	1,296,396	1,566,186	0.685434	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	2,020,221	2,020,221			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	153,448,205	184,805,475	338,253,680			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	153,448,205	184,805,475	338,253,680			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/27/2018 10:15 am

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
88.05	08805	RURAL HEALTH CLINIC VI	0.000000		88.05
88.06	08806	RURAL HEALTH CLINIC VII	0.000000		88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0.000000		88.07
88.08	08808	RURAL HEALTH CLINIC IX	0.000000		88.08
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 10/01/2016 To 09/30/2017 | Worksheet D Part I Date/Time Prepared: 2/27/2018 10:15 am

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	753,679	0	753,679	13,432	56.11	30.00
31.00	INTENSIVE CARE UNIT	211,855		211,855	1,886	112.33	31.00
41.00	SUBPROVIDER - IRF	149,420	0	149,420	2,156	69.30	41.00
43.00	NURSERY	39,832		39,832	1,164	34.22	43.00
200.00	Total (lines 30 through 199)	1,154,786		1,154,786	18,638		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	7,397	415,046				30.00
31.00	INTENSIVE CARE UNIT	1,000	112,330				31.00
41.00	SUBPROVIDER - IRF	1,696	117,533				41.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	10,093	644,909				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part II Date/Time Prepared: 2/27/2018 10:15 am

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	1,095,960	28,737,664	0.038137	6,940,059	264,673	50.00
51.00	05100	RECOVERY ROOM	103,367	5,238,777	0.019731	717,678	14,161	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	49,953	608,405	0.082105	67,554	5,547	52.00
53.00	05300	ANESTHESIOLOGY	85,613	8,192,221	0.010451	2,248,351	23,498	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	666,398	9,863,187	0.067564	1,340,353	90,560	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	782,172	5,877,574	0.133077	2,658	354	55.00
56.00	05600	RADIOISOTOPE	226,861	2,521,713	0.089963	270,453	24,331	56.00
57.00	05700	CT SCAN	186,490	18,899,433	0.009867	2,356,207	23,249	57.00
58.00	05800	MRI	186,350	5,476,762	0.034026	306,521	10,430	58.00
59.00	05900	CARDIAC CATHETERIZATION	85,658	7,049,119	0.012152	1,368,423	16,629	59.00
60.00	06000	LABORATORY	380,200	38,555,569	0.009861	6,513,810	64,233	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	15,173	1,214,944	0.012489	332,689	4,155	62.00
64.00	06400	INTRAVENOUS THERAPY	116,079	1,544,548	0.075154	279,972	21,041	64.00
65.00	06500	RESPIRATORY THERAPY	150,675	797,922	0.188834	143,041	27,011	65.00
66.00	06600	PHYSICAL THERAPY	61,925	1,761,968	0.035145	472,671	16,612	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,128	887,646	0.011410	201,886	2,304	67.00
68.00	06800	SPEECH PATHOLOGY	6,588	300,272	0.021940	41,378	908	68.00
69.00	06900	ELECTROCARDIOLOGY	46,847	1,939,161	0.024158	335,616	8,108	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	29,569	593,115	0.049854	5,797	289	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	200,242	106,950,698	0.001872	31,917,510	59,750	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	82,204	7,509,887	0.010946	511,582	5,600	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	327,153	62,582,674	0.005228	15,514,536	81,110	73.00
74.00	07400	RENAL DIALYSIS	1,936	55,600	0.034820	36,125	1,258	74.00
76.00	03950	DIABETES CENTER	1,677	23,342	0.071845	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	42,781	290,555	0.147239	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	3,991	15,416	0.258887	2	1	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	36,717	607,492	0.060440	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	141,725	662,283	0.213995	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	78,749	1,099,113	0.071648	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	87,958	873,296	0.100720	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	51,350	873,296	0.058800	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	7,185	51,163	0.140434	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	15,627	143,904	0.108593	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	3,716	135,306	0.027464	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	41,710	638,977	0.065276	0	0	88.08
91.00	09100	EMERGENCY	423,922	2,610,336	0.162401	306,139	49,717	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	53,530	1,566,186	0.034179	218,730	7,476	92.00
200.00		Total (lines 50 through 199)	5,888,179	326,749,524		72,449,741	823,005	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part III Date/Time Prepared: 2/27/2018 10:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	13,432	0.00	7,397	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,886	0.00	1,000	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	2,156	0.00	1,696	41.00
43.00	04300	NURSERY		0	1,164	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	18,638		10,093	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		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	0	41.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/27/2018 10:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	0	0	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	0	0	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	0	0	0	0	88.08
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 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/27/2018 10:15 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	28,737,664	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	5,238,777	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	608,405	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	8,192,221	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,863,187	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	5,877,574	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	2,521,713	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	18,899,433	0.000000	57.00
58.00	05800	MRI	0	0	0	5,476,762	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	7,049,119	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	38,555,569	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,214,944	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,544,548	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	797,922	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,761,968	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	887,646	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	300,272	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,939,161	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	593,115	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	106,950,698	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,509,887	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	62,582,674	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	55,600	0.000000	74.00
76.00	03950	DIABETES CENTER	0	0	0	23,342	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	290,555	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	15,416	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	607,492	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	662,283	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	1,099,113	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	873,296	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	873,296	0.000000	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	51,163	0.000000	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	0	0	143,904	0.000000	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	0	0	135,306	0.000000	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	0	0	638,977	0.000000	88.08
91.00	09100	EMERGENCY	0	0	0	2,610,336	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,566,186	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	326,749,524		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/27/2018 10:15 am

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		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	6,940,059	0	5,557,252	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	717,678	0	1,513,695	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	67,554	0	34,009	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,248,351	0	1,105,161	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,340,353	0	2,061,444	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	2,658	0	2,519,362	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	270,453	0	1,096,593	0	56.00
57.00	05700	CT SCAN	0.000000	2,356,207	0	4,953,172	0	57.00
58.00	05800	MRI	0.000000	306,521	0	1,734,629	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	1,368,423	0	2,237,690	0	59.00
60.00	06000	LABORATORY	0.000000	6,513,810	0	5,118,218	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	332,689	0	210,406	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	279,972	0	280,215	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	143,041	0	278,980	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	472,671	0	1,740	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	201,886	0	620	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	41,378	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	335,616	0	524,160	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	5,797	0	195,749	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	31,917,510	0	12,111,478	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	511,582	0	3,946,705	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	15,514,536	0	9,463,181	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	36,125	0	0	0	74.00
76.00	03950	DIABETES CENTER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	156,983	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	2	0	4,970	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000	0	0	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0.000000	0	0	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0.000000	0	0	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0.000000	0	0	0	0	88.08
91.00	09100	EMERGENCY	0.000000	306,139	0	534,138	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	218,730	0	601,680	0	92.00
200.00		Total (lines 50 through 199)		72,449,741	0	56,242,230	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/27/2018 10:15 am

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		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	0.171456	5,557,252	0	0	952,824	50.00
51.00	05100	RECOVERY ROOM	0.395926	1,513,695	0	0	599,311	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3.203005	34,009	0	0	108,931	52.00
53.00	05300	ANESTHESIOLOGY	0.060289	1,105,161	0	0	66,629	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.399284	2,061,444	0	0	823,102	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.622634	2,519,362	0	0	1,568,640	55.00
56.00	05600	RADIOISOTOPE	0.277433	1,096,593	0	0	304,231	56.00
57.00	05700	CT SCAN	0.048676	4,953,172	0	0	241,101	57.00
58.00	05800	MRI	0.102865	1,734,629	0	0	178,433	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.278255	2,237,690	0	0	622,648	59.00
60.00	06000	LABORATORY	0.154491	5,118,218	590	0	790,719	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.625811	210,406	12	0	131,674	62.00
64.00	06400	INTRAVENOUS THERAPY	0.545158	280,215	0	0	152,761	64.00
65.00	06500	RESPIRATORY THERAPY	2.332591	278,980	0	0	650,746	65.00
66.00	06600	PHYSICAL THERAPY	0.934282	1,740	0	0	1,626	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.538396	620	0	0	334	67.00
68.00	06800	SPEECH PATHOLOGY	0.861349	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108644	524,160	0	0	56,947	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.597975	195,749	0	0	117,053	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.099211	12,111,478	0	0	1,201,592	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.580030	3,946,705	0	0	2,289,207	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.134451	9,463,181	0	140	1,272,334	73.00
74.00	07400	RENAL DIALYSIS	1.977212	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	3.851641	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.303512	156,983	0	0	204,629	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	10.679359	4,970	0	0	53,076	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
88.05	08805	RURAL HEALTH CLINIC VI	0.000000				0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0.000000				0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0.000000				0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0.000000				0	88.08
91.00	09100	EMERGENCY	2.366695	534,138	0	0	1,264,142	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.685434	601,680	0	0	412,412	92.00
200.00		Subtotal (see instructions)		56,242,230	602	140	14,065,102	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		56,242,230	602	140	14,065,102	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/27/2018 10:15 am

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	91	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	8	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	0	19		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
88.05	08805	RURAL HEALTH CLINIC VI	0	0		88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	0		88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	0		88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	0		88.08
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)	99	19		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	99	19		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 26-0025 | Component CCN: 26-T025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part II Date/Time Prepared: 2/27/2018 10:15 am

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	1,095,960	28,737,664	0.038137	168	6	50.00
51.00	05100	RECOVERY ROOM	103,367	5,238,777	0.019731	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	49,953	608,405	0.082105	1	0	52.00
53.00	05300	ANESTHESIOLOGY	85,613	8,192,221	0.010451	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	666,398	9,863,187	0.067564	28,117	1,900	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	782,172	5,877,574	0.133077	0	0	55.00
56.00	05600	RADIOISOTOPE	226,861	2,521,713	0.089963	195	18	56.00
57.00	05700	CT SCAN	186,490	18,899,433	0.009867	42,954	424	57.00
58.00	05800	MRI	186,350	5,476,762	0.034026	9,675	329	58.00
59.00	05900	CARDIAC CATHETERIZATION	85,658	7,049,119	0.012152	155	2	59.00
60.00	06000	LABORATORY	380,200	38,555,569	0.009861	170,367	1,680	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	15,173	1,214,944	0.012489	6,229	78	62.00
64.00	06400	INTRAVENOUS THERAPY	116,079	1,544,548	0.075154	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	150,675	797,922	0.188834	3,850	727	65.00
66.00	06600	PHYSICAL THERAPY	61,925	1,761,968	0.035145	424,652	14,924	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,128	887,646	0.011410	469,033	5,352	67.00
68.00	06800	SPEECH PATHOLOGY	6,588	300,272	0.021940	56,877	1,248	68.00
69.00	06900	ELECTROCARDIOLOGY	46,847	1,939,161	0.024158	4,640	112	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	29,569	593,115	0.049854	349	17	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	200,242	106,950,698	0.001872	178,317	334	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	82,204	7,509,887	0.010946	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	327,153	62,582,674	0.005228	189,573	991	73.00
74.00	07400	RENAL DIALYSIS	1,936	55,600	0.034820	3,150	110	74.00
76.00	03950	DIABETES CENTER	1,677	23,342	0.071845	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	42,781	290,555	0.147239	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	3,991	15,416	0.258887	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	36,717	607,492	0.060440	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	141,725	662,283	0.213995	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	78,749	1,099,113	0.071648	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	87,958	873,296	0.100720	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	51,350	873,296	0.058800	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	7,185	51,163	0.140434	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	15,627	143,904	0.108593	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	3,716	135,306	0.027464	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	41,710	638,977	0.065276	0	0	88.08
91.00	09100	EMERGENCY	423,922	2,610,336	0.162401	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,566,186	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	5,834,649	326,749,524		1,588,302	28,252	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0025 | Component CCN: 26-T025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/27/2018 10:15 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	0	0	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	0	0	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	0	0	0	0	88.08
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 through 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 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/27/2018 10:15 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	28,737,664	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	5,238,777	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	608,405	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	8,192,221	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,863,187	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	5,877,574	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	2,521,713	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	18,899,433	0.000000	57.00
58.00	05800	MRI	0	0	0	5,476,762	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	7,049,119	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	38,555,569	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,214,944	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,544,548	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	797,922	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,761,968	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	887,646	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	300,272	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,939,161	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	593,115	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	106,950,698	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,509,887	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	62,582,674	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	55,600	0.000000	74.00
76.00	03950	DIABETES CENTER	0	0	0	23,342	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	290,555	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	15,416	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	607,492	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	662,283	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	1,099,113	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	873,296	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	873,296	0.000000	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	51,163	0.000000	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	0	0	143,904	0.000000	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	0	0	135,306	0.000000	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	0	0	638,977	0.000000	88.08
91.00	09100	EMERGENCY	0	0	0	2,610,336	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,566,186	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	326,749,524		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0025 | Component CCN: 26-T025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/27/2018 10:15 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	168	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	1	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	28,117	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	195	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	42,954	0	0	0	57.00
58.00	05800	MRI	0.000000	9,675	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	155	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	170,367	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	6,229	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	3,850	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	424,652	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	469,033	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	56,877	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	4,640	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	349	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	178,317	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	189,573	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	3,150	0	0	0	74.00
76.00	03950	DIABETES CENTER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000	0	0	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0.000000	0	0	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0.000000	0	0	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0.000000	0	0	0	0	88.08
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,588,302	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part I | Date/Time Prepared: 2/27/2018 10:15 am

Title XIX | Hospital | Cost

	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	753,679	0	753,679	13,432	56.11	30.00
31.00	INTENSIVE CARE UNIT	211,855		211,855	1,886	112.33	31.00
41.00	SUBPROVIDER - IRF	149,420	0	149,420	2,156	69.30	41.00
43.00	NURSERY	39,832		39,832	1,164	34.22	43.00
200.00	Total (lines 30 through 199)	1,154,786		1,154,786	18,638		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	835	46,852		30.00
31.00	INTENSIVE CARE UNIT	204	22,915		31.00
41.00	SUBPROVIDER - IRF	0	0		41.00
43.00	NURSERY	122	4,175		43.00
200.00	Total (lines 30 through 199)	1,161	73,942		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part II Date/Time Prepared: 2/27/2018 10:15 am

Title XIX | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,095,960	28,737,664	0.038137	54,893	2,093	50.00
51.00	05100	RECOVERY ROOM	103,367	5,238,777	0.019731	36,152	713	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	49,953	608,405	0.082105	5,069	416	52.00
53.00	05300	ANESTHESIOLOGY	85,613	8,192,221	0.010451	42,639	446	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	666,398	9,863,187	0.067564	151,870	10,261	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	782,172	5,877,574	0.133077	0	0	55.00
56.00	05600	RADIOISOTOPE	226,861	2,521,713	0.089963	18,898	1,700	56.00
57.00	05700	CT SCAN	186,490	18,899,433	0.009867	268,889	2,653	57.00
58.00	05800	MRI	186,350	5,476,762	0.034026	50,972	1,734	58.00
59.00	05900	CARDIAC CATHETERIZATION	85,658	7,049,119	0.012152	122,676	1,491	59.00
60.00	06000	LABORATORY	380,200	38,555,569	0.009861	807,303	7,961	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	15,173	1,214,944	0.012489	5,710	71	62.00
64.00	06400	INTRAVENOUS THERAPY	116,079	1,544,548	0.075154	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	150,675	797,922	0.188834	11,822	2,232	65.00
66.00	06600	PHYSICAL THERAPY	61,925	1,761,968	0.035145	20,348	715	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,128	887,646	0.011410	4,837	55	67.00
68.00	06800	SPEECH PATHOLOGY	6,588	300,272	0.021940	6,287	138	68.00
69.00	06900	ELECTROCARDIOLOGY	46,847	1,939,161	0.024158	36,636	885	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	29,569	593,115	0.049854	1,047	52	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	200,242	106,950,698	0.001872	1,931,259	3,615	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	82,204	7,509,887	0.010946	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	327,153	62,582,674	0.005228	1,516,786	7,930	73.00
74.00	07400	RENAL DIALYSIS	1,936	55,600	0.034820	4,550	158	74.00
76.00	03950	DIABETES CENTER	1,677	23,342	0.071845	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	42,781	290,555	0.147239	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	3,991	15,416	0.258887	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	36,717	607,492	0.060440	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	141,725	662,283	0.213995	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	78,749	1,099,113	0.071648	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	87,958	873,296	0.100720	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	51,350	873,296	0.058800	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	7,185	51,163	0.140434	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	15,627	143,904	0.108593	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	3,716	135,306	0.027464	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	41,710	638,977	0.065276	0	0	88.08
91.00	09100	EMERGENCY	423,922	2,610,336	0.162401	301,031	48,888	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	53,530	1,566,186	0.034179	39,330	1,344	92.00
200.00		Total (lines 50 through 199)	5,888,179	326,749,524		5,439,004	95,551	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part III Date/Time Prepared: 2/27/2018 10:15 am

Title XIX | Hospital | Cost

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	13,432	0.00	835	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,886	0.00	204	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	2,156	0.00	0	41.00
43.00	04300	NURSERY		0	1,164	0.00	122	43.00
200.00		Total (lines 30 through 199)		0	18,638		1,161	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		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	0	41.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/27/2018 10:15 am

Title XIX | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	0	0	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	0	0	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	0	0	0	0	88.08
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 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/27/2018 10:15 am

Title XIX | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	28,737,664	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	5,238,777	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	608,405	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	8,192,221	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,863,187	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	5,877,574	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	2,521,713	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	18,899,433	0.000000	57.00
58.00	05800	MRI	0	0	0	5,476,762	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	7,049,119	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	38,555,569	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,214,944	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,544,548	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	797,922	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,761,968	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	887,646	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	300,272	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,939,161	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	593,115	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	106,950,698	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,509,887	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	62,582,674	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	55,600	0.000000	74.00
76.00	03950	DIABETES CENTER	0	0	0	23,342	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	290,555	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	15,416	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	607,492	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	662,283	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	1,099,113	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	873,296	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	873,296	0.000000	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	51,163	0.000000	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	0	0	143,904	0.000000	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	0	0	135,306	0.000000	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	0	0	638,977	0.000000	88.08
91.00	09100	EMERGENCY	0	0	0	2,610,336	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,566,186	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	326,749,524		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/27/2018 10:15 am

Title XIX | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	54,893	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	36,152	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	5,069	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	42,639	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	151,870	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	18,898	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	268,889	0	0	0	57.00
58.00	05800	MRI	0.000000	50,972	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	122,676	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	807,303	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	5,710	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	11,822	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	20,348	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	4,837	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	6,287	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	36,636	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	1,047	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,931,259	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,516,786	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	4,550	0	0	0	74.00
76.00	03950	DIABETES CENTER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000	0	0	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0.000000	0	0	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0.000000	0	0	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0.000000	0	0	0	0	88.08
91.00	09100	EMERGENCY	0.000000	301,031	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	39,330	0	0	0	92.00
200.00		Total (lines 50 through 199)		5,439,004	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/27/2018 10:15 am

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	0.171456	0	1,190,520	0	0	50.00
51.00	05100	RECOVERY ROOM	0.395926	0	262,045	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3.203005	0	10,317	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.060289	0	296,653	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.399284	0	636,742	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.622634	0	179,889	0	0	55.00
56.00	05600	RADIOISOTOPE	0.277433	0	107,172	0	0	56.00
57.00	05700	CT SCAN	0.048676	0	1,103,429	0	0	57.00
58.00	05800	MRI	0.102865	0	407,386	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.278255	0	211,356	0	0	59.00
60.00	06000	LABORATORY	0.154491	0	2,315,125	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.625811	0	35,605	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.545158	0	124,162	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2.332591	0	31,706	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.934282	0	15,877	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.538396	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.861349	0	2,632	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108644	0	93,811	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.597975	0	41,780	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.099211	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.580030	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.134451	0	2,455,263	0	0	73.00
74.00	07400	RENAL DIALYSIS	1.977212	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	3.851641	0	152	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.303512	0	3,094	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	10.679359	0	2,798	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1.291304				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.947624				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1.281394				0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1.527634				0	88.03
88.04	08804	RURAL HEALTH CLINIC V	1.467325				0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	1.745402				0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	1.044314				0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0.905252				0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	2.172546				0	88.08
91.00	09100	EMERGENCY	2.366695	0	242,084	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.685434	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	9,769,598	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	9,769,598	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/27/2018 10:15 am

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	204,122	0		50.00
51.00	05100	RECOVERY ROOM	103,750	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	33,045	0		52.00
53.00	05300	ANESTHESIOLOGY	17,885	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	254,241	0		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	112,005	0		55.00
56.00	05600	RADIOISOTOPE	29,733	0		56.00
57.00	05700	CT SCAN	53,711	0		57.00
58.00	05800	MRI	41,906	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	58,811	0		59.00
60.00	06000	LABORATORY	357,666	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	22,282	0		62.00
64.00	06400	INTRAVENOUS THERAPY	67,688	0		64.00
65.00	06500	RESPIRATORY THERAPY	73,957	0		65.00
66.00	06600	PHYSICAL THERAPY	14,834	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	2,267	0		68.00
69.00	06900	ELECTROCARDIOLOGY	10,192	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	24,983	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	330,113	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	DIABETES CENTER	585	0		76.00
76.97	07697	CARDIAC REHABILITATION	4,033	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	29,881	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
88.05	08805	RURAL HEALTH CLINIC VI	0	0		88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	0		88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	0		88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	0		88.08
91.00	09100	EMERGENCY	572,939	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	2,420,629	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	2,420,629	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/27/2018 10:15 am

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)	13,432	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,432	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)	12,478	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)	7,397	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	15,114,737	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	15,114,737	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	15,114,737	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)	1,125.28	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	8,323,696	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)	8,323,696	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/27/2018 10:15 am

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	3,935,861	1,886	2,086.88	1,000	2,086,880	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)	11,809,133	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	22,219,709	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)	527,376	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	823,005	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,350,381	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	20,869,328	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)	954	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,125.28	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,073,517	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/27/2018 10:15 am

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	753,679	15,114,737	0.049864	1,073,517	53,530	90.00
91.00	Nursing School cost	0	15,114,737	0.000000	1,073,517	0	91.00
92.00	Allied health cost	0	15,114,737	0.000000	1,073,517	0	92.00
93.00	All other Medical Education	0	15,114,737	0.000000	1,073,517	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 26-0025 Component CCN: 26-T025	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/27/2018 10:15 am
	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)	2,156	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,156	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)	2,156	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)	1,696	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)	2,991,087	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)	2,991,087	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)	2,991,087	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)	1,387.33	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,352,912	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)	2,352,912	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-0025 | Component CCN: 26-T025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/27/2018 10:15 am

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)	802,250	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,155,162	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)	117,533	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	28,252	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	145,785	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,009,377	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 Component CCN: 26-T025	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/27/2018 10:15 am
	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	149,420	2,991,087	0.049955	0	0	90.00
91.00	Nursing School cost	0	2,991,087	0.000000	0	0	91.00
92.00	Allied health cost	0	2,991,087	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,991,087	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/27/2018 10:15 am

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)	13,432	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,432	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)	12,478	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)	835	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)	122	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	15,114,737	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	15,114,737	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	15,114,737	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)	1,125.28	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	939,609	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)	939,609	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/27/2018 10:15 am

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)	852,876	1,164	732.71	122	89,391	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,935,861	1,886	2,086.88	204	425,724	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)	1,492,325	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,947,049	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)	954	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,125.28	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,073,517	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/27/2018 10:15 am

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	753,679	15,114,737	0.049864	1,073,517	53,530	90.00
91.00	Nursing School cost	0	15,114,737	0.000000	1,073,517	0	91.00
92.00	Allied health cost	0	15,114,737	0.000000	1,073,517	0	92.00
93.00	All other Medical Education	0	15,114,737	0.000000	1,073,517	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/27/2018 10:15 am

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		3,377,870		30.00
31.00	03100	INTENSIVE CARE UNIT		845,300		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	0.171456	6,940,059	1,189,915	50.00
51.00	05100	RECOVERY ROOM	0.395926	717,678	284,147	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3.203005	67,554	216,376	52.00
53.00	05300	ANESTHESIOLOGY	0.065758	2,248,351	147,847	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.399284	1,340,353	535,182	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.622634	2,658	1,655	55.00
56.00	05600	RADIOISOTOPE	0.277433	270,453	75,033	56.00
57.00	05700	CT SCAN	0.048676	2,356,207	114,691	57.00
58.00	05800	MRI	0.102865	306,521	31,530	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.278255	1,368,423	380,771	59.00
60.00	06000	LABORATORY	0.155833	6,513,810	1,015,067	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.625811	332,689	208,200	62.00
64.00	06400	INTRAVENOUS THERAPY	0.545158	279,972	152,629	64.00
65.00	06500	RESPIRATORY THERAPY	2.332591	143,041	333,656	65.00
66.00	06600	PHYSICAL THERAPY	0.934282	472,671	441,608	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.538396	201,886	108,695	67.00
68.00	06800	SPEECH PATHOLOGY	0.861349	41,378	35,641	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108644	335,616	36,463	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.597975	5,797	3,466	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.099211	31,917,510	3,166,568	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.580030	511,582	296,733	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.134451	15,514,536	2,085,945	73.00
74.00	07400	RENAL DIALYSIS	1.977212	36,125	71,427	74.00
76.00	03950	DIABETES CENTER	3.851641	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.303512	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	10.679359	2	21	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
88.05	08805	RURAL HEALTH CLINIC VI	0.000000		0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0.000000		0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0.000000		0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0.000000		0	88.08
91.00	09100	EMERGENCY	2.371281	306,139	725,942	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.685434	218,730	149,925	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		72,449,741	11,809,133	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)		72,449,741		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 26-0025 | Component CCN: 26-T025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/27/2018 10:15 am

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		1,529,100		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.171456	168	29	50.00
51.00	05100	RECOVERY ROOM	0.395926	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3.203005	1	3	52.00
53.00	05300	ANESTHESIOLOGY	0.065758	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.399284	28,117	11,227	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.622634	0	0	55.00
56.00	05600	RADIOISOTOPE	0.277433	195	54	56.00
57.00	05700	CT SCAN	0.048676	42,954	2,091	57.00
58.00	05800	MRI	0.102865	9,675	995	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.278255	155	43	59.00
60.00	06000	LABORATORY	0.155833	170,367	26,549	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.625811	6,229	3,898	62.00
64.00	06400	INTRAVENOUS THERAPY	0.545158	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2.332591	3,850	8,980	65.00
66.00	06600	PHYSICAL THERAPY	0.934282	424,652	396,745	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.538396	469,033	252,525	67.00
68.00	06800	SPEECH PATHOLOGY	0.861349	56,877	48,991	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108644	4,640	504	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.597975	349	209	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.099211	178,317	17,691	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.580030	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.134451	189,573	25,488	73.00
74.00	07400	RENAL DIALYSIS	1.977212	3,150	6,228	74.00
76.00	03950	DIABETES CENTER	3.851641	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.303512	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	10.679359	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
88.05	08805	RURAL HEALTH CLINIC VI	0.000000		0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0.000000		0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0.000000		0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0.000000		0	88.08
91.00	09100	EMERGENCY	2.371281	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.685434	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,588,302	802,250	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)		1,588,302		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/27/2018 10:15 am

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		293,016		30.00
31.00	03100	INTENSIVE CARE UNIT		125,507		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		17,644		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.171456	54,893	9,412	50.00
51.00	05100	RECOVERY ROOM	0.395926	36,152	14,314	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3.203005	5,069	16,236	52.00
53.00	05300	ANESTHESIOLOGY	0.060289	42,639	2,571	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.399284	151,870	60,639	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.622634	0	0	55.00
56.00	05600	RADIOISOTOPE	0.277433	18,898	5,243	56.00
57.00	05700	CT SCAN	0.048676	268,889	13,088	57.00
58.00	05800	MRI	0.102865	50,972	5,243	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.278255	122,676	34,135	59.00
60.00	06000	LABORATORY	0.154491	807,303	124,721	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.625811	5,710	3,573	62.00
64.00	06400	INTRAVENOUS THERAPY	0.545158	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2.332591	11,822	27,576	65.00
66.00	06600	PHYSICAL THERAPY	0.934282	20,348	19,011	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.538396	4,837	2,604	67.00
68.00	06800	SPEECH PATHOLOGY	0.861349	6,287	5,415	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108644	36,636	3,980	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.597975	1,047	626	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.099211	1,931,259	191,602	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.580030	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.134451	1,516,786	203,933	73.00
74.00	07400	RENAL DIALYSIS	1.977212	4,550	8,996	74.00
76.00	03950	DIABETES CENTER	3.851641	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.303512	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	10.679359	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.291304	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.947624	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1.281394	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1.527634	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	1.467325	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	1.745402	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	1.044314	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0.905252	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	2.172546	0	0	88.08
91.00	09100	EMERGENCY	2.366695	301,031	712,449	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.685434	39,330	26,958	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,439,004	1,492,325	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)		5,439,004		202.00

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		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)	15,938,735	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)	503,024	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	2,025,737	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	83.39	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 § 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 § 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 § 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 § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 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)	4.63	30.00
31.00	Percentage of Medicaid patient days (see instructions)	14.69	31.00
32.00	Sum of lines 30 and 31	19.32	32.00
33.00	Allowable disproportionate share percentage (see instructions)	5.31	33.00
34.00	Disproportionate share adjustment (see instructions)	211,587	34.00

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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	5,977,483,147	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000091264	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	545,529	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	545,529	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	545,529		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)	17,198,875		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	21,637,508		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		21,637,508	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,339,374	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		5,250	54.00
54.01	Islet isolation add-on payment		0	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)		22,982,132	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		22,982,132	61.00
62.00	Deductibles billed to program beneficiaries		2,052,568	62.00
63.00	Coinsurance billed to program beneficiaries		22,526	63.00
64.00	Allowable bad debts (see instructions)		503,558	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		327,313	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		415,226	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		21,234,351	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 Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		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)		183,898	70.93
70.94	HRR adjustment amount (see instructions)		-172,194	70.94
70.95	Recovery of accelerated depreciation		0	70.95

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		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)		232,177	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		21,013,878	71.00
71.01	Sequestration adjustment (see instructions)		420,278	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		20,872,445	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, 71.02, 72, and 73)		-278,845	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
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (line 209 plus line 210) (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 26-0025	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part B Date/Time Prepared: 2/27/2018 10:15 am
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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	118	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	14,065,102	2.00
3.00	OPPS payments	9,985,168	3.00
4.00	Outlier payment (see instructions)	601,539	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.882	5.00
6.00	Line 2 times line 5	12,405,420	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	85.34	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)	118	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	742	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)	742	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)	742	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	624	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) (see instructions)	118	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	10,586,707	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	12	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,799,801	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)	8,787,012	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)	8,787,012	30.00
31.00	Primary payer payments	155	31.00
32.00	Subtotal (line 30 minus line 31)	8,786,857	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)	234,714	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	152,564	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	101,066	36.00
37.00	Subtotal (see instructions)	8,939,421	37.00
38.00	MSP-LCC reconciliation amount from PS&R	484	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	8,938,937	40.00
40.01	Sequestration adjustment (see instructions)	178,779	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	8,732,822	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	27,336	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

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		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		20,872,445		8,732,822	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)		20,872,445		8,732,822	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		27,336	6.01
6.02	SETTLEMENT TO PROGRAM		278,845		0	6.02
7.00	Total Medicare program liability (see instructions)		20,593,600		8,760,158	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 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 2/27/2018 10:15 am

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		2,505,173		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)		2,505,173		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)		2,505,173		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 10/01/2016 To 09/30/2017	Worksheet E-1 Part II Date/Time Prepared: 2/27/2018 10:15 am
	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		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 26-0025 Component CCN: 26-T025	Period: From 10/01/2016 To 09/30/2017	Worksheet E-3 Part III Date/Time Prepared: 2/27/2018 10:15 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	2,458,376	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	132,601	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)	5.906849	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)	2,590,977	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)	2,590,977	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	2,590,977	19.00
20.00	Deductibles	26,124	20.00
21.00	Subtotal (line 19 minus line 20)	2,564,853	21.00
22.00	Coinsurance	8,554	22.00
23.00	Subtotal (line 21 minus line 22)	2,556,299	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)	2,556,299	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	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	2,556,299	32.00
32.01	Sequestration adjustment (see instructions)	51,126	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	2,505,173	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, 32.02, 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	132,601	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 10/01/2016 To 09/30/2017	Worksheet E-3 Part VII Date/Time Prepared: 2/27/2018 10:15 am
	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	2,947,049		1.00
2.00	Medical and other services		2,420,629	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	2,947,049	2,420,629	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)	2,947,049	2,420,629	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	436,167		8.00
9.00	Ancillary service charges	5,439,004	9,769,598	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)	5,875,171	9,769,598	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)	5,875,171	9,769,598	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	2,928,122	7,348,969	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)	2,947,049	2,420,629	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)	2,947,049	2,420,629	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)	2,947,049	2,420,629	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)	2,947,049	2,420,629	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	2,947,049	2,420,629	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)	2,947,049	2,420,629	40.00
41.00	Interim payments	1,256,347	1,487,521	41.00
42.00	Balance due provider/program (line 40 minus line 41)	1,690,702	933,108	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 10/01/2016 To 09/30/2017 | Worksheet G | Date/Time Prepared: 2/27/2018 10:15 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	16,064,713	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	17,563,230	0	0	0	4.00
5.00	Other receivable	1,275,128	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	3,055,896	0	0	0	7.00
8.00	Prepaid expenses	1,102,034	0	0	0	8.00
9.00	Other current assets	646,420	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)	39,707,421	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,479,295	0	0	0	12.00
13.00	Land improvements	7,090,135	0	0	0	13.00
14.00	Accumulated depreciation	-6,095,856	0	0	0	14.00
15.00	Buildings	43,662,581	0	0	0	15.00
16.00	Accumulated depreciation	-28,314,578	0	0	0	16.00
17.00	Leasehold improvements	21,667,211	0	0	0	17.00
18.00	Accumulated depreciation	-12,596,604	0	0	0	18.00
19.00	Fixed equipment	1,516,001	0	0	0	19.00
20.00	Accumulated depreciation	-251,353	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	75,597,816	0	0	0	23.00
24.00	Accumulated depreciation	-61,338,668	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	3,966,726	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	47,382,706	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	60,476,926	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	4,628,957	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	65,105,883	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	152,196,010	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	8,079,427	0	0	0	37.00
38.00	Salaries, wages, and fees payable	8,181,590	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,914,170	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	9,504,322	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	28,679,509	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	6,870,722	0	0	0	47.00
48.00	Unsecured loans	4,201,653	0	0	0	48.00
49.00	Other long term liabilities	2,554,695	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	13,627,070	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	42,306,579	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	109,889,431				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)	109,889,431	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	152,196,010	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-1 | Date/Time Prepared: 2/27/2018 10:15 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		103,090,604		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		6,550,212				2.00
3.00	Total (sum of line 1 and line 2)		109,640,816		0		3.00
4.00	RESTRICTED ASSETS	248,615		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		248,615		0		10.00
11.00	Subtotal (line 3 plus line 10)		109,889,431		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		109,889,431		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	RESTRICTED ASSETS		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/27/2018 10:15 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,953,442		5,953,442	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	1,987,672		1,987,672	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)	7,941,114		7,941,114	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,542,821		1,542,821	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)	1,542,821		1,542,821	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	9,483,935		9,483,935	17.00
18.00	Ancillary services	142,850,794	174,637,378	317,488,172	18.00
19.00	Outpatient services	847,897	3,328,625	4,176,522	19.00
20.00	RURAL HEALTH CLINIC	0	607,492	607,492	20.00
20.01	RURAL HEALTH CLINIC II	0	662,283	662,283	20.01
20.02	RURAL HEALTH CLINIC III	0	1,099,113	1,099,113	20.02
20.03	RURAL HEALTH CLINIC IV	0	873,296	873,296	20.03
20.04	RURAL HEALTH CLINIC V	0	873,296	873,296	20.04
20.05	RURAL HEALTH CLINIC VI	0	51,163	51,163	20.05
20.06	RURAL HEALTH CLINIC VII	0	143,904	143,904	20.06
20.07	RURAL HEALTH CLINIC VIII	0	135,306	135,306	20.07
20.08	RURAL HEALTH CLINIC IX	0	638,977	638,977	20.08
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,020,221	2,020,221	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	3,575,944	6,351,401	9,927,345	27.00
27.01	PHYSICIAN REVENUE - NRCC	0	26,726,496	26,726,496	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	156,758,570	218,148,951	374,907,521	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		141,557,406		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)		141,557,406		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-3 | Date/Time Prepared: 2/27/2018 10:15 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	374,907,521	1.00
2.00	Less contractual allowances and discounts on patients' accounts	238,053,454	2.00
3.00	Net patient revenues (line 1 minus line 2)	136,854,067	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	141,557,406	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,703,339	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	599,661	6.00
7.00	Income from investments	3,097,750	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	631,185	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	1,107	17.00
18.00	Revenue from sale of medical records and abstracts	25,593	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	339,611	22.00
23.00	Governmental appropriations	0	23.00
24.00	DAYCARE INCOME	737,772	24.00
24.01	NON OPERATING INCOME	4,432,908	24.01
24.02	OTHER REVENUE	395,210	24.02
24.03	EHR MEANINGFUL USE	732,065	24.03
24.04	CONTRACTED SERVICES	260,689	24.04
25.00	Total other income (sum of lines 6-24)	11,253,551	25.00
26.00	Total (line 5 plus line 25)	6,550,212	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
27.01	OTHER EXPENSES (SPECIFY)	0	27.01
27.02	OTHER EXPENSES (SPECIFY)	0	27.02
27.03	OTHER EXPENSES (SPECIFY)	0	27.03
27.04	OTHER EXPENSES (SPECIFY)	0	27.04
27.05	OTHER EXPENSES (SPECIFY)	0	27.05
27.06	OTHER EXPENSES (SPECIFY)	0	27.06
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)	6,550,212	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 26-0025 | HHA CCN: 26-7282 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H | Date/Time Prepared: 2/27/2018 10:15 am

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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		2,485	2,485	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	1,118	1,118	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	236,438	29,321	0	0	112,373	378,132	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	424,121	52,596	0	0	6,198	482,915	6.00
7.00	Physical Therapy	221,392	27,455	0	0	0	248,847	7.00
8.00	Occupational Therapy	89,629	11,115	0	0	706	101,450	8.00
9.00	Speech Pathology	10,307	1,278	0	0	727	12,312	9.00
10.00	Medical Social Services	2,486	308	0	0	0	2,794	10.00
11.00	Home Health Aide	55,590	6,894	0	0	0	62,484	11.00
12.00	Supplies (see instructions)	0	0	0	0	505	505	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)	1,039,963	128,967	0	0	124,112	1,293,042	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	2,485	0	2,485			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	1,118	0	1,118			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	378,132	0	378,132			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	482,915	0	482,915			6.00
7.00	Physical Therapy	0	248,847	0	248,847			7.00
8.00	Occupational Therapy	0	101,450	0	101,450			8.00
9.00	Speech Pathology	0	12,312	0	12,312			9.00
10.00	Medical Social Services	0	2,794	0	2,794			10.00
11.00	Home Health Aide	0	62,484	0	62,484			11.00
12.00	Supplies (see instructions)	0	505	0	505			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	1,293,042	0	1,293,042			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 10/01/2016 To 09/30/2017 | Worksheet H-1 Part I | Date/Time Prepared: 2/27/2018 10:15 am

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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	2,485	2,485				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	1,118	0	0	1,118		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	378,132	2,485	0	1,118	0	381,735	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	482,915	0	0	0	0	482,915	6.00
7.00	Physical Therapy	248,847	0	0	0	0	248,847	7.00
8.00	Occupational Therapy	101,450	0	0	0	0	101,450	8.00
9.00	Speech Pathology	12,312	0	0	0	0	12,312	9.00
10.00	Medical Social Services	2,794	0	0	0	0	2,794	10.00
11.00	Home Health Aide	62,484	0	0	0	0	62,484	11.00
12.00	Supplies (see instructions)	505	0	0	0	0	505	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)	1,293,042	2,485	0	1,118	0	1,293,042	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	381,735			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	202,287	685,202		6.00
7.00	Physical Therapy	104,239	353,086		7.00
8.00	Occupational Therapy	42,496	143,946		8.00
9.00	Speech Pathology	5,157	17,469		9.00
10.00	Medical Social Services	1,170	3,964		10.00
11.00	Home Health Aide	26,174	88,658		11.00
12.00	Supplies (see instructions)	212	717		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)		1,293,042		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 26-0025 | HHA CCN: 26-7282 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-1 Part II | Date/Time Prepared: 2/27/2018 10:15 am

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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	-381,735	911,307	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	482,915	6.00
7.00	Physical Therapy	0	0	0	0	0	248,847	7.00
8.00	Occupational Therapy	0	0	0	0	0	101,450	8.00
9.00	Speech Pathology	0	0	0	0	0	12,312	9.00
10.00	Medical Social Services	0	0	0	0	0	2,794	10.00
11.00	Home Health Aide	0	0	0	0	0	62,484	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	505	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	-381,735	911,307	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	2,485	0	1,118	0		381,735	25.00
26.00	Unit Cost Multiplier	3.823077	0.000000	1.720000	0.000000		0.418887	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 26-0025 | HHA CCN: 26-7282 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-2 Part I | Date/Time Prepared: 2/27/2018 10:15 am

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	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	20,884	4,988	58,919	84,791	24,874	1.00
2.00	Skilled Nursing Care	685,202	0	0	105,688	790,890	232,014	2.00
3.00	Physical Therapy	353,086	0	0	55,170	408,256	119,765	3.00
4.00	Occupational Therapy	143,946	0	0	22,335	166,281	48,780	4.00
5.00	Speech Pathology	17,469	0	0	2,568	20,037	5,878	5.00
6.00	Medical Social Services	3,964	0	0	619	4,583	1,344	6.00
7.00	Home Health Aide	88,658	0	0	13,853	102,511	30,072	7.00
8.00	Supplies (see instructions)	717	0	0	0	717	210	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)	1,293,042	20,884	4,988	259,152	1,578,066	462,937	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	7,381	49,255	0	20,928	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)	7,381	49,255	0	20,928	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 10/01/2016 To 09/30/2017 | Worksheet H-2 Part I | Date/Time Prepared: 2/27/2018 10:15 am

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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	149,880	0	0	0	337,109	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	1,022,904	0	2.00
3.00	Physical Therapy	0	0	0	0	528,021	0	3.00
4.00	Occupational Therapy	0	0	0	0	215,061	0	4.00
5.00	Speech Pathology	0	0	0	0	25,915	0	5.00
6.00	Medical Social Services	0	0	0	0	5,927	0	6.00
7.00	Home Health Aide	0	0	0	0	132,583	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	927	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)	149,880	0	0	0	2,268,447	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	337,109						1.00
2.00	Skilled Nursing Care	1,022,904	178,545	1,201,449				2.00
3.00	Physical Therapy	528,021	92,164	620,185				3.00
4.00	Occupational Therapy	215,061	37,538	252,599				4.00
5.00	Speech Pathology	25,915	4,523	30,438				5.00
6.00	Medical Social Services	5,927	1,035	6,962				6.00
7.00	Home Health Aide	132,583	23,142	155,725				7.00
8.00	Supplies (see instructions)	927	162	1,089				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)	2,268,447	337,109	2,268,447				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.		0.174547					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 10/01/2016 To 09/30/2017 | Worksheet H-2 Part II | Date/Time Prepared: 2/27/2018 10:15 am

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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	3,481	236,438	0	84,791	3,000	1.00
2.00	Skilled Nursing Care	0	0	424,120	0	790,890	0	2.00
3.00	Physical Therapy	0	0	221,392	0	408,256	0	3.00
4.00	Occupational Therapy	0	0	89,629	0	166,281	0	4.00
5.00	Speech Pathology	0	0	10,307	0	20,037	0	5.00
6.00	Medical Social Services	0	0	2,486	0	4,583	0	6.00
7.00	Home Health Aide	0	0	55,590	0	102,511	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	717	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	3,481	1,039,962		1,578,066	3,000	20.00
21.00	Total cost to be allocated	20,884	4,988	259,152		462,937	7,381	21.00
22.00	Unit cost multiplier	6.961333	1.432922	0.249194		0.293357	2.460333	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	29,006	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	29,006	20.00
21.00	Total cost to be allocated	49,255	0	20,928	0	0	149,880	21.00
22.00	Unit cost multiplier	16.418333	0.000000	6.976000	0.000000	0.000000	5.167207	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

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

Period:
From 10/01/2016
To 09/30/2017

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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 10/01/2016 To 09/30/2017 | Worksheet H-3 Part I | Date/Time Prepared: 2/27/2018 10:15 am

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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	1,201,449		1,201,449	4,446	270.23	1.00
2.00	Physical Therapy	3.00	620,185	0	620,185	2,685	230.98	2.00
3.00	Occupational Therapy	4.00	252,599	0	252,599	1,087	232.38	3.00
4.00	Speech Pathology	5.00	30,438	0	30,438	125	243.50	4.00
5.00	Medical Social Services	6.00	6,962		6,962	176	39.56	5.00
6.00	Home Health Aide	7.00	155,725		155,725	722	215.69	6.00
7.00	Total (sum of lines 1-6)		2,267,358	0	2,267,358	9,241		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	1,832			8.00
8.01	Skilled Nursing Care		99914	0	247			8.01
9.00	Physical Therapy		99926	0	1,339			9.00
9.01	Physical Therapy		99914	0	155			9.01
10.00	Occupational Therapy		99926	0	635			10.00
10.01	Occupational Therapy		99914	0	10			10.01
11.00	Speech Pathology		99926	0	80			11.00
11.01	Speech Pathology		99914	0	0			11.01
12.00	Medical Social Services		99926	0	15			12.00
12.01	Medical Social Services		99914	0	0			12.01
13.00	Home Health Aide		99926	0	311			13.00
13.01	Home Health Aide		99914	0	7			13.01
14.00	Total (sum of lines 8-13)			0	4,631			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	1,089	4,269	5,358	43,025	0.124532	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	Part B Not Subject to Deductibles & Coinsurance	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	2,079		0	561,808		1.00
2.00	Physical Therapy	0	1,494		0	345,084		2.00
3.00	Occupational Therapy	0	645		0	149,885		3.00
4.00	Speech Pathology	0	80		0	19,480		4.00
5.00	Medical Social Services	0	15		0	593		5.00
6.00	Home Health Aide	0	318		0	68,589		6.00
7.00	Total (sum of lines 1-6)	0	4,631		0	1,145,439		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 26-0025 | HHA CCN: 26-7282 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-3 Part I | Date/Time Prepared: 2/27/2018 10:15 am

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

		Program Covered Charges			Cost of Services			
			Part B			Part B		
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	21,846	0	0	2,721	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	561,808		1.00
2.00	Physical Therapy	345,084		2.00
3.00	Occupational Therapy	149,885		3.00
4.00	Speech Pathology	19,480		4.00
5.00	Medical Social Services	593		5.00
6.00	Home Health Aide	68,589		6.00
7.00	Total (sum of lines 1-6)	1,145,439		7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 26-0025 HHA CCN: 26-7282 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-3 Part II Date/Time Prepared: 2/27/2018 10:15 am

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.934282	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.538396	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.861349	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.099211	43,025	4,269	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.134451	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 26-0025 | HHA CCN: 26-7282 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-4 Part I-II | Date/Time Prepared: 2/27/2018 10:15 am

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		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	746,976	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	9,105	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	7,178	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	19,926	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	783,185	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	783,185	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	783,185	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	783,185	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
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	783,185	31.00
31.01	Sequestration adjustment (see instructions)	0	0	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	783,185	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 10/01/2016 To 09/30/2017 | Worksheet H-5 | Date/Time Prepared: 2/27/2018 10:15 am

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		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		783,185	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		783,185	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		783,185	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 10/01/2016 To 09/30/2017	Worksheet L Parts I-III Date/Time Prepared: 2/27/2018 10:15 am
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		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,280,385	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	58,989	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)	39.82	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)	1,339,374	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 10/01/2016 To 09/30/2017 | Worksheet M-1 | Date/Time Prepared: 2/27/2018 10:15 am

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	102,725	0	102,725	0	102,725	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	130,406	0	130,406	0	130,406	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)	233,131	0	233,131	0	233,131	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	9,142	9,142	0	9,142	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	9,142	9,142	0	9,142	14.00
15.00	Medical Supplies	0	9,170	9,170	0	9,170	15.00
16.00	Transportation (Health Care Staff)	0	604	604	0	604	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	9,774	9,774	0	9,774	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	233,131	18,916	252,047	0	252,047	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	12,486	12,486	0	12,486	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	12,486	12,486	0	12,486	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	7,458	7,458	0	7,458	29.00
30.00	Administrative Costs	120,985	116,806	237,791	0	237,791	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	120,985	124,264	245,249	0	245,249	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	354,116	155,666	509,782	0	509,782	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-1

Component CCN: 26-8512 | Date/Time Prepared: 2/27/2018 10:15 am

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	102,725		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	130,406		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	233,131		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	9,142		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	9,142		14.00
15.00	Medical Supplies	0	9,170		15.00
16.00	Transportation (Health Care Staff)	0	604		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	9,774		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	252,047		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	12,486		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	12,486		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	7,458		29.00
30.00	Administrative Costs	0	237,791		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	245,249		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	509,782		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Component CCN: 26-3984 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-1 | Date/Time Prepared: 2/27/2018 10:15 am

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	252,638	0	252,638	0	252,638	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	131,593	0	131,593	0	131,593	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	80,096	0	80,096	0	80,096	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)	464,327	0	464,327	0	464,327	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	19,932	19,932	0	19,932	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	19,932	19,932	0	19,932	14.00
15.00	Medical Supplies	0	6,333	6,333	0	6,333	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	6,333	6,333	0	6,333	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	464,327	26,265	490,592	0	490,592	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	14,539	14,539	0	14,539	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	14,539	14,539	0	14,539	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	18,599	18,599	0	18,599	29.00
30.00	Administrative Costs	106,616	156,876	263,492	25,400	288,892	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	106,616	175,475	282,091	25,400	307,491	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	570,943	216,279	787,222	25,400	812,622	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-1

Component CCN: 26-3984 | Date/Time Prepared: 2/27/2018 10:15 am

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	252,638		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	131,593		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	80,096		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	464,327		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	19,932		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	19,932		14.00
15.00	Medical Supplies	0	6,333		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	6,333		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	490,592		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	14,539		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	14,539		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	18,599		29.00
30.00	Administrative Costs	0	288,892		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	307,491		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	812,622		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Component CCN: 26-8513 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-1 | Date/Time Prepared: 2/27/2018 10:15 am

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	212,388	0	212,388	0	212,388	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	111,003	0	111,003	0	111,003	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	138,221	0	138,221	0	138,221	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)	461,612	0	461,612	0	461,612	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	483	483	0	483	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	483	483	0	483	14.00
15.00	Medical Supplies	0	14,348	14,348	0	14,348	15.00
16.00	Transportation (Health Care Staff)	0	604	604	0	604	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	14,952	14,952	0	14,952	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	461,612	15,435	477,047	0	477,047	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	71,050	71,050	0	71,050	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	71,050	71,050	0	71,050	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	187	187	0	187	29.00
30.00	Administrative Costs	110,567	132,580	243,147	0	243,147	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	110,567	132,767	243,334	0	243,334	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	572,179	219,252	791,431	0	791,431	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Component CCN: 26-8513 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-1 | Date/Time Prepared: 2/27/2018 10:15 am

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	212,388		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	111,003		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	138,221		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	461,612		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	483		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	483		14.00
15.00	Medical Supplies	0	14,348		15.00
16.00	Transportation (Health Care Staff)	0	604		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	14,952		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	477,047		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	71,050		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	71,050		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	187		29.00
30.00	Administrative Costs	0	243,147		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	243,334		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	791,431		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Component CCN: 26-8723 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-1 | Date/Time Prepared: 2/27/2018 10:15 am

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	570,966	0	570,966	-285,483	285,483	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	101,646	101,646	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	113,933	0	113,933	-16,295	97,638	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)	684,899	0	684,899	-200,132	484,767	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	32,487	32,487	-2,535	29,952	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	32,487	32,487	-2,535	29,952	14.00
15.00	Medical Supplies	0	16,818	16,818	-3,502	13,316	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	16,818	16,818	-3,502	13,316	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	684,899	49,305	734,204	-206,169	528,035	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	61,595	61,595	-30,798	30,797	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	61,595	61,595	-30,798	30,797	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	5,639	5,639	0	5,639	29.00
30.00	Administrative Costs	115,432	208,519	323,951	-11,679	312,272	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	115,432	214,158	329,590	-11,679	317,911	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	800,331	325,058	1,125,389	-248,646	876,743	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Component CCN: 26-8723 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-1 | Date/Time Prepared: 2/27/2018 10:15 am

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	285,483		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	101,646		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	97,638		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	484,767		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	29,952		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	29,952		14.00
15.00	Medical Supplies	0	13,316		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	13,316		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	528,035		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	30,797		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	30,797		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	5,639		29.00
30.00	Administrative Costs	0	312,272		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	317,911		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	876,743		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Component CCN: 26-8724 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-1 | Date/Time Prepared: 2/27/2018 10:15 am

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	285,483	285,483	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	203,291	0	203,291	-101,646	101,645	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	81,344	0	81,344	16,295	97,639	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)	284,635	0	284,635	200,132	484,767	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	25,501	25,501	2,535	28,036	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	25,501	25,501	2,535	28,036	14.00
15.00	Medical Supplies	0	9,815	9,815	3,502	13,317	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	9,815	9,815	3,502	13,317	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	284,635	35,316	319,951	206,169	526,120	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	30,798	30,798	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	30,798	30,798	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	4,667	4,667	0	4,667	29.00
30.00	Administrative Costs	147,723	116,541	264,264	11,679	275,943	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	147,723	121,208	268,931	11,679	280,610	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	432,358	156,524	588,882	248,646	837,528	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Component CCN: 26-8724 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-1 | Date/Time Prepared: 2/27/2018 10:15 am

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	285,483		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	101,645		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	97,639		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	484,767		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	28,036		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	28,036		14.00
15.00	Medical Supplies	0	13,317		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	13,317		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	526,120		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	30,798		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	30,798		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	4,667		29.00
30.00	Administrative Costs	-90	275,853		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-90	280,520		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-90	837,438		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Component CCN: 26-8756 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-1 | Date/Time Prepared: 2/27/2018 10:15 am

RHC VI | 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	10,578	0	10,578	0	10,578	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	14,012	0	14,012	0	14,012	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	17,402	0	17,402	0	17,402	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)	41,992	0	41,992	0	41,992	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	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	155	155	0	155	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	155	155	0	155	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	41,992	155	42,147	0	42,147	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	33	33	0	33	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	33	33	0	33	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	592	592	0	592	29.00
30.00	Administrative Costs	0	7,831	7,831	0	7,831	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	8,423	8,423	0	8,423	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	41,992	8,611	50,603	0	50,603	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Component CCN: 26-8756 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-1 | Date/Time Prepared: 2/27/2018 10:15 am

RHC VI | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	10,578		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	14,012		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	17,402		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	41,992		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	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	155		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	155		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	42,147		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	33		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	33		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	592		29.00
30.00	Administrative Costs	0	7,831		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	8,423		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	50,603		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Component CCN: 26-8757 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-1 | Date/Time Prepared: 2/27/2018 10:15 am

RHC VII | 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	23,271	0	23,271	0	23,271	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	12,153	0	12,153	0	12,153	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	24,135	0	24,135	0	24,135	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)	59,559	0	59,559	0	59,559	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	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	380	380	0	380	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	380	380	0	380	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	59,559	380	59,939	0	59,939	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	135	135	0	135	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	135	135	0	135	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	1,940	1,940	0	1,940	29.00
30.00	Administrative Costs	0	16,376	16,376	0	16,376	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	18,316	18,316	0	18,316	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	59,559	18,831	78,390	0	78,390	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-1

Component CCN: 26-8757 | Date/Time Prepared: 2/27/2018 10:15 am

RHC VII | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	23,271		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	12,153		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	24,135		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	59,559		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	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	380		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	380		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	59,939		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	135		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	135		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	1,940		29.00
30.00	Administrative Costs	0	16,376		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	18,316		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	78,390		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Component CCN: 26-8758 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-1 | Date/Time Prepared: 2/27/2018 10:15 am

RHC VIII | 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	36,914	0	36,914	0	36,914	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	11,118	0	11,118	0	11,118	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	12,209	0	12,209	0	12,209	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)	60,241	0	60,241	0	60,241	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	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	100	100	0	100	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	100	100	0	100	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	60,241	100	60,341	0	60,341	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	6,084	6,084	0	6,084	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	6,084	6,084	0	6,084	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	158	158	0	158	29.00
30.00	Administrative Costs	0	8,041	8,041	0	8,041	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	8,199	8,199	0	8,199	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	60,241	14,383	74,624	0	74,624	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Component CCN: 26-8758 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-1 | Date/Time Prepared: 2/27/2018 10:15 am

RHC VIII | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	36,914		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	11,118		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	12,209		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	60,241		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	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	100		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	100		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	60,341		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	6,084		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	6,084		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	158		29.00
30.00	Administrative Costs	0	8,041		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	8,199		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	74,624		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Component CCN: 26-8754 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-1 | Date/Time Prepared: 2/27/2018 10:15 am

RHC IX | 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	447,105	0	447,105	0	447,105	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	117,052	0	117,052	0	117,052	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	105,237	0	105,237	0	105,237	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)	669,394	0	669,394	0	669,394	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	40	40	0	40	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	40	40	0	40	14.00
15.00	Medical Supplies	0	2,649	2,649	0	2,649	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	2,649	2,649	0	2,649	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	669,394	2,689	672,083	0	672,083	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	33,955	33,955	0	33,955	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	33,955	33,955	0	33,955	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	70	70	0	70	29.00
30.00	Administrative Costs	30,180	95,554	125,734	0	125,734	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	30,180	95,624	125,804	0	125,804	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	699,574	132,268	831,842	0	831,842	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Component CCN: 26-8754 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-1 | Date/Time Prepared: 2/27/2018 10:15 am

RHC IX | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	447,105		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	117,052		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	105,237		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	669,394		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	40		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	40		14.00
15.00	Medical Supplies	0	2,649		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	2,649		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	672,083		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	33,955		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	33,955		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	70		29.00
30.00	Administrative Costs	0	125,734		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	125,804		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	831,842		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025 | Component CCN: 26-8512 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-2 | Date/Time Prepared: 2/27/2018 10:15 am

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	0.50	1,111	4,200	2,100		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.91	2,518	2,100	1,911		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.41	3,629		4,011	4,011	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)	1.41	3,629			4,011	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)					252,047	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					12,486	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					264,533	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.952800	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					245,249	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					274,675	15.00
16.00	Total overhead (sum of lines 14 and 15)					519,924	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					519,924	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					495,384	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					747,431	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025 | Component CCN: 26-3984 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-2 | Date/Time Prepared: 2/27/2018 10:15 am

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	0.50	557	4,200	2,100		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.05	2,773	2,100	2,205		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.55	3,330		4,305	4,305	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)	1.55	3,330			4,305	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)					490,592	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					14,539	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					505,131	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.971217	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					307,491	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					477,256	15.00
16.00	Total overhead (sum of lines 14 and 15)					784,747	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					784,747	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					762,160	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,252,752	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025 | Component CCN: 26-8513 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-2 | Date/Time Prepared: 2/27/2018 10:15 am

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	0.91	2,506	4,200	3,822		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.01	2,341	2,100	2,121		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.92	4,847		5,943	5,943	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)	1.92	4,847			5,943	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)					477,047	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					71,050	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					548,097	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.870370	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					243,334	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					616,966	15.00
16.00	Total overhead (sum of lines 14 and 15)					860,300	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					860,300	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					748,779	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,225,826	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025 | Component CCN: 26-8723 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-2 | Date/Time Prepared: 2/27/2018 10:15 am

RHC IV | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.67	5,219	4,200	7,014		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.00	2,811	2,100	2,100		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.67	8,030		9,114	9,114	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.67	8,030			9,114	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)					528,035	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					30,797	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					558,832	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.944890	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					317,911	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					457,334	15.00
16.00	Total overhead (sum of lines 14 and 15)					775,245	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					775,245	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					732,521	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,260,556	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025 | Component CCN: 26-8724 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-2 | Date/Time Prepared: 2/27/2018 10:15 am

RHC V | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.23	2,829	4,200	5,166		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.00	3,255	2,100	2,100		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.23	6,084		7,266	7,266	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.23	6,084			7,266	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)					526,120	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					30,798	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					556,918	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.944699	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					280,520	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					443,971	15.00
16.00	Total overhead (sum of lines 14 and 15)					724,491	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					724,491	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					684,426	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,210,546	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025 | Component CCN: 26-8756 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-2 | Date/Time Prepared: 2/27/2018 10:15 am

RHC VI | 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	0.04	66	4,200	168		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.13	243	2,100	273		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.17	309		441	441	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)	0.17	309			441	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)					42,147	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					33	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					42,180	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.999218	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					8,423	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					38,697	15.00
16.00	Total overhead (sum of lines 14 and 15)					47,120	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					47,120	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					47,083	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					89,230	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025 | Component CCN: 26-8757 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-2 | Date/Time Prepared: 2/27/2018 10:15 am

RHC VII | 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	0.08	353	4,200	336		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.04	152	2,100	84		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.12	505		420	505	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)	0.12	505			505	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)					59,939	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					135	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					60,074	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.997753	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					18,316	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					71,891	15.00
16.00	Total overhead (sum of lines 14 and 15)					90,207	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					90,207	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					90,004	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					149,943	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025 | Component CCN: 26-8758 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-2 | Date/Time Prepared: 2/27/2018 10:15 am

RHC VIII | 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	0.14	439	4,200	588		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.10	242	2,100	210		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.24	681		798	798	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)	0.24	681			798	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)					60,341	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					6,084	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					66,425	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.908408	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					8,199	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					47,862	15.00
16.00	Total overhead (sum of lines 14 and 15)					56,061	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					56,061	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					50,926	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					111,267	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025 | Component CCN: 26-8754 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-2 | Date/Time Prepared: 2/27/2018 10:15 am

RHC IX | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.51	2,171	4,200	6,342		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.86	1,245	2,100	1,806		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.37	3,416		8,148	8,148	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.37	3,416			8,148	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)					672,083	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					33,955	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					706,038	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.951908	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					125,804	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					556,365	15.00
16.00	Total overhead (sum of lines 14 and 15)					682,169	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					682,169	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					649,362	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,321,445	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 26-0025 Component CCN: 26-8512	Period: From 10/01/2016 To 09/30/2017	Worksheet M-3 Date/Time Prepared: 2/27/2018 10:15 am
	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)		747,431	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		25,221	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		722,210	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		4,011	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)		4,011	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		180.06	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	81.32	82.30	8.00
9.00	Rate for Program covered visits (see instructions)	81.32	82.30	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	753	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	61,972	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	61,972	16.00
16.01	Total program charges (see instructions)(from contractor's records)		110,943	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		430	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		240	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.)		36,949	16.04
16.05	Total program cost (see instructions)	0	37,189	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		15,546	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		18,994	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		37,189	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		16,715	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		53,904	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		53,904	26.00
26.01	Sequestration adjustment (see instructions)		1,078	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		35,258	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		17,568	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 10/01/2016 To 09/30/2017	Worksheet M-3 Date/Time Prepared: 2/27/2018 10:15 am
	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)		1,252,752	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		21,554	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,231,198	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		4,305	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)		4,305	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		285.99	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	81.32	82.30	8.00
9.00	Rate for Program covered visits (see instructions)	81.32	82.30	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	910	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	74,893	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	74,893	16.00
16.01	Total program charges (see instructions)(from contractor's records)		140,009	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		770	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		412	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.)		44,952	16.04
16.05	Total program cost (see instructions)	0	45,364	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		18,291	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		24,190	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		45,364	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		11,472	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		56,836	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		56,836	26.00
26.01	Sequestration adjustment (see instructions)		1,137	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		42,867	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		12,832	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 10/01/2016 To 09/30/2017	Worksheet M-3 Date/Time Prepared: 2/27/2018 10:15 am
	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)		1,225,826	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		144,850	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,080,976	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		5,943	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)		5,943	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		181.89	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	81.32	82.30	8.00
9.00	Rate for Program covered visits (see instructions)	81.32	82.30	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,613	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	132,750	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	132,750	16.00
16.01	Total program charges (see instructions)(from contractor's records)		259,796	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,895	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,479	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.)		84,848	16.04
16.05	Total program cost (see instructions)	0	86,327	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		25,211	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		46,338	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		86,327	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		85,992	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		172,319	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		172,319	26.00
26.01	Sequestration adjustment (see instructions)		3,446	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		82,378	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		86,495	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 10/01/2016 To 09/30/2017	Worksheet M-3 Date/Time Prepared: 2/27/2018 10:15 am
	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)		1,260,556	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		39,660	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,220,896	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		9,114	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)		9,114	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		133.96	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	81.32	82.30	8.00
9.00	Rate for Program covered visits (see instructions)	81.32	82.30	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,298	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	189,125	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	189,125	16.00
16.01	Total program charges (see instructions)(from contractor's records)		309,141	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		6,965	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		4,261	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.)		115,607	16.04
16.05	Total program cost (see instructions)	0	119,868	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		40,355	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		52,365	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		119,868	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		21,591	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		141,459	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		141,459	26.00
26.01	Sequestration adjustment (see instructions)		2,829	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		114,730	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		23,900	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 10/01/2016 To 09/30/2017	Worksheet M-3 Date/Time Prepared: 2/27/2018 10:15 am
	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)		1,210,546	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		27,853	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,182,693	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		7,266	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		7,266	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		162.77	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	81.32	82.30	8.00
9.00	Rate for Program covered visits (see instructions)	81.32	82.30	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,434	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	118,018	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	118,018	16.00
16.01	Total program charges (see instructions)(from contractor's records)		208,371	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		7,829	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		4,434	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.)		70,182	16.04
16.05	Total program cost (see instructions)	0	74,616	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		25,856	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		34,938	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		74,616	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		10,237	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		84,853	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		84,853	26.00
26.01	Sequestration adjustment (see instructions)		1,697	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		71,054	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		12,102	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: 26-8756	Period: From 10/01/2016 To 09/30/2017	Worksheet M-3 Date/Time Prepared: 2/27/2018 10:15 am
	Title XVIII	RHC VI	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)		89,230	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		89,230	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		441	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)		441	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		202.34	7.00

		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	81.32	82.30	8.00
9.00	Rate for Program covered visits (see instructions)	81.32	82.30	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	0	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	0	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		0	16.04
16.05	Total program cost (see instructions)	0	0	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		0	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		0	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		0	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		0	26.00
26.01	Sequestration adjustment (see instructions)		0	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		0	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		0	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: 26-8757	Period: From 10/01/2016 To 09/30/2017	Worksheet M-3 Date/Time Prepared: 2/27/2018 10:15 am
	Title XVIII	RHC VII	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)		149,943	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		149,943	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		505	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)		505	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		296.92	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	81.32	82.30	8.00
9.00	Rate for Program covered visits (see instructions)	81.32	82.30	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	0	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	0	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		0	16.04
16.05	Total program cost (see instructions)	0	0	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		0	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		0	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		0	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		0	26.00
26.01	Sequestration adjustment (see instructions)		0	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		0	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		0	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: 26-8758	Period: From 10/01/2016 To 09/30/2017	Worksheet M-3 Date/Time Prepared: 2/27/2018 10:15 am
	Title XVIII	RHC VIII	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)		111,267	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		111,267	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		798	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)		798	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		139.43	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	81.32	82.30	8.00
9.00	Rate for Program covered visits (see instructions)	81.32	82.30	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	0	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	0	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		0	16.04
16.05	Total program cost (see instructions)	0	0	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		0	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		0	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		0	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		0	26.00
26.01	Sequestration adjustment (see instructions)		0	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		0	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		0	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: 26-8754	Period: From 10/01/2016 To 09/30/2017	Worksheet M-3 Date/Time Prepared: 2/27/2018 10:15 am
	Title XVIII	RHC IX	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)		1,321,445	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		38,574	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,282,871	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		8,148	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)		8,148	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		157.45	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	81.32	82.30	8.00
9.00	Rate for Program covered visits (see instructions)	81.32	82.30	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	415	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	34,155	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	34,155	16.00
16.01	Total program charges (see instructions)(from contractor's records)		72,464	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)		59	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.)		26,352	16.04
16.05	Total program cost (see instructions)	0	26,411	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		1,156	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		14,237	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		26,411	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		3,694	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		30,105	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		30,105	26.00
26.01	Sequestration adjustment (see instructions)		602	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		25,834	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		3,669	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 10/01/2016 To 09/30/2017	Worksheet M-4 Date/Time Prepared: 2/27/2018 10:15 am
	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)	233,131	233,131	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001421	0.007331	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	331	1,709	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	3,913	2,552	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	4,244	4,261	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	252,047	252,047	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	495,384	495,384	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.016838	0.016906	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	8,341	8,375	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	12,585	12,636	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	25	129	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	503.40	97.95	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	19	73	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	9,565	7,150	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)		25,221	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)		16,715	16.00

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

Provider CCN: 26-0025 | Component CCN: 26-3984 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-4 | Date/Time Prepared: 2/27/2018 10:15 am

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)	464,327	464,327	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000724	0.007500	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	336	3,482	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	2,002	2,621	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	2,338	6,103	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	490,592	490,592	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	762,160	762,160	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.004766	0.012440	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	3,632	9,481	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	5,970	15,584	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	14	145	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	426.43	107.48	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	8	75	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	3,411	8,061	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)		21,554	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)		11,472	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 26-0025 Component CCN: 26-8513	Period: From 10/01/2016 To 09/30/2017	Worksheet M-4 Date/Time Prepared: 2/27/2018 10:15 am
	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)	461,612	461,612	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.009640	0.014520	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	4,450	6,703	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	36,542	8,675	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	40,992	15,378	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	477,047	477,047	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	748,779	748,779	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.085929	0.032236	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	64,342	24,138	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	105,334	39,516	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	231	348	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	455.99	113.55	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	146	171	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	66,575	19,417	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)		144,850	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)		85,992	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 26-0025 Component CCN: 26-8723	Period: From 10/01/2016 To 09/30/2017	Worksheet M-4 Date/Time Prepared: 2/27/2018 10:15 am
	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)	484,767	484,767	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001831	0.006902	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	888	3,346	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	8,839	3,540	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	9,727	6,886	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	528,035	528,035	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	732,521	732,521	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.018421	0.013041	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	13,494	9,553	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	23,221	16,439	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	61	230	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	380.67	71.47	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	34	121	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	12,943	8,648	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)		39,660	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)		21,591	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 26-0025 Component CCN: 26-8724	Period: From 10/01/2016 To 09/30/2017	Worksheet M-4 Date/Time Prepared: 2/27/2018 10:15 am
	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)	484,767	484,767	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001617	0.005605	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	784	2,717	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	6,341	2,263	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	7,125	4,980	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	526,120	526,120	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	684,426	684,426	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.013543	0.009466	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	9,269	6,479	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	16,394	11,459	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	45	156	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	364.31	73.46	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	16	60	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	5,829	4,408	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)		27,853	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)		10,237	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 26-0025 Component CCN: 26-8754	Period: From 10/01/2016 To 09/30/2017	Worksheet M-4 Date/Time Prepared: 2/27/2018 10:15 am
	Title XVIII	RHC IX	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	669,394	669,394	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.002766	0.004217	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,852	2,823	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	12,985	1,959	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	14,837	4,782	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	672,083	672,083	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	649,362	649,362	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.022076	0.007115	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	14,335	4,620	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	29,172	9,402	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	82	125	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	355.76	75.22	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	7	16	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	2,490	1,204	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)		38,574	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)		3,694	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 10/01/2016 To 09/30/2017	Worksheet M-5 Date/Time Prepared: 2/27/2018 10:15 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		35,258	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)		35,258	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		17,568	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		52,826	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 10/01/2016 To 09/30/2017	Worksheet M-5 Date/Time Prepared: 2/27/2018 10:15 am
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		42,867	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)		42,867	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		12,832	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		55,699	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 10/01/2016 To 09/30/2017	Worksheet M-5 Date/Time Prepared: 2/27/2018 10:15 am
		RHC III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		82,378	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)		82,378	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		86,495	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		168,873	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 10/01/2016 To 09/30/2017	Worksheet M-5 Date/Time Prepared: 2/27/2018 10:15 am
		RHC IV	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		114,730	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)		114,730	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		23,900	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		138,630	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 26-0025 Component CCN: 26-8724	Period: From 10/01/2016 To 09/30/2017	Worksheet M-5 Date/Time Prepared: 2/27/2018 10:15 am
		RHC V	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		71,054	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)		71,054	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		12,102	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		83,156	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: 26-8754	Period: From 10/01/2016 To 09/30/2017	Worksheet M-5 Date/Time Prepared: 2/27/2018 10:15 am
		RHC IX	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		25,834	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)		25,834	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		3,669	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		29,503	7.00

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