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 10/01/2017 To 09/30/2018	Worksheet S Parts I-III Date/Time Prepared: 2/27/2019 3:19 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/27/2019 Time: 3:19 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY 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 10/01/2017 and ending 09/30/2018 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.

[X] 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) ROBERT GASAWAY
Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
Title

(Dated when report is electronically signed.)
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	-112,642	10,450	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	10,094	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		18,216		0	10.00
10.01	RURAL HEALTH CLINIC II	0		20,267		0	10.01
10.02	RURAL HEALTH CLINIC III	0		49,555		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		18,151		0	10.03
10.04	RURAL HEALTH CLINIC V	0		25,468		0	10.04
10.05	RURAL HEALTH CLINIC VI	0		1,179		0	10.05
10.06	RURAL HEALTH CLINIC VII	0		3,132		0	10.06
10.07	RURAL HEALTH CLINIC VIII	0		3,726		0	10.07
10.08	RURAL HEALTH CLINIC IX	0		46,325		0	10.08
10.09	RURAL HEALTH CLINIC X	0		2,275		0	10.09
200.00	Total	0	-102,548	198,744	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 2/27/2019 3:19 pm

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

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	HANNIBAL REGIONAL HOSPITAL	260025	99926	1	01/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	HANNIBAL REGIONAL HOSPITAL	26T025	99926	5	10/01/2015	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	HANNIBAL REGIONAL - HHA	267282	99926		04/10/1990	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	HANNIBAL REG - SHELBINA	268512	99926		06/11/1997	N	O	O	15.00
15.01	Hospital-Based Health Clinic - RHC II	HANNIBAL REG - LAGRANGE	263984	99926		04/03/1992	N	O	O	15.01
15.02	Hospital-Based Health Clinic - RHC III	HANNIBAL REG - MONROE CITY	268513	99926		06/11/1997	N	O	O	15.02
15.03	Hospital-Based Health Clinic - RHC IV	HANNIBAL REG - LOUISIANA	268723	99926		04/01/2014	N	O	O	15.03
15.04	Hospital-Based Health Clinic - RHC V	HANNIBAL REG - BOWLING GREEN	268724	99926		04/01/2014	N	O	O	15.04
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
15.09	Hospital-Based Health Clinic - RHC X	HANNIBAL REG - WALMART	268759	99926		11/07/2017	N	O	O	15.09
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)	10/01/2017	09/30/2018	20.00
21.00	Type of Control (see instructions)	2		21.00

		1.00	2.00	3.00	
	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	N	22.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 2/27/2019 3:19 pm

		1.00	2.00	3.00	
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

		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.	1,031	0	54	0	1,090	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.	10/01/2017	09/30/2018	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), (ii), or (iii)? 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), (ii), or (iii)? 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 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2019 3:19 pm

		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)						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)						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)						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).						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)						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)						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 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2019 3:19 pm

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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 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 10/01/2017 To 09/30/2018	Worksheet S-2 Part I Date/Time Prepared: 2/27/2019 3:19 pm

		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 an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? 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 10/01/2017 To 09/30/2018	Worksheet S-2 Part I Date/Time Prepared: 2/27/2019 3:19 pm

		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:	269,602	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 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 2/27/2019 3:19 pm

	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)	01/01/2017	03/31/2017	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 10/01/2017 To 09/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 2/27/2019 3:19 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	01/24/2019	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	01/22/2019	Y	01/22/2019	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 10/01/2017 To 09/30/2018 | Worksheet S-2 Part II Date/Time Prepared: 2/27/2019 3:19 pm

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446	KEVIN.WELLEN@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 26-0025	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part II Date/Time Prepared: 2/27/2019 3:19 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-3 Part I Date/Time Prepared: 2/27/2019 3:19 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	78	28,470	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
26.09	RURAL HEALTH CLINIC X	88.09				0	26.09
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 10/01/2017 To 09/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 2/27/2019 3:19 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	7,889	773	13,266			1.00
2.00	HMO and other (see instructions)	1,077	1,090				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)	7,889	773	13,266			7.00
8.00	INTENSIVE CARE UNIT	1,130	206	1,798			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		93	1,158			13.00
14.00	Total (see instructions)	9,019	1,072	16,222	0.00	862.91	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	1,936	0	2,489	0.00	14.94	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	5,427	227	10,319	0.00	17.38	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	796	1,178	3,615	0.00	6.54	26.00
26.01	RURAL HEALTH CLINIC II	911	78	3,109	0.00	6.64	26.01
26.02	RURAL HEALTH CLINIC III	1,581	242	5,293	0.00	8.68	26.02
26.03	RURAL HEALTH CLINIC IV	1,987	384	6,763	0.00	9.79	26.03
26.04	RURAL HEALTH CLINIC V	1,814	489	10,173	0.00	14.61	26.04
26.05	RURAL HEALTH CLINIC VI	121	72	876	0.00	2.16	26.05
26.06	RURAL HEALTH CLINIC VII	677	69	3,008	0.00	4.36	26.06
26.07	RURAL HEALTH CLINIC VIII	251	174	2,309	0.00	2.16	26.07
26.08	RURAL HEALTH CLINIC IX	3,550	1,006	19,461	0.00	33.88	26.08
26.09	RURAL HEALTH CLINIC X	306	110	5,133	0.00	5.45	26.09
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	989.50	27.00
28.00	Observation Bed Days		0	946			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	13	176			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 10/01/2017 To 09/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 2/27/2019 3:19 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,125	286	4,358	1.00
2.00	HMO and other (see instructions)			278	292		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	2,125	286	4,358	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	211	0	264	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
26.09	RURAL HEALTH CLINIC X	0.00					26.09
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 10/01/2017 To 09/30/2018 | Worksheet S-3 Part II Date/Time Prepared: 2/27/2019 3:19 pm

		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	73,881,670	0	73,881,670	2,058,163.00	35.90	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		260,434	0	260,434	1,425.56	182.69	4.00
4.01	Physicians - Part A - Teaching		10,262,785	0	10,262,785	53,558.52	191.62	4.01
5.00	Physician and Non Physician-Part B		2,424,087	0	2,424,087	163,913.20	14.79	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	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)		20,415,249	-341,777	20,073,472	363,981.23	55.15	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,888,342	0	2,888,342	36,288.25	79.59	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		492,028	0	492,028	2,934.88	167.65	13.00
14.00	Home office and/or related organization 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)		16,165,543	0	16,165,543			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		5,246,794	0	5,246,794			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		28,776	0	28,776			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		1,465,185	0	1,465,185			23.00
24.00	Wage-related costs (RHC/FQHC)		1,495,018	0	1,495,018			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	540,433	319,251	859,684	38,477.28	22.34	26.00
27.00	Administrative & General	5.00	12,771,626	106,772	12,878,398	421,738.47	30.54	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-3 Part II | Date/Time Prepared: 2/27/2019 3:19 pm

		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.)		339,423	0	339,423	1,858.43	182.64	28.00
29.00	Maintenance & Repairs	6.00	432,059	0	432,059	25,084.00	17.22	29.00
30.00	Operation of Plant	7.00	748,498	0	748,498	32,199.00	23.25	30.00
31.00	Laundry & Linen Service	8.00	30,979	0	30,979	2,954.00	10.49	31.00
32.00	Housekeeping	9.00	646,082	0	646,082	50,619.00	12.76	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	916,813	0	916,813	58,010.00	15.80	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	1,203,726	0	1,203,726	33,490.00	35.94	38.00
39.00	Central Services and Supply	14.00	164,157	0	164,157	9,486.00	17.31	39.00
40.00	Pharmacy	15.00	1,746,548	-1,746,548	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	969,928	0	969,928	45,367.00	21.38	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 10/01/2017 To 09/30/2018 | Worksheet S-3 Part III Date/Time Prepared: 2/27/2019 3:19 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		61,534,221	0	61,534,221	1,842,549.71	33.40	1.00
2.00	Excluded area salaries (see instructions)		20,415,249	-341,777	20,073,472	363,981.23	55.15	2.00
3.00	Subtotal salaries (line 1 minus line 2)		41,118,972	341,777	41,460,749	1,478,568.48	28.04	3.00
4.00	Subtotal other wages & related costs (see inst.)		3,380,370	0	3,380,370	39,223.13	86.18	4.00
5.00	Subtotal wage-related costs (see inst.)		16,194,319	0	16,194,319	0.00	39.06	5.00
6.00	Total (sum of lines 3 thru 5)		60,693,661	341,777	61,035,438	1,517,791.61	40.21	6.00
7.00	Total overhead cost (see instructions)		20,510,272	-1,320,525	19,189,747	719,283.18	26.68	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-3 Part IV Date/Time Prepared: 2/27/2019 3:19 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	2,684,856	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)	1,307,978	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	413,167	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)	0	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)	14,354,479	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	-38,446	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	83,898	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)	221,235	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	21,552	14.00
15.00	'Workers' Compensation Insurance	480,546	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	4,403,171	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	21,054	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))	331,747	21.00
22.00	Day Care Cost and Allowances	87,453	22.00
23.00	Tuition Reimbursement	28,625	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	24,401,315	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 10/01/2017 To 09/30/2018 | Worksheet S-3 Part V Date/Time Prepared: 2/27/2019 3:19 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	2,888,342	24,401,315	1.00
2.00	Hospital	2,888,342	24,401,315	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
14.09	Hospital-Based Health Clinic RHC 9	0	0	14.09
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 10/01/2017 To 09/30/2018 | Worksheet S-4 | Date/Time Prepared: 2/27/2019 3:19 pm

Home Health Agency I | PPS

						1.00	
0.00	County				MARION		0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	1,773	0	1,064	2,837	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	326.00	38.00	289.00	653.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			1.00	0.00	1.00	4.00
5.00	Other Administrative Personnel			2.00	0.00	2.00	5.00
6.00	Direct Nursing Service			8.00	0.00	8.00	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			5.00	0.00	5.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.00	0.00	1.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			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).			99914			20.00
20.01				99926			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	1,973	188	72	47	2,280	21.00
22.00	Skilled Nursing Visit Charges	434,010	41,360	15,840	10,340	501,550	22.00
23.00	Physical Therapy Visits	1,574	141	9	38	1,762	23.00
24.00	Physical Therapy Visit Charges	352,350	31,725	2,025	8,550	394,650	24.00
25.00	Occupational Therapy Visits	723	153	4	13	893	25.00
26.00	Occupational Therapy Visit Charges	162,675	34,425	900	2,925	200,925	26.00
27.00	Speech Pathology Visits	49	5	0	0	54	27.00
28.00	Speech Pathology Visit Charges	11,025	1,125	0	0	12,150	28.00
29.00	Medical Social Service Visits	12	2	0	1	15	29.00
30.00	Medical Social Service Visit Charges	2,700	450	0	225	3,375	30.00
31.00	Home Health Aide Visits	325	93	0	5	423	31.00
32.00	Home Health Aide Visit Charges	39,000	11,160	0	600	50,760	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,656	582	85	104	5,427	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)	1,001,760	120,245	18,765	22,640	1,163,410	35.00
36.00	Total Number of Episodes (standard/non outlier)	310		33	7	350	36.00
37.00	Total Number of Outlier Episodes		13		1	14	37.00
38.00	Total Non-Routine Medical Supply Charges	12,079	1,343	702	92	14,216	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 26-0025 | Component CCN: 26-8512 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-8 | Date/Time Prepared: 2/27/2019 3:19 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			400 S. CENTER STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	SHELBINA		MO	63468	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	CLINIC			08:00	17:00	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC name, CCN number						14.00
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
			County				
			4.00				
2.00	City, State, ZIP Code, County		SHELBY				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

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

Period:
From 10/01/2017
To 09/30/2018

Worksheet S-8

Date/Time Prepared:
2/27/2019 3:19 pm

RHC I

Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 26-0025 | Component CCN: 26-3984 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-8 | Date/Time Prepared: 2/27/2019 3:19 pm

RHC II | Cost

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

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	17:00	08:00	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
			Provider name		CCN number	
			1.00		2.00	
14.00	RHC/FQHC name, CCN number					14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		LEWIS				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

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

Period:
From 10/01/2017
To 09/30/2018

Worksheet S-8

Date/Time Prepared:
2/27/2019 3:19 pm

RHC II

Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 26-0025 | Component CCN: 26-8513 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-8 | Date/Time Prepared: 2/27/2019 3:19 pm

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			821 BUSINESS HWYS 24 & 36		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	MONROE CITY		MO	63456	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	17:00	08:00	11.00

		1.00	2.00		
12.00	Have you received an approval for an exception to the productivity standard?	N			12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0		13.00

				Provider name	CCN number	
				1.00	2.00	
14.00	RHC/FQHC name, CCN number					14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		MONROE				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

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

Period:
From 10/01/2017
To 09/30/2018

Worksheet S-8

Date/Time Prepared:
2/27/2019 3:19 pm

RHC III

Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 26-0025 | Component CCN: 26-8723 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-8 | Date/Time Prepared: 2/27/2019 3:19 pm

RHC IV | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			211 SOUTH 3RD STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	LOUISIANA		MO	63353	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	CLINIC			08:00	17:00	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC name, CCN number						14.00
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
			County				
			4.00				
2.00	City, State, ZIP Code, County		PIKE				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

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

Period:
From 10/01/2017
To 09/30/2018

Worksheet S-8
Date/Time Prepared:
2/27/2019 3:19 pm

RHC IV

Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 26-0025 | Component CCN: 26-8724 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-8 | Date/Time Prepared: 2/27/2019 3:19 pm

RHC V | Cost

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

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC	10:00	17:00	07:00	19:00	07:00	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	19:00	07:00	19:00	07:00	19:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

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

Period:
From 10/01/2017
To 09/30/2018

Worksheet S-8
Date/Time Prepared:
2/27/2019 3:19 pm

RHC V

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	19:00	10:00	17:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 26-0025 | Component CCN: 26-8756 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-8 | Date/Time Prepared: 2/27/2019 3:19 pm

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 10/01/2017
To 09/30/2018

Worksheet S-8

Date/Time Prepared:
2/27/2019 3:19 pm

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 10/01/2017 To 09/30/2018 | Worksheet S-8 | Date/Time Prepared: 2/27/2019 3:19 pm

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 10/01/2017
To 09/30/2018

Worksheet S-8

Date/Time Prepared:
2/27/2019 3:19 pm

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 10/01/2017 To 09/30/2018 | Worksheet S-8 | Date/Time Prepared: 2/27/2019 3:19 pm

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 10/01/2017
To 09/30/2018

Worksheet S-8

Date/Time Prepared:
2/27/2019 3:19 pm

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 10/01/2017 To 09/30/2018 | Worksheet S-8 | Date/Time Prepared: 2/27/2019 3:19 pm

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 10/01/2017
To 09/30/2018

Worksheet S-8

Date/Time Prepared:
2/27/2019 3:19 pm

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-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 26-0025 | Component CCN: 26-8759 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-8 | Date/Time Prepared: 2/27/2019 3:19 pm

RHC X | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			3650 STARDUST 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	11:00	18:00	08:00	20:00	08:00	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?					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		MARION				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	20:00	08:00	20:00	08:00	20:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 26-0025 Component CCN: 26-8759	Period: From 10/01/2017 To 09/30/2018	Worksheet S-8 Date/Time Prepared: 2/27/2019 3:19 pm
		RHC X	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	20:00	08:00	19:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-10 | Date/Time Prepared: 2/27/2019 3:19 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.306322	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	17,951,787	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?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	39,924,680	6.00
7.00	Medicaid cost (line 1 times line 6)	12,229,808	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	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)	0	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)	6,031,748	2,229,335	8,261,083	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,847,657	2,229,335	4,076,992	21.00
22.00	Payments received from patients for amounts previously written off as charity care	30,225	4,913	35,138	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,817,432	2,224,422	4,041,854	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)	12,162,002	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	556,656	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	856,394	27.01
28.00	Non-Medicare bad debt expense (see instructions)	11,305,608	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	3,762,894	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	7,804,748	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,804,748	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A | Date/Time Prepared: 2/27/2019 3:19 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,848,831	2,848,831	63,031	2,911,862	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		5,193,931	5,193,931	-1,132,717	4,061,214	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	540,433	16,170,368	16,710,801	406,704	17,117,505	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,771,626	10,177,763	22,949,389	3,413	22,952,802	5.00
6.00	00600	MAINTENANCE & REPAIRS	432,059	71,940	503,999	0	503,999	6.00
7.00	00700	OPERATION OF PLANT	748,498	2,776,813	3,525,311	-414,634	3,110,677	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	30,979	287,693	318,672	0	318,672	8.00
9.00	00900	HOUSEKEEPING	646,082	210,290	856,372	414,634	1,271,006	9.00
10.00	01000	DIETARY	916,813	852,044	1,768,857	0	1,768,857	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,203,726	234,412	1,438,138	148,898	1,587,036	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	164,157	169,713	333,870	-7,795	326,075	14.00
15.00	01500	PHARMACY	1,746,548	941,452	2,688,000	-1,746,548	941,452	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	969,928	578,761	1,548,689	0	1,548,689	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,149,062	3,824,626	10,973,688	-23,847	10,949,841	30.00
31.00	03100	INTENSIVE CARE UNIT	1,732,698	337,454	2,070,152	0	2,070,152	31.00
41.00	04100	SUBPROVIDER - IRF	879,265	1,054,131	1,933,396	0	1,933,396	41.00
43.00	04300	NURSERY	288,449	129,555	418,004	2,570	420,574	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,462,903	1,834,301	3,297,204	-198,574	3,098,630	50.00
51.00	05100	RECOVERY ROOM	972,297	148,348	1,120,645	0	1,120,645	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	735,388	144,828	880,216	5,225	885,441	52.00
53.00	05300	ANESTHESIOLOGY	2,269,947	293,564	2,563,511	0	2,563,511	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,297,090	978,231	2,275,321	358,644	2,633,965	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	835,107	638,705	1,473,812	316,764	1,790,576	55.00
56.00	05600	RADIOISOTOPE	117,678	139,661	257,339	121,456	378,795	56.00
57.00	05700	CT SCAN	319,443	42,847	362,290	21,215	383,505	57.00
58.00	05800	MRI	100,081	146,150	246,231	155,376	401,607	58.00
59.00	05900	CARDIAC CATHETERIZATION	562,704	2,762,025	3,324,729	-1,044,870	2,279,859	59.00
60.00	06000	LABORATORY	2,358,006	2,625,382	4,983,388	25,292	5,008,680	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	110,590	378,788	489,378	0	489,378	62.00
64.00	06400	INTRAVENOUS THERAPY	461,253	72,586	533,839	0	533,839	64.00
65.00	06500	RESPIRATORY THERAPY	862,921	262,305	1,125,226	0	1,125,226	65.00
66.00	06600	PHYSICAL THERAPY	442,574	800,949	1,243,523	0	1,243,523	66.00
67.00	06700	OCCUPATIONAL THERAPY	52,713	459,556	512,269	0	512,269	67.00
68.00	06800	SPEECH PATHOLOGY	201,057	56,664	257,721	0	257,721	68.00
69.00	06900	ELECTROCARDIOLOGY	72,927	46,071	118,998	0	118,998	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	168,632	29,901	198,533	0	198,533	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	10,465,594	10,465,594	-1,981,014	8,484,580	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,224,458	3,224,458	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,603,156	6,603,156	1,746,548	8,349,704	73.00
74.00	07400	RENAL DIALYSIS	0	71,895	71,895	0	71,895	74.00
76.00	03950	DIABETES CENTER	91,279	15,708	106,987	0	106,987	76.00
76.97	07697	CARDIAC REHABILITATION	183,123	34,090	217,213	0	217,213	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	94,990	10,980	105,970	0	105,970	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	357,978	166,489	524,467	92,003	616,470	88.00
88.01	08801	RURAL HEALTH CLINIC II	562,393	237,537	799,930	-66,603	733,327	88.01
88.02	08802	RURAL HEALTH CLINIC III	610,864	241,776	852,640	0	852,640	88.02
88.03	08803	RURAL HEALTH CLINIC IV	858,734	340,036	1,198,770	-269,073	929,697	88.03
88.04	08804	RURAL HEALTH CLINIC V	1,085,606	470,876	1,556,482	269,073	1,825,555	88.04
88.05	08805	RURAL HEALTH CLINIC VI	131,248	54,262	185,510	0	185,510	88.05
88.06	08806	RURAL HEALTH CLINIC VII	254,551	95,178	349,729	0	349,729	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	196,736	35,771	232,507	0	232,507	88.07
88.08	08808	RURAL HEALTH CLINIC IX	3,850,871	996,056	4,846,927	-21,035	4,825,892	88.08
88.09	08809	RURAL HEALTH CLINIC X	382,906	116,695	499,601	-50,205	449,396	88.09
91.00	09100	EMERGENCY	2,060,773	5,711,415	7,772,188	0	7,772,188	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,170,401	261,040	1,431,441	0	1,431,441	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		355,029	355,029	0	355,029	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	55,516,087	84,004,222	139,520,309	418,389	139,938,698	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	17,463,352	5,332,523	22,795,875	-11,685	22,784,190	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	902,231	247,150	1,149,381	-406,704	742,677	194.01
194.02	07952	HWY 61 BUILDING	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	73,881,670	89,583,895	163,465,565	0	163,465,565	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A | Date/Time Prepared: 2/27/2019 3:19 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-128,706	2,783,156		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-7,854	4,053,360		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-132,390	16,985,115		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,842,421	26,795,223		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	503,999		6.00
7.00	00700	OPERATION OF PLANT	-11,917	3,098,760		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	318,672		8.00
9.00	00900	HOUSEKEEPING	0	1,271,006		9.00
10.00	01000	DIETARY	-647,899	1,120,958		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	-2,100	1,584,936		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	326,075		14.00
15.00	01500	PHARMACY	-45,057	896,395		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-59,456	1,489,233		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,945,281	8,004,560		30.00
31.00	03100	INTENSIVE CARE UNIT	-2,192	2,067,960		31.00
41.00	04100	SUBPROVIDER - IRF	-22,874	1,910,522		41.00
43.00	04300	NURSERY	0	420,574		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-663,328	2,435,302		50.00
51.00	05100	RECOVERY ROOM	0	1,120,645		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-20	885,421		52.00
53.00	05300	ANESTHESIOLOGY	-2,268,206	295,305		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-405	2,633,560		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	1,790,576		55.00
56.00	05600	RADIOISOTOPE	0	378,795		56.00
57.00	05700	CT SCAN	0	383,505		57.00
58.00	05800	MRI	0	401,607		58.00
59.00	05900	CARDIAC CATHETERIZATION	-1,171,657	1,108,202		59.00
60.00	06000	LABORATORY	-863,773	4,144,907		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	489,378		62.00
64.00	06400	INTRAVENOUS THERAPY	0	533,839		64.00
65.00	06500	RESPIRATORY THERAPY	0	1,125,226		65.00
66.00	06600	PHYSICAL THERAPY	-23,755	1,219,768		66.00
67.00	06700	OCCUPATIONAL THERAPY	-92,331	419,938		67.00
68.00	06800	SPEECH PATHOLOGY	-117,488	140,233		68.00
69.00	06900	ELECTROCARDIOLOGY	-6,308	112,690		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	198,533		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,484,580		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,224,458		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,349,704		73.00
74.00	07400	RENAL DIALYSIS	0	71,895		74.00
76.00	03950	DIABETES CENTER	0	106,987		76.00
76.97	07697	CARDIAC REHABILITATION	0	217,213		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	105,970		76.98
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	616,470		88.00
88.01	08801	RURAL HEALTH CLINIC II	-24	733,303		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	852,640		88.02
88.03	08803	RURAL HEALTH CLINIC IV	-235	929,462		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	1,825,555		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	185,510		88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	349,729		88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	232,507		88.07
88.08	08808	RURAL HEALTH CLINIC IX	-3,770	4,822,122		88.08
88.09	08809	RURAL HEALTH CLINIC X	0	449,396		88.09
91.00	09100	EMERGENCY	-4,764,498	3,007,690		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	1,431,441		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-355,029	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-10,494,132	129,444,566		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	22,784,190		192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0		194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	742,677		194.01
194.02	07952	HWY 61 BUILDING	0	0		194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-10,494,132	152,971,433		200.00

RECLASSIFICATIONS | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-6 | Date/Time Prepared: 2/27/2019 3:19 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - ADMISSION KITS				
1.00	NURSERY	43.00	0	2,570	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	5,225	2.00
	0		0	7,795	
	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	358,644	3.00
4.00	RADIOLOGY - THERAPEUTIC	55.00	0	316,764	4.00
5.00	RADIOISOTOPE	56.00	0	121,456	5.00
6.00	CT SCAN	57.00	0	21,215	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	1,186,249	
	D - PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	116,563	1.00
	0		0	116,563	
	E - IMPLANTS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,224,458	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	3,224,458	
	F - WALMART RHC				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	39,364	10,841	1.00
	0		39,364	10,841	
	G - CHILDREN'S CENTER				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	319,251	87,453	1.00
	0		319,251	87,453	
	H - LOUISIANA CLINIC				
1.00	RURAL HEALTH CLINIC V	88.04	425,271	112,382	1.00
	0		425,271	112,382	
	I - BOWLING GREEN CLINIC				
1.00	RURAL HEALTH CLINIC IV	88.03	219,948	48,632	1.00
	0		219,948	48,632	
	J - OUTSIDE CLEANING SERVICE				
1.00	HOUSEKEEPING	9.00	0	414,634	1.00
	0		0	414,634	
	K - PHARMACY SALARIES				
1.00	DRUGS CHARGED TO PATIENTS	73.00	1,746,548	0	1.00
	0		1,746,548	0	
	L - MEDICAL DIRECTORSHIPS				
1.00	ADMINISTRATIVE & GENERAL	5.00	106,772	0	1.00
2.00		0.00	0	0	2.00
	0		106,772	0	
	M - RHC SALARIES				
1.00	RURAL HEALTH CLINIC	88.00	92,003	0	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	21,035	0	2.00
	TOTALS		113,038	0	
500.00	Grand Total: Increases		2,970,192	5,209,007	500.00

RECLASSIFICATIONS | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-6 | Date/Time Prepared: 2/27/2019 3:19 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - ADMISSION KITS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	7,795	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	7,795			
	C - CAPITAL LEASE EXP						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,186,249	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	1,186,249			
	D - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	116,563	5		1.00
	0		0	116,563			
	E - IMPLANTS						
1.00	OPERATING ROOM	50.00	0	198,574	0		1.00
2.00	CARDIAC CATHETERIZATION	59.00	0	1,044,870	0		2.00
3.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,981,014	0		3.00
	0		0	3,224,458			
	F - WALMART RHC						
1.00	RURAL HEALTH CLINIC X	88.09	39,364	10,841	0		1.00
	0		39,364	10,841			
	G - CHILDREN'S CENTER						
1.00	CHILD DEVELOPMENT CENTER	194.01	319,251	87,453	0		1.00
	0		319,251	87,453			
	H - LOUISIANA CLINIC						
1.00	RURAL HEALTH CLINIC IV	88.03	425,271	112,382	0		1.00
	0		425,271	112,382			
	I - BOWLING GREEN CLINIC						
1.00	RURAL HEALTH CLINIC V	88.04	219,948	48,632	0		1.00
	0		219,948	48,632			
	J - OUTSIDE CLEANING SERVICE						
1.00	OPERATION OF PLANT	7.00	0	414,634	0		1.00
	0		0	414,634			
	K - PHARMACY SALARIES						
1.00	PHARMACY	15.00	1,746,548	0	0		1.00
	0		1,746,548	0			
	L - MEDICAL DIRECTORSHIPS						
1.00	ADULTS & PEDIATRICS	30.00	23,847	0	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	82,925	0	0		2.00
	0		106,772	0			
	M - RHC SALARIES						
1.00	RURAL HEALTH CLINIC II	88.01	92,003	0	0		1.00
2.00	RURAL HEALTH CLINIC IX	88.08	21,035	0	0		2.00
	TOTALS		113,038	0			
500.00	Grand Total: Decreases		2,970,192	5,209,007			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 2/27/2019 3:19 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,479,295	0	0	0	0	1.00
2.00	Land Improvements	7,090,135	1,731,176	0	1,731,176	2,455	2.00
3.00	Buildings and Fixtures	43,662,581	754,846	0	754,846	0	3.00
4.00	Building Improvements	21,667,211	2,016,027	0	2,016,027	41,334	4.00
5.00	Fixed Equipment	1,516,001	28,760	0	28,760	0	5.00
6.00	Movable Equipment	75,597,816	2,944,817	0	2,944,817	3,310,353	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	152,013,039	7,475,626	0	7,475,626	3,354,142	8.00
9.00	Reconciling Items	-3,966,726	-24,425,141	0	-24,425,141	-5,773,997	9.00
10.00	Total (line 8 minus line 9)	155,979,765	31,900,767	0	31,900,767	9,128,139	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	8,818,856	0	2.00
3.00	Buildings and Fixtures	44,417,427	0	3.00
4.00	Building Improvements	23,641,904	0	4.00
5.00	Fixed Equipment	1,544,761	0	5.00
6.00	Movable Equipment	75,232,280	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	156,134,523	0	8.00
9.00	Reconciling Items	-22,617,870	0	9.00
10.00	Total (line 8 minus line 9)	178,752,393	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-7 Part II | Date/Time Prepared: 2/27/2019 3:19 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,798,182	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,193,931	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	7,992,113	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	50,649	2,848,831	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,193,931	2.00
3.00	Total (sum of lines 1-2)	50,649	8,042,762	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 2/27/2019 3:19 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	79,357,482	0	79,357,482	0.540742	63,031	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	76,777,041	9,377,824	67,399,217	0.459258	53,532	2.00
3.00	Total (sum of lines 1-2)	156,134,523	9,377,824	146,756,699	1.000000	116,563	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	63,031	2,669,476	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	53,532	3,999,828	0	2.00
3.00	Total (sum of lines 1-2)	0	0	116,563	6,669,304	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	63,031	0	50,649	2,783,156	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	53,532	0	0	4,053,360	2.00
3.00	Total (sum of lines 1-2)	0	116,563	0	50,649	6,836,516	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8 | Date/Time Prepared: 2/27/2019 3:19 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-355,029	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	-8,999	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	-12,841,594			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	-647,899	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	-33,095	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	-372,507	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8 | Date/Time Prepared: 2/27/2019 3:19 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISC INCOME - A&P	B	-10,435	ADULTS & PEDIATRICS	30.00	0	33.01
33.02	MISC INCOME - EKG	B	-6,308	ELECTROCARDIOLOGY	69.00	0	33.02
33.03	MISC INCOME - ICU	B	-2,192	INTENSIVE CARE UNIT	31.00	0	33.03
33.04	MISC INCOME - LAB	B	-1,556	LABORATORY	60.00	0	33.04
33.05	MISC INCOME - PHARMACY	B	-45,057	PHARMACY	15.00	0	33.05
33.06	MISC INCOME - RADIOLOGY	B	-405	RADIOLOGY-DIAGNOSTIC	54.00	0	33.06
33.07	MISC INCOME - L&D	B	-20	DELIVERY ROOM & LABOR ROOM	52.00	0	33.07
33.08	MISC INCOME - PLANT OPS	B	-2,918	OPERATION OF PLANT	7.00	0	33.08
33.09	MISC INCOME - ER	B	-1,404	EMERGENCY	91.00	0	33.09
33.10	MISC INCOME - RHC I (SHELBINA)	B	0	RURAL HEALTH CLINIC	88.00	0	33.10
33.11	MISC INCOME - RHC II (CANTON/LAGRANG	B	-24	RURAL HEALTH CLINIC II	88.01	0	33.11
33.12	MISC INCOME - RHC III (MONROE)	B	0	RURAL HEALTH CLINIC III	88.02	0	33.12
33.13	MISC INCOME - RHC IV (LOUISIANA)	B	-235	RURAL HEALTH CLINIC IV	88.03	0	33.13
33.14	MISC INCOME - RHC V (BOWLING GREEN)	B	0	RURAL HEALTH CLINIC V	88.04	0	33.14
33.15	MISC INCOME - RHC VI (KIRKSVILLE)	B	0	RURAL HEALTH CLINIC VI	88.05	0	33.15
33.16	MISC INCOME - RHC VII (LANCASTER)	B	0	RURAL HEALTH CLINIC VII	88.06	0	33.16
33.17	MISC INCOME - RHC VIII (LA PLATA)	B	0	RURAL HEALTH CLINIC VIII	88.07	0	33.17
33.18	MISC INCOME - RHC IX (HRMG 2ND FLOOR	B	-3,770	RURAL HEALTH CLINIC IX	88.08	0	33.18
33.19	MISC INCOME - PT	B	0	PHYSICAL THERAPY	66.00	0	33.19
33.20	MISC INCOME - NURSING ADMIN	B	-2,100	NURSING ADMINISTRATION	13.00	0	33.20
34.00	NON ALLOWED ADVERTISING COSTS	A	-1,108,844	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	ADVERTISING EMPLOYEE BENEFITS	A	-54,039	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.01
35.00	LOBBYING EXPENSE	A	-15,131	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	ALCOHOLIC BEVERAGE EXPENSE	A	-1,964	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	DEVELOPMENT SALARIES	A	-124,361	ADMINISTRATIVE & GENERAL	5.00	0	37.00
37.01	DEVELOPMENT EXPENSE	A	-111,016	ADMINISTRATIVE & GENERAL	5.00	0	37.01
37.02	FOUNDATION EMPLOYEE BENEFITS	A	-28,945	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.02
38.00	DEFINED BENEFIT PENSION PLAN	A	1,307,978	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
39.00	CONTRIBUTIONS	A	-52,400	ADMINISTRATIVE & GENERAL	5.00	0	39.00
39.01	RECRUITMENT FEES	A	-441,951	ADMINISTRATIVE & GENERAL	5.00	0	39.01
39.02	RECRUITMENT FEES	A	-2,703	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.02
39.03	PATIENT PHONE	A	-29,599	ADMINISTRATIVE & GENERAL	5.00	0	39.03
39.04	PATIENT PHONE	A	-7,854	CAP REL COSTS-MVBLE EQUIP	2.00	9	39.04
39.05	DAYCARE REVENUE	B	-266,847	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.05
40.00	MEDICAID/FRA	A	6,444,935	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	EMPLOYED PHYSICIAN BENEFITS	A	-1,087,834	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	41.00
45.00	STAFF DEVELOPMENT	B	-35,848	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	NURSERY PHOTOS	B	0	NURSERY	43.00	0	45.01
45.02	SPEECH CONTRACT SERVICE	B	-117,488	SPEECH PATHOLOGY	68.00	0	45.02
45.03	BUILDING RENTAL INCOME	B	-145,721	CAP REL COSTS-BLDG & FIXT	1.00	9	45.03
45.04	EEG CONTRACT SERVICE	B	0	ELECTROENCEPHALOGRAPHY	70.00	0	45.04
45.05	PT CONTRACT SERVICE	B	-23,755	PHYSICAL THERAPY	66.00	0	45.05
45.06	MEDICAL RECORDS REVENUE	B	-26,361	MEDICAL RECORDS & LIBRARY	16.00	0	45.06
45.07	SLEEP CONTRACT SERVICE	B	0	ELECTROENCEPHALOGRAPHY	70.00	0	45.07
45.08	R/T CONTRACT SERVICE	B	0	RESPIRATORY THERAPY	65.00	0	45.08
45.09	O/T CONTRACT SERVICE	B	-92,331	OCCUPATIONAL THERAPY	67.00	0	45.09
45.10	PHYSICIAN PENSION EXPENSE	A	-2,272	ADMINISTRATIVE & GENERAL	5.00	0	45.10
45.11	PHYSICIAN PENSION EXPENSE	A	-49,170	ADULTS & PEDIATRICS	30.00	0	45.11
45.12	PHYSICIAN PENSION EXPENSE	A	0	INTENSIVE CARE UNIT	31.00	0	45.12
45.13	PHYSICIAN PENSION EXPENSE	A	-608	SUBPROVIDER - IRF	41.00	0	45.13
45.14	PHYSICIAN PENSION EXPENSE	A	-610	OPERATING ROOM	50.00	0	45.14
45.15	PHYSICIAN PENSION EXPENSE	A	-79,020	ANESTHESIOLOGY	53.00	0	45.15
45.16	PHYSICIAN PENSION EXPENSE	A	0	CARDIAC CATHETERIZATION	59.00	0	45.16
45.17	PHYSICIAN PENSION EXPENSE	A	-21,841	LABORATORY	60.00	0	45.17
45.18	PHYSICIAN PENSION EXPENSE	A	0	EMERGENCY	91.00	0	45.18
45.19	PALMYRA CLINIC DEPRECIATION	A	17,015	CAP REL COSTS-BLDG & FIXT	1.00	9	45.19
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-10,494,132				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.

ADJUSTMENTS TO EXPENSES | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8 | Date/Time Prepared: 2/27/2019 3:19 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	

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 10/01/2017 To 09/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 2/27/2019 3:19 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	696,142	97,343	598,799	211,500	3,828	1.00
2.00	30.00	ADULTS & PEDIATRICS	2,885,676	2,885,676	0	0	0	2.00
3.00	41.00	SUBPROVIDER - IRF	22,266	22,266	0	0	0	3.00
4.00	50.00	OPERATING ROOM	662,718	662,718	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	2,258,967	2,148,380	110,587	239,400	592	5.00
6.00	59.00	CARDIAC CATHETERIZATION	1,171,657	1,171,657	0	0	0	6.00
7.00	60.00	LABORATORY	926,624	800,624	126,000	260,300	674	7.00
8.00	91.00	EMERGENCY	4,763,094	4,763,094	0	211,500	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			13,387,144	12,551,758	835,386		5,094	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	389,241	19,462	325	280	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	34,424	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	400	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	68,137	3,407	33,588	1,644	0	5.00
6.00	59.00	CARDIAC CATHETERIZATION	0	0	2,650	0	0	6.00
7.00	60.00	LABORATORY	84,347	4,217	13,977	1,901	0	7.00
8.00	91.00	EMERGENCY	0	0	4,000	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			541,725	27,086	89,364	3,825	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	389,521	209,278	306,621		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,885,676		2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	22,266		3.00
4.00	50.00	OPERATING ROOM	0	0	0	662,718		4.00
5.00	53.00	ANESTHESIOLOGY	0	69,781	40,806	2,189,186		5.00
6.00	59.00	CARDIAC CATHETERIZATION	0	0	0	1,171,657		6.00
7.00	60.00	LABORATORY	0	86,248	39,752	840,376		7.00
8.00	91.00	EMERGENCY	0	0	0	4,763,094		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	545,550	289,836	12,841,594		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I | Date/Time Prepared: 2/27/2019 3:19 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,783,156	2,783,156				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,053,360		4,053,360			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	16,985,115	39,219	7,617	17,031,951		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	26,795,223	570,108	1,376,654	3,112,962	31,854,947	5.00
6.00	00600	MAINTENANCE & REPAIRS	503,999	0	1,362	108,455	613,816	6.00
7.00	00700	OPERATION OF PLANT	3,098,760	110,794	73,931	187,887	3,471,372	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	318,672	11,591	0	7,776	338,039	8.00
9.00	00900	HOUSEKEEPING	1,271,006	6,650	9,306	162,179	1,449,141	9.00
10.00	01000	DIETARY	1,120,958	34,736	12,601	230,137	1,398,432	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,584,936	3,704	204,961	302,158	2,095,759	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	326,075	9,753	10,330	41,207	387,365	14.00
15.00	01500	PHARMACY	896,395	12,005	15,902	0	924,302	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,489,233	32,655	114	243,470	1,765,472	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,004,560	246,049	67,902	1,425,173	9,743,684	30.00
31.00	03100	INTENSIVE CARE UNIT	2,067,960	41,615	89,437	434,940	2,633,952	31.00
41.00	04100	SUBPROVIDER - IRF	1,910,522	53,627	20,967	215,123	2,200,239	41.00
43.00	04300	NURSERY	420,574	2,975	14,509	72,406	510,464	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,435,302	63,202	1,044,941	360,533	3,903,978	50.00
51.00	05100	RECOVERY ROOM	1,120,645	49,780	1,227	244,065	1,415,717	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	885,421	0	37,001	184,596	1,107,018	52.00
53.00	05300	ANESTHESIOLOGY	295,305	2,681	20,802	28,771	347,559	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,633,560	76,029	141,770	325,594	3,176,953	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1,790,576	137,572	146,968	209,628	2,284,744	55.00
56.00	05600	RADIOISOTOPE	378,795	8,874	98,520	29,539	515,728	56.00
57.00	05700	CT SCAN	383,505	4,090	76,039	80,186	543,820	57.00
58.00	05800	MRI	401,607	6,035	15,342	25,122	448,106	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,108,202	26,063	29,449	141,249	1,304,963	59.00
60.00	06000	LABORATORY	4,144,907	42,888	145,391	387,824	4,721,010	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	489,378	965	150	27,760	518,253	62.00
64.00	06400	INTRAVENOUS THERAPY	533,839	49,838	40,561	115,783	740,021	64.00
65.00	06500	RESPIRATORY THERAPY	1,125,226	18,562	32,666	216,610	1,393,064	65.00
66.00	06600	PHYSICAL THERAPY	1,219,768	26,721	780	111,094	1,358,363	66.00
67.00	06700	OCCUPATIONAL THERAPY	419,938	1,280	0	13,232	434,450	67.00
68.00	06800	SPEECH PATHOLOGY	140,233	458	0	50,469	191,160	68.00
69.00	06900	ELECTROCARDIOLOGY	112,690	0	16,322	18,306	147,318	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	198,533	5,134	18,419	42,330	264,416	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,484,580	0	0	0	8,484,580	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,224,458	0	0	0	3,224,458	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,349,704	0	0	438,417	8,788,121	73.00
74.00	07400	RENAL DIALYSIS	71,895	0	0	0	71,895	74.00
76.00	03950	DIABETES CENTER	106,987	0	0	22,913	129,900	76.00
76.97	07697	CARDIAC REHABILITATION	217,213	18,927	15,252	45,967	297,359	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	105,970	0	0	23,844	129,814	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	616,470	0	8,106	112,954	737,530	88.00
88.01	08801	RURAL HEALTH CLINIC II	733,303	0	46,672	118,077	898,052	88.01
88.02	08802	RURAL HEALTH CLINIC III	852,640	41,021	4,429	153,338	1,051,428	88.02
88.03	08803	RURAL HEALTH CLINIC IV	929,462	0	317	164,019	1,093,798	88.03
88.04	08804	RURAL HEALTH CLINIC V	1,825,555	0	2,992	324,048	2,152,595	88.04
88.05	08805	RURAL HEALTH CLINIC VI	185,510	8,580	0	32,946	227,036	88.05
88.06	08806	RURAL HEALTH CLINIC VII	349,729	24,704	0	63,897	438,330	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	232,507	5,441	0	49,384	287,332	88.07
88.08	08808	RURAL HEALTH CLINIC IX	4,822,122	382,985	0	961,362	6,166,469	88.08
88.09	08809	RURAL HEALTH CLINIC X	449,396	2,760	1,140	86,236	539,532	88.09
91.00	09100	EMERGENCY	3,007,690	209,954	37,726	459,848	3,715,218	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,431,441	21,451	5,323	293,793	1,752,008	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	129,444,566	2,411,476	3,893,898	12,507,607	124,389,080	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	22,784,190	281,386	157,124	4,378,005	27,600,705	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	742,677	71,617	2,338	146,339	962,971	194.01

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I Date/Time Prepared: 2/27/2019 3:19 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
194.02	07952	HWY 61 BUILDING	0	18,677	0	0	18,677	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	152,971,433	2,783,156	4,053,360	17,031,951	152,971,433	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I | Date/Time Prepared: 2/27/2019 3:19 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	31,854,947					5.00
6.00	00600	MAINTENANCE & REPAIRS	161,440	775,256				6.00
7.00	00700	OPERATION OF PLANT	913,009	39,513	4,423,894			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	88,908	4,134	24,855	455,936		8.00
9.00	00900	HOUSEKEEPING	381,140	2,372	14,260	0	1,846,913	9.00
10.00	01000	DIETARY	367,803	12,388	74,487	0	31,375	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	551,208	1,321	7,942	0	3,345	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	101,881	3,478	20,914	0	8,809	14.00
15.00	01500	PHARMACY	243,102	4,281	25,744	0	10,844	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	464,339	11,646	70,025	0	29,495	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,562,696	87,749	527,619	167,216	222,238	30.00
31.00	03100	INTENSIVE CARE UNIT	692,758	14,841	89,237	20,900	37,588	31.00
41.00	04100	SUBPROVIDER - IRF	578,687	19,125	114,996	26,413	48,438	41.00
43.00	04300	NURSERY	134,258	1,061	6,378	0	2,687	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,026,789	22,540	135,527	57,973	57,085	50.00
51.00	05100	RECOVERY ROOM	372,349	17,753	106,747	17,273	44,963	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	291,158	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	91,412	956	5,750	0	2,422	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	835,574	27,114	163,034	38,079	68,672	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	600,913	49,062	295,004	7,676	124,259	55.00
56.00	05600	RADIOISOTOPE	135,642	3,165	19,028	0	8,015	56.00
57.00	05700	CT SCAN	143,031	1,459	8,770	0	3,694	57.00
58.00	05800	MRI	117,857	2,152	12,941	0	5,451	58.00
59.00	05900	CARDIAC CATHETERIZATION	343,220	9,295	55,888	7,377	23,541	59.00
60.00	06000	LABORATORY	1,241,678	15,295	91,966	8	38,737	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	136,306	344	2,070	0	872	62.00
64.00	06400	INTRAVENOUS THERAPY	194,634	17,774	106,870	4,593	45,015	64.00
65.00	06500	RESPIRATORY THERAPY	366,391	6,620	39,804	0	16,766	65.00
66.00	06600	PHYSICAL THERAPY	357,264	9,529	57,299	1,701	24,135	66.00
67.00	06700	OCCUPATIONAL THERAPY	114,265	456	2,745	0	1,156	67.00
68.00	06800	SPEECH PATHOLOGY	50,277	163	981	0	413	68.00
69.00	06900	ELECTROCARDIOLOGY	38,746	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	69,544	1,831	11,009	1,596	4,637	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,231,538	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	848,068	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,311,372	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	18,909	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	34,165	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	78,209	6,750	40,586	0	17,095	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	34,143	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	193,979	0	0	86	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	236,198	0	0	330	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	276,537	14,629	87,965	541	37,052	88.02
88.03	08803	RURAL HEALTH CLINIC IV	287,681	0	0	992	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	566,156	0	0	992	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	59,713	3,060	18,399	0	7,750	88.05
88.06	08806	RURAL HEALTH CLINIC VII	115,286	8,810	52,975	0	22,314	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	75,571	1,941	11,668	0	4,915	88.07
88.08	08808	RURAL HEALTH CLINIC IX	1,621,849	136,586	821,260	0	345,920	88.08
88.09	08809	RURAL HEALTH CLINIC X	141,903	984	5,918	24	2,493	88.09
91.00	09100	EMERGENCY	977,143	74,876	450,218	102,166	189,636	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	460,797	7,650	45,999	0	19,375	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,337,496	642,703	3,626,878	455,936	1,511,202	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,259,267	100,351	603,393	0	254,155	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	253,272	25,541	153,574	0	64,687	194.01
194.02	07952	HWY 61 BUILDING	4,912	6,661	40,049	0	16,869	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)	31,854,947	775,256	4,423,894	455,936	1,846,913	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I Date/Time Prepared: 2/27/2019 3:19 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,884,485					10.00
11.00	01100	CAFETERIA	1,332,700	1,332,700				11.00
13.00	01300	NURSING ADMINISTRATION	0	39,753	2,699,328			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,259	0	533,706		14.00
15.00	01500	PHARMACY	0	61,036	0	0	1,269,309	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	421,580	274,071	1,182,711	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	55,960	64,863	313,210	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	74,245	36,888	178,077	0	0	41.00
43.00	04300	NURSERY	0	9,234	44,544	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	58,863	283,642	0	0	50.00
51.00	05100	RECOVERY ROOM	0	37,827	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	25,506	123,091	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	23,457	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	48,222	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	21,210	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	3,876	0	0	0	56.00
57.00	05700	CT SCAN	0	11,284	0	0	0	57.00
58.00	05800	MRI	0	3,383	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	18,543	0	0	0	59.00
60.00	06000	LABORATORY	0	93,036	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	4,963	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	17,407	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	33,901	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	17,160	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,580	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,543	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,185	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	6,864	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	386,732	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	146,974	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,269,309	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	0	3,531	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	6,148	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	3,210	15,526	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	84,221	0	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC X	0	0	0	0	0	88.09
91.00	09100	EMERGENCY	0	111,357	366,305	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	192,222	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,884,485	1,144,381	2,699,328	533,706	1,269,309	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	188,319	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)	1,884,485	1,332,700	2,699,328	533,706	1,269,309	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I | Date/Time Prepared: 2/27/2019 3:19 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,340,977					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,316,941	16,506,505	54,185	16,560,690		30.00
31.00	03100	INTENSIVE CARE UNIT	93,639	4,016,948	-53,174	3,963,774		31.00
41.00	04100	SUBPROVIDER - IRF	298,353	3,575,461	0	3,575,461		41.00
43.00	04300	NURSERY	280,917	989,543	0	989,543		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,546,397	0	5,546,397		50.00
51.00	05100	RECOVERY ROOM	0	2,012,629	0	2,012,629		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,546,773	0	1,546,773		52.00
53.00	05300	ANESTHESIOLOGY	0	471,556	0	471,556		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,357,648	0	4,357,648		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	3,382,868	0	3,382,868		55.00
56.00	05600	RADIOISOTOPE	0	685,454	0	685,454		56.00
57.00	05700	CT SCAN	0	712,058	0	712,058		57.00
58.00	05800	MRI	0	589,890	0	589,890		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,762,827	0	1,762,827		59.00
60.00	06000	LABORATORY	0	6,201,730	0	6,201,730		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	662,808	0	662,808		62.00
64.00	06400	INTRAVENOUS THERAPY	0	1,126,314	-1,011	1,125,303		64.00
65.00	06500	RESPIRATORY THERAPY	0	1,856,546	0	1,856,546		65.00
66.00	06600	PHYSICAL THERAPY	0	1,825,451	0	1,825,451		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	560,652	0	560,652		67.00
68.00	06800	SPEECH PATHOLOGY	0	245,537	0	245,537		68.00
69.00	06900	ELECTROCARDIOLOGY	0	189,249	0	189,249		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	359,897	0	359,897		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,102,850	0	11,102,850		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,219,500	0	4,219,500		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,368,802	0	12,368,802		73.00
74.00	07400	RENAL DIALYSIS	0	90,804	0	90,804		74.00
76.00	03950	DIABETES CENTER	0	167,596	0	167,596		76.00
76.97	07697	CARDIAC REHABILITATION	0	446,147	0	446,147		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	182,693	0	182,693		76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	931,595	0	931,595		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,134,580	0	1,134,580		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,468,152	0	1,468,152		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	1,382,471	0	1,382,471		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	2,719,743	0	2,719,743		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	315,958	0	315,958		88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	637,715	0	637,715		88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	381,427	0	381,427		88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	9,176,305	0	9,176,305		88.08
88.09	08809	RURAL HEALTH CLINIC X	0	690,854	0	690,854		88.09
91.00	09100	EMERGENCY	351,127	6,338,046	0	6,338,046		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	2,478,051	0	2,478,051		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,340,977	115,418,030	0	115,418,030		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	36,006,190	0	36,006,190		192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0		194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	1,460,045	0	1,460,045		194.01
194.02	07952	HWY 61 BUILDING	0	87,168	0	87,168		194.02
200.00		Cross Foot Adjustments		0	0	0		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I Date/Time Prepared: 2/27/2019 3:19 pm

	Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		16.00	24.00	25.00	26.00		
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	2,340,977	152,971,433	0	152,971,433		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II | Date/Time Prepared: 2/27/2019 3:19 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	196	39,219	7,617	47,032	47,032	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	320,752	570,108	1,376,654	2,267,514	8,594	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	1,362	1,362	299	6.00
7.00	00700	OPERATION OF PLANT	97,049	110,794	73,931	281,774	519	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	849	11,591	0	12,440	21	8.00
9.00	00900	HOUSEKEEPING	6,664	6,650	9,306	22,620	448	9.00
10.00	01000	DIETARY	5,542	34,736	12,601	52,879	635	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,426	3,704	204,961	210,091	834	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,268	9,753	10,330	23,351	114	14.00
15.00	01500	PHARMACY	151,733	12,005	15,902	179,640	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,086	32,655	114	36,855	672	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	49,632	246,049	67,902	363,583	3,935	30.00
31.00	03100	INTENSIVE CARE UNIT	18,625	41,615	89,437	149,677	1,201	31.00
41.00	04100	SUBPROVIDER - IRF	4,347	53,627	20,967	78,941	594	41.00
43.00	04300	NURSERY	1,426	2,975	14,509	18,910	200	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	190,743	63,202	1,044,941	1,298,886	995	50.00
51.00	05100	RECOVERY ROOM	488	49,780	1,227	51,495	674	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,956	0	37,001	39,957	510	52.00
53.00	05300	ANESTHESIOLOGY	1,935	2,681	20,802	25,418	79	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	364,765	76,029	141,770	582,564	899	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	318,704	137,572	146,968	603,244	579	55.00
56.00	05600	RADIOISOTOPE	124,036	8,874	98,520	231,430	82	56.00
57.00	05700	CT SCAN	21,215	4,090	76,039	101,344	221	57.00
58.00	05800	MRI	155,885	6,035	15,342	177,262	69	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,392	26,063	29,449	59,904	390	59.00
60.00	06000	LABORATORY	34,650	42,888	145,391	222,929	1,071	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	591	965	150	1,706	77	62.00
64.00	06400	INTRAVENOUS THERAPY	1,179	49,838	40,561	91,578	320	64.00
65.00	06500	RESPIRATORY THERAPY	39,721	18,562	32,666	90,949	598	65.00
66.00	06600	PHYSICAL THERAPY	2,037	26,721	780	29,538	307	66.00
67.00	06700	OCCUPATIONAL THERAPY	84	1,280	0	1,364	37	67.00
68.00	06800	SPEECH PATHOLOGY	1,474	458	0	1,932	139	68.00
69.00	06900	ELECTROCARDIOLOGY	1,608	0	16,322	17,930	51	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,292	5,134	18,419	24,845	117	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	1,210	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	1,315	0	0	1,315	63	76.00
76.97	07697	CARDIAC REHABILITATION	107	18,927	15,252	34,286	127	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	66	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	14,941	0	8,106	23,047	312	88.00
88.01	08801	RURAL HEALTH CLINIC II	81,263	0	46,672	127,935	326	88.01
88.02	08802	RURAL HEALTH CLINIC III	3,713	41,021	4,429	49,163	423	88.02
88.03	08803	RURAL HEALTH CLINIC IV	56,174	0	317	56,491	453	88.03
88.04	08804	RURAL HEALTH CLINIC V	183,030	0	2,992	186,022	895	88.04
88.05	08805	RURAL HEALTH CLINIC VI	10,855	8,580	0	19,435	91	88.05
88.06	08806	RURAL HEALTH CLINIC VII	24,297	24,704	0	49,001	176	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	1,926	5,441	0	7,367	136	88.07
88.08	08808	RURAL HEALTH CLINIC IX	12,813	382,985	0	395,798	2,654	88.08
88.09	08809	RURAL HEALTH CLINIC X	11,860	2,760	1,140	15,760	238	88.09
91.00	09100	EMERGENCY	6,204	209,954	37,726	253,884	1,270	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	6,971	21,451	5,323	33,745	811	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,348,819	2,411,476	3,893,898	8,654,193	34,532	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	166,311	281,386	157,124	604,821	12,096	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	906	71,617	2,338	74,861	404	194.01
194.02	07952	HWY 61 BUILDING	0	18,677	0	18,677	0	194.02

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II Date/Time Prepared: 2/27/2019 3:19 pm

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2,516,036	2,783,156	4,053,360	9,352,552	47,032	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II | Date/Time Prepared: 2/27/2019 3:19 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,276,108					5.00
6.00	00600	MAINTENANCE & REPAIRS	11,535	13,196				6.00
7.00	00700	OPERATION OF PLANT	65,237	673	348,203			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,353	70	1,956	20,840		8.00
9.00	00900	HOUSEKEEPING	27,234	40	1,122	0	51,464	9.00
10.00	01000	DIETARY	26,281	211	5,863	0	874	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	39,386	22	625	0	93	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,280	59	1,646	0	245	14.00
15.00	01500	PHARMACY	17,370	73	2,026	0	302	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	33,179	198	5,512	0	822	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	183,113	1,494	41,529	7,645	6,193	30.00
31.00	03100	INTENSIVE CARE UNIT	49,500	253	7,024	955	1,047	31.00
41.00	04100	SUBPROVIDER - IRF	41,349	326	9,051	1,207	1,350	41.00
43.00	04300	NURSERY	9,593	18	502	0	75	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	73,367	384	10,667	2,650	1,591	50.00
51.00	05100	RECOVERY ROOM	26,606	302	8,402	789	1,253	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,804	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	6,532	16	453	0	67	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	59,704	462	12,832	1,740	1,914	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	42,937	835	23,220	351	3,462	55.00
56.00	05600	RADIOISOTOPE	9,692	54	1,498	0	223	56.00
57.00	05700	CT SCAN	10,220	25	690	0	103	57.00
58.00	05800	MRI	8,421	37	1,019	0	152	58.00
59.00	05900	CARDIAC CATHETERIZATION	24,524	158	4,399	337	656	59.00
60.00	06000	LABORATORY	88,722	260	7,239	0	1,079	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	9,740	6	163	0	24	62.00
64.00	06400	INTRAVENOUS THERAPY	13,907	303	8,412	210	1,254	64.00
65.00	06500	RESPIRATORY THERAPY	26,180	113	3,133	0	467	65.00
66.00	06600	PHYSICAL THERAPY	25,528	162	4,510	78	673	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,165	8	216	0	32	67.00
68.00	06800	SPEECH PATHOLOGY	3,592	3	77	0	12	68.00
69.00	06900	ELECTROCARDIOLOGY	2,769	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,969	31	867	73	129	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	159,451	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	60,597	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	165,155	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,351	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	2,441	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	5,588	115	3,195	0	476	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	2,440	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	13,860	0	0	4	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	16,877	0	0	15	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	19,759	249	6,924	25	1,032	88.02
88.03	08803	RURAL HEALTH CLINIC IV	20,556	0	0	45	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	40,454	0	0	45	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	4,267	52	1,448	0	216	88.05
88.06	08806	RURAL HEALTH CLINIC VII	8,238	150	4,170	0	622	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	5,400	33	918	0	137	88.07
88.08	08808	RURAL HEALTH CLINIC IX	115,886	2,323	64,638	0	9,642	88.08
88.09	08809	RURAL HEALTH CLINIC X	10,139	17	466	1	69	88.09
91.00	09100	EMERGENCY	69,820	1,275	35,437	4,670	5,284	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	32,925	130	3,621	0	540	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,738,993	10,940	285,470	20,840	42,110	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	518,667	1,708	47,493	0	7,082	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	18,097	435	12,088	0	1,802	194.01
194.02	07952	HWY 61 BUILDING	351	113	3,152	0	470	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)	2,276,108	13,196	348,203	20,840	51,464	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II | Date/Time Prepared: 2/27/2019 3:19 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	86,743					10.00
11.00	01100	CAFETERIA	61,344	61,344				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,830	252,881			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	518	0	33,213		14.00
15.00	01500	PHARMACY	0	2,809	0	0	202,220	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	19,405	12,616	110,800	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,576	2,986	29,342	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	3,418	1,698	16,683	0	0	41.00
43.00	04300	NURSERY	0	425	4,173	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,709	26,572	0	0	50.00
51.00	05100	RECOVERY ROOM	0	1,741	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,174	11,532	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,080	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,220	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	976	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	178	0	0	0	56.00
57.00	05700	CT SCAN	0	519	0	0	0	57.00
58.00	05800	MRI	0	156	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	854	0	0	0	59.00
60.00	06000	LABORATORY	0	4,282	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	228	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	801	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,560	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	790	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	349	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	117	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	147	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	316	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	24,065	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,148	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	202,220	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	0	163	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	283	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	148	1,455	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	3,877	0	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC X	0	0	0	0	0	88.09
91.00	09100	EMERGENCY	0	5,126	34,316	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	18,008	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	86,743	52,676	252,881	33,213	202,220	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	8,668	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)	86,743	61,344	252,881	33,213	202,220	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II | Date/Time Prepared: 2/27/2019 3:19 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	77,238					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,450	793,763	0	793,763		30.00
31.00	03100	INTENSIVE CARE UNIT	3,090	247,651	0	247,651		31.00
41.00	04100	SUBPROVIDER - IRF	9,844	164,461	0	164,461		41.00
43.00	04300	NURSERY	9,269	43,165	0	43,165		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,417,821	0	1,417,821		50.00
51.00	05100	RECOVERY ROOM	0	91,262	0	91,262		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	73,977	0	73,977		52.00
53.00	05300	ANESTHESIOLOGY	0	33,645	0	33,645		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	662,335	0	662,335		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	675,604	0	675,604		55.00
56.00	05600	RADIOISOTOPE	0	243,157	0	243,157		56.00
57.00	05700	CT SCAN	0	113,122	0	113,122		57.00
58.00	05800	MRI	0	187,116	0	187,116		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	91,222	0	91,222		59.00
60.00	06000	LABORATORY	0	325,582	0	325,582		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	11,944	0	11,944		62.00
64.00	06400	INTRAVENOUS THERAPY	0	116,785	0	116,785		64.00
65.00	06500	RESPIRATORY THERAPY	0	123,000	0	123,000		65.00
66.00	06600	PHYSICAL THERAPY	0	61,586	0	61,586		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	10,171	0	10,171		67.00
68.00	06800	SPEECH PATHOLOGY	0	5,872	0	5,872		68.00
69.00	06900	ELECTROCARDIOLOGY	0	20,897	0	20,897		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	31,347	0	31,347		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	183,516	0	183,516		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	69,745	0	69,745		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	368,585	0	368,585		73.00
74.00	07400	RENAL DIALYSIS	0	1,351	0	1,351		74.00
76.00	03950	DIABETES CENTER	0	3,982	0	3,982		76.00
76.97	07697	CARDIAC REHABILITATION	0	44,070	0	44,070		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	4,109	0	4,109		76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	37,223	0	37,223		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	145,153	0	145,153		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	77,575	0	77,575		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	77,545	0	77,545		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	227,416	0	227,416		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	25,509	0	25,509		88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	62,357	0	62,357		88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	13,991	0	13,991		88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	594,818	0	594,818		88.08
88.09	08809	RURAL HEALTH CLINIC X	0	26,690	0	26,690		88.09
91.00	09100	EMERGENCY	11,585	422,667	0	422,667		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	89,780	0	89,780		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	77,238	8,021,567	0	8,021,567		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,200,535	0	1,200,535		192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0		194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	107,687	0	107,687		194.01
194.02	07952	HWY 61 BUILDING	0	22,763	0	22,763		194.02
200.00		Cross Foot Adjustments		0	0	0		200.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II Date/Time Prepared: 2/27/2019 3:19 pm

	Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		16.00	24.00	25.00	26.00		
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	77,238	9,352,552	0	9,352,552		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/27/2019 3:19 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	389,236					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,375,124				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,485	4,463	67,851,144			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	79,732	806,671	12,401,299	-31,854,947	121,116,486	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	798	432,059	0	613,816	6.00
7.00	00700	OPERATION OF PLANT	15,495	43,321	748,498	0	3,471,372	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,621	0	30,979	0	338,039	8.00
9.00	00900	HOUSEKEEPING	930	5,453	646,082	0	1,449,141	9.00
10.00	01000	DIETARY	4,858	7,384	916,813	0	1,398,432	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	518	120,100	1,203,726	0	2,095,759	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,364	6,053	164,157	0	387,365	14.00
15.00	01500	PHARMACY	1,679	9,318	0	0	924,302	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,567	67	969,928	0	1,765,472	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,411	39,788	5,677,550	0	9,743,684	30.00
31.00	03100	INTENSIVE CARE UNIT	5,820	52,407	1,732,698	0	2,633,952	31.00
41.00	04100	SUBPROVIDER - IRF	7,500	12,286	856,999	0	2,200,239	41.00
43.00	04300	NURSERY	416	8,502	288,449	0	510,464	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,839	612,298	1,436,278	0	3,903,978	50.00
51.00	05100	RECOVERY ROOM	6,962	719	972,297	0	1,415,717	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	21,681	735,388	0	1,107,018	52.00
53.00	05300	ANESTHESIOLOGY	375	12,189	114,616	0	347,559	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,633	83,072	1,297,090	0	3,176,953	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	19,240	86,118	835,107	0	2,284,744	55.00
56.00	05600	RADIOISOTOPE	1,241	57,729	117,678	0	515,728	56.00
57.00	05700	CT SCAN	572	44,556	319,443	0	543,820	57.00
58.00	05800	MRI	844	8,990	100,081	0	448,106	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,645	17,256	562,704	0	1,304,963	59.00
60.00	06000	LABORATORY	5,998	85,194	1,545,000	0	4,721,010	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	135	88	110,590	0	518,253	62.00
64.00	06400	INTRAVENOUS THERAPY	6,970	23,767	461,253	0	740,021	64.00
65.00	06500	RESPIRATORY THERAPY	2,596	19,141	862,921	0	1,393,064	65.00
66.00	06600	PHYSICAL THERAPY	3,737	457	442,574	0	1,358,363	66.00
67.00	06700	OCCUPATIONAL THERAPY	179	0	52,713	0	434,450	67.00
68.00	06800	SPEECH PATHOLOGY	64	0	201,057	0	191,160	68.00
69.00	06900	ELECTROCARDIOLOGY	0	9,564	72,927	0	147,318	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	718	10,793	168,632	0	264,416	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	8,484,580	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,224,458	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,746,548	0	8,788,121	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	71,895	74.00
76.00	03950	DIABETES CENTER	0	0	91,279	0	129,900	76.00
76.97	07697	CARDIAC REHABILITATION	2,647	8,937	183,123	0	297,359	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	94,990	0	129,814	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,750	449,981	0	737,530	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	27,348	470,390	0	898,052	88.01
88.02	08802	RURAL HEALTH CLINIC III	5,737	2,595	610,864	0	1,051,428	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	186	653,411	0	1,093,798	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	1,753	1,290,929	0	2,152,595	88.04
88.05	08805	RURAL HEALTH CLINIC VI	1,200	0	131,248	0	227,036	88.05
88.06	08806	RURAL HEALTH CLINIC VII	3,455	0	254,551	0	438,330	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	761	0	196,736	0	287,332	88.07
88.08	08808	RURAL HEALTH CLINIC IX	53,562	0	3,829,836	0	6,166,469	88.08
88.09	08809	RURAL HEALTH CLINIC X	386	668	343,542	0	539,532	88.09
91.00	09100	EMERGENCY	29,363	22,106	1,831,924	0	3,715,218	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,000	3,119	1,170,400	0	1,752,008	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	337,255	2,281,685	49,827,338	-31,854,947	92,534,133	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	39,353	92,069	17,440,826	0	27,600,705	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	10,016	1,370	582,980	0	962,971	194.01

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/27/2019 3:19 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
194.02	07952	HWY 61 BUILDING	2,612	0	0	0	18,677	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,783,156	4,053,360	17,031,951		31,854,947	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.150305	1.706589	0.251019		0.263011	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			47,032		2,276,108	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000693		0.018793	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/27/2019 3:19 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	304,019					6.00
7.00	00700	OPERATION OF PLANT	15,495	288,524				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,621	1,621	484,952			8.00
9.00	00900	HOUSEKEEPING	930	930	0	285,973		9.00
10.00	01000	DIETARY	4,858	4,858	0	4,858	281,765	10.00
11.00	01100	CAFETERIA	0	0	0	0	199,263	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	4,567	4,567	0	4,567	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,411	34,411	177,858	34,411	63,034	30.00
31.00	03100	INTENSIVE CARE UNIT	5,820	5,820	22,230	5,820	8,367	31.00
41.00	04100	SUBPROVIDER - IRF	7,500	7,500	28,094	7,500	11,101	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	61,662	8,839	0	50.00
51.00	05100	RECOVERY ROOM	6,962	6,962	18,372	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	40,502	10,633	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	19,240	19,240	8,165	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	7,847	3,645	0	59.00
60.00	06000	LABORATORY	5,998	5,998	9	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	4,885	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	3,737	3,737	1,809	3,737	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	179	179	0	179	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	1,698	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	91	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	351	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	5,737	5,737	575	5,737	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	1,055	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	1,055	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	1,200	1,200	0	1,200	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	3,455	3,455	0	3,455	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	761	761	0	761	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	53,562	53,562	0	53,562	0	88.08
88.09	08809	RURAL HEALTH CLINIC X	386	386	26	386	0	88.09
91.00	09100	EMERGENCY	29,363	29,363	108,668	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)	252,038	236,543	484,952	233,992	281,765	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	39,353	39,353	0	39,353	0	192.00
194.00	07950	PHYSICIAN OFFICES PITTSFIELD	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	10,016	10,016	0	10,016	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 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/27/2019 3:19 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	775,256	4,423,894	455,936	1,846,913	1,884,485	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.550025	15.332846	0.940167	6.458347	6.688144	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	13,196	348,203	20,840	51,464	86,743	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.043405	1.206842	0.042973	0.179961	0.307856	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/27/2019 3:19 pm

		Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	53,975					11.00
13.00	01300	NURSING ADMINISTRATION	1,610	470,980				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	456	0	11,709,038			14.00
15.00	01500	PHARMACY	2,472	0	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	30,075	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,100	206,360	0	0	16,919	30.00
31.00	03100	INTENSIVE CARE UNIT	2,627	54,649	0	0	1,203	31.00
41.00	04100	SUBPROVIDER - IRF	1,494	31,071	0	0	3,833	41.00
43.00	04300	NURSERY	374	7,772	0	0	3,609	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,384	49,490	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	1,033	21,477	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	950	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,953	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	859	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	157	0	0	0	0	56.00
57.00	05700	CT SCAN	457	0	0	0	0	57.00
58.00	05800	MRI	137	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	751	0	0	0	0	59.00
60.00	06000	LABORATORY	3,768	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	201	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	705	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,373	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	695	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	307	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	103	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	129	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	278	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	8,484,580	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	3,224,458	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	143	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	249	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	130	2,709	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	3,411	0	0	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC X	0	0	0	0	0	88.09
91.00	09100	EMERGENCY	4,510	63,913	0	0	4,511	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	33,539	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)	46,348	470,980	11,709,038	100	30,075	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,627	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

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/27/2019 3:19 pm

		Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,332,700	2,699,328	533,706	1,269,309	2,340,977	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.691061	5.731301	0.045581	12,693.090000	77.837972	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	61,344	252,881	33,213	202,220	77,238	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.136526	0.536925	0.002837	2,022.200000	2.568180	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-2 | Date/Time Prepared: 2/27/2019 3:19 pm

		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 & IV THERAPY	1	30.00	54,185	7.00
8.00		ICU OBSERVATION	1	31.00	-53,174	8.00
9.00		IV THERAPY	1	64.00	-1,011	9.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/27/2019 3:19 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,560,690		16,560,690	0	16,560,690	30.00
31.00	03100	INTENSIVE CARE UNIT	3,963,774		3,963,774	0	3,963,774	31.00
41.00	04100	SUBPROVIDER - IRF	3,575,461		3,575,461	0	3,575,461	41.00
43.00	04300	NURSERY	989,543		989,543	0	989,543	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,546,397		5,546,397	0	5,546,397	50.00
51.00	05100	RECOVERY ROOM	2,012,629		2,012,629	0	2,012,629	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,546,773		1,546,773	0	1,546,773	52.00
53.00	05300	ANESTHESIOLOGY	471,556		471,556	40,806	512,362	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,357,648		4,357,648	0	4,357,648	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	3,382,868		3,382,868	0	3,382,868	55.00
56.00	05600	RADIOISOTOPE	685,454		685,454	0	685,454	56.00
57.00	05700	CT SCAN	712,058		712,058	0	712,058	57.00
58.00	05800	MRI	589,890		589,890	0	589,890	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,762,827		1,762,827	0	1,762,827	59.00
60.00	06000	LABORATORY	6,201,730		6,201,730	39,752	6,241,482	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	662,808		662,808	0	662,808	62.00
64.00	06400	INTRAVENOUS THERAPY	1,125,303		1,125,303	0	1,125,303	64.00
65.00	06500	RESPIRATORY THERAPY	1,856,546	0	1,856,546	0	1,856,546	65.00
66.00	06600	PHYSICAL THERAPY	1,825,451	0	1,825,451	0	1,825,451	66.00
67.00	06700	OCCUPATIONAL THERAPY	560,652	0	560,652	0	560,652	67.00
68.00	06800	SPEECH PATHOLOGY	245,537	0	245,537	0	245,537	68.00
69.00	06900	ELECTROCARDIOLOGY	189,249		189,249	0	189,249	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	359,897		359,897	0	359,897	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,102,850		11,102,850	0	11,102,850	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,219,500		4,219,500	0	4,219,500	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,368,802		12,368,802	0	12,368,802	73.00
74.00	07400	RENAL DIALYSIS	90,804		90,804	0	90,804	74.00
76.00	03950	DIABETES CENTER	167,596		167,596	0	167,596	76.00
76.97	07697	CARDIAC REHABILITATION	446,147		446,147	0	446,147	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	182,693		182,693	0	182,693	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	931,595		931,595	0	931,595	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,134,580		1,134,580	0	1,134,580	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,468,152		1,468,152	0	1,468,152	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,382,471		1,382,471	0	1,382,471	88.03
88.04	08804	RURAL HEALTH CLINIC V	2,719,743		2,719,743	0	2,719,743	88.04
88.05	08805	RURAL HEALTH CLINIC VI	315,958		315,958	0	315,958	88.05
88.06	08806	RURAL HEALTH CLINIC VII	637,715		637,715	0	637,715	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	381,427		381,427	0	381,427	88.07
88.08	08808	RURAL HEALTH CLINIC IX	9,176,305		9,176,305	0	9,176,305	88.08
88.09	08809	RURAL HEALTH CLINIC X	690,854		690,854	0	690,854	88.09
91.00	09100	EMERGENCY	6,338,046		6,338,046	0	6,338,046	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,102,336		1,102,336		1,102,336	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,478,051		2,478,051		2,478,051	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	116,520,366	0	116,520,366	80,558	116,600,924	200.00
201.00		Less Observation Beds	1,102,336		1,102,336		1,102,336	201.00
202.00		Total (see instructions)	115,418,030	0	115,418,030	80,558	115,498,588	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/27/2019 3:19 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,019,703		6,019,703			30.00
31.00	03100	INTENSIVE CARE UNIT	1,491,612		1,491,612			31.00
41.00	04100	SUBPROVIDER - IRF	2,260,200		2,260,200			41.00
43.00	04300	NURSERY	252,936		252,936			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,141,400	19,799,444	30,940,844	0.179258	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,625,727	3,749,202	5,374,929	0.374448	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	496,911	138,970	635,881	2.432488	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	3,922,348	5,124,265	9,046,613	0.052125	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,531,855	8,581,483	11,113,338	0.392110	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	14,346	5,518,180	5,532,526	0.611451	0.000000	55.00
56.00	05600	RADIOISOTOPE	481,925	2,091,799	2,573,724	0.266328	0.000000	56.00
57.00	05700	CT SCAN	4,990,615	15,466,650	20,457,265	0.034807	0.000000	57.00
58.00	05800	MRI	720,750	5,872,993	6,593,743	0.089462	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,384,921	4,957,926	8,342,847	0.211298	0.000000	59.00
60.00	06000	LABORATORY	11,839,222	29,490,452	41,329,674	0.150055	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	516,803	736,614	1,253,417	0.528801	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	43,368	2,260,738	2,304,106	0.488390	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	236,726	429,864	666,590	2.785139	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,246,092	206,369	1,452,461	1.256799	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	948,975	242,497	1,191,472	0.470554	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	124,986	433,823	558,809	0.439393	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	626,855	1,484,067	2,110,922	0.089652	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	9,068	596,009	605,077	0.594795	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	61,783,514	54,831,299	116,614,813	0.095210	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	954,446	6,102,189	7,056,635	0.597948	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,870,428	38,594,193	71,464,621	0.173076	0.000000	73.00
74.00	07400	RENAL DIALYSIS	37,525	0	37,525	2.419827	0.000000	74.00
76.00	03950	DIABETES CENTER	0	20,437	20,437	8.200617	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	3,494	393,211	396,705	1.124632	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	210	10,310	10,520	17.366255	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	692,784	692,784			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	685,265	685,265			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,321,239	1,321,239			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	977,400	977,400			88.03
88.04	08804	RURAL HEALTH CLINIC V	0	2,120,119	2,120,119			88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	192,828	192,828			88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	577,118	577,118			88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	490,423	490,423			88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	4,212,218	4,212,218			88.08
88.09	08809	RURAL HEALTH CLINIC X	0	826,168	826,168			88.09
91.00	09100	EMERGENCY	742,180	2,228,077	2,970,257	2.133838	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	459,540	1,292,412	1,751,952	0.629204	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	2,258,763	2,258,763			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	151,778,681	225,007,798	376,786,479			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	151,778,681	225,007,798	376,786,479			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/27/2019 3:19 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
31.00	03100	INTENSIVE CARE UNIT	
41.00	04100	SUBPROVIDER - IRF	
43.00	04300	NURSERY	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.179258
51.00	05100	RECOVERY ROOM	0.374448
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.432488
53.00	05300	ANESTHESIOLOGY	0.056636
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.392110
55.00	05500	RADIOLOGY - THERAPEUTIC	0.611451
56.00	05600	RADIOISOTOPE	0.266328
57.00	05700	CT SCAN	0.034807
58.00	05800	MRI	0.089462
59.00	05900	CARDIAC CATHETERIZATION	0.211298
60.00	06000	LABORATORY	0.151017
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.528801
64.00	06400	INTRAVENOUS THERAPY	0.488390
65.00	06500	RESPIRATORY THERAPY	2.785139
66.00	06600	PHYSICAL THERAPY	1.256799
67.00	06700	OCCUPATIONAL THERAPY	0.470554
68.00	06800	SPEECH PATHOLOGY	0.439393
69.00	06900	ELECTROCARDIOLOGY	0.089652
70.00	07000	ELECTROENCEPHALOGRAPHY	0.594795
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.095210
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.597948
73.00	07300	DRUGS CHARGED TO PATIENTS	0.173076
74.00	07400	RENAL DIALYSIS	2.419827
76.00	03950	DIABETES CENTER	8.200617
76.97	07697	CARDIAC REHABILITATION	1.124632
76.98	07698	HYPERBARIC OXYGEN THERAPY	17.366255
		OUTPATIENT SERVICE COST CENTERS	
88.00	08800	RURAL HEALTH CLINIC	
88.01	08801	RURAL HEALTH CLINIC II	
88.02	08802	RURAL HEALTH CLINIC III	
88.03	08803	RURAL HEALTH CLINIC IV	
88.04	08804	RURAL HEALTH CLINIC V	
88.05	08805	RURAL HEALTH CLINIC VI	
88.06	08806	RURAL HEALTH CLINIC VII	
88.07	08807	RURAL HEALTH CLINIC VIII	
88.08	08808	RURAL HEALTH CLINIC IX	
88.09	08809	RURAL HEALTH CLINIC X	
91.00	09100	EMERGENCY	2.133838
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.629204
		OTHER REIMBURSABLE COST CENTERS	
101.00	10100	HOME HEALTH AGENCY	
		SPECIAL PURPOSE COST CENTERS	
113.00	11300	INTEREST EXPENSE	
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/27/2019 3:19 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,560,690		16,560,690	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,963,774		3,963,774	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	3,575,461		3,575,461	0	0	41.00
43.00	04300	NURSERY	989,543		989,543	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,546,397		5,546,397	0	0	50.00
51.00	05100	RECOVERY ROOM	2,012,629		2,012,629	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,546,773		1,546,773	0	0	52.00
53.00	05300	ANESTHESIOLOGY	471,556		471,556	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,357,648		4,357,648	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	3,382,868		3,382,868	0	0	55.00
56.00	05600	RADIOISOTOPE	685,454		685,454	0	0	56.00
57.00	05700	CT SCAN	712,058		712,058	0	0	57.00
58.00	05800	MRI	589,890		589,890	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,762,827		1,762,827	0	0	59.00
60.00	06000	LABORATORY	6,201,730		6,201,730	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	662,808		662,808	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	1,125,303		1,125,303	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,856,546	0	1,856,546	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,825,451	0	1,825,451	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	560,652	0	560,652	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	245,537	0	245,537	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	189,249		189,249	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	359,897		359,897	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,102,850		11,102,850	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,219,500		4,219,500	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,368,802		12,368,802	0	0	73.00
74.00	07400	RENAL DIALYSIS	90,804		90,804	0	0	74.00
76.00	03950	DIABETES CENTER	167,596		167,596	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	446,147		446,147	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	182,693		182,693	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	931,595		931,595	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,134,580		1,134,580	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,468,152		1,468,152	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,382,471		1,382,471	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	2,719,743		2,719,743	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	315,958		315,958	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	637,715		637,715	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	381,427		381,427	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	9,176,305		9,176,305	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC X	690,854		690,854	0	0	88.09
91.00	09100	EMERGENCY	6,338,046		6,338,046	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,102,336		1,102,336		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,478,051		2,478,051		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	116,520,366	0	116,520,366	0	0	200.00
201.00		Less Observation Beds	1,102,336		1,102,336		0	201.00
202.00		Total (see instructions)	115,418,030	0	115,418,030	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/27/2019 3:19 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,019,703		6,019,703			30.00
31.00	03100	INTENSIVE CARE UNIT	1,491,612		1,491,612			31.00
41.00	04100	SUBPROVIDER - IRF	2,260,200		2,260,200			41.00
43.00	04300	NURSERY	252,936		252,936			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,141,400	19,799,444	30,940,844	0.179258	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,625,727	3,749,202	5,374,929	0.374448	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	496,911	138,970	635,881	2.432488	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	3,922,348	5,124,265	9,046,613	0.052125	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,531,855	8,581,483	11,113,338	0.392110	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	14,346	5,518,180	5,532,526	0.611451	0.000000	55.00
56.00	05600	RADIOISOTOPE	481,925	2,091,799	2,573,724	0.266328	0.000000	56.00
57.00	05700	CT SCAN	4,990,615	15,466,650	20,457,265	0.034807	0.000000	57.00
58.00	05800	MRI	720,750	5,872,993	6,593,743	0.089462	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,384,921	4,957,926	8,342,847	0.211298	0.000000	59.00
60.00	06000	LABORATORY	11,839,222	29,490,452	41,329,674	0.150055	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	516,803	736,614	1,253,417	0.528801	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	43,368	2,260,738	2,304,106	0.488390	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	236,726	429,864	666,590	2.785139	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,246,092	206,369	1,452,461	1.256799	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	948,975	242,497	1,191,472	0.470554	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	124,986	433,823	558,809	0.439393	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	626,855	1,484,067	2,110,922	0.089652	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	9,068	596,009	605,077	0.594795	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	61,783,514	54,831,299	116,614,813	0.095210	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	954,446	6,102,189	7,056,635	0.597948	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,870,428	38,594,193	71,464,621	0.173076	0.000000	73.00
74.00	07400	RENAL DIALYSIS	37,525	0	37,525	2.419827	0.000000	74.00
76.00	03950	DIABETES CENTER	0	20,437	20,437	8.200617	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	3,494	393,211	396,705	1.124632	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	210	10,310	10,520	17.366255	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	692,784	692,784	1.344712	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	685,265	685,265	1.655681	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,321,239	1,321,239	1.111193	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	977,400	977,400	1.414437	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	2,120,119	2,120,119	1.282826	0.000000	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	192,828	192,828	1.638548	0.000000	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	577,118	577,118	1.104999	0.000000	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	490,423	490,423	0.777751	0.000000	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	4,212,218	4,212,218	2.178497	0.000000	88.08
88.09	08809	RURAL HEALTH CLINIC X	0	826,168	826,168	0.836215	0.000000	88.09
91.00	09100	EMERGENCY	742,180	2,228,077	2,970,257	2.133838	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	459,540	1,292,412	1,751,952	0.629204	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	2,258,763	2,258,763			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	151,778,681	225,007,798	376,786,479			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	151,778,681	225,007,798	376,786,479			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/27/2019 3:19 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	55.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
76.00	03950	DIABETES CENTER	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000	88.04
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
88.09	08809	RURAL HEALTH CLINIC X	0.000000	88.09
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 10/01/2017 To 09/30/2018 | Worksheet D Part I Date/Time Prepared: 2/27/2019 3:19 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	793,763	0	793,763	14,212	55.85	30.00
31.00	INTENSIVE CARE UNIT	247,651		247,651	1,798	137.74	31.00
41.00	SUBPROVIDER - IRF	164,461	0	164,461	2,489	66.08	41.00
43.00	NURSERY	43,165		43,165	1,158	37.28	43.00
200.00	Total (lines 30 through 199)	1,249,040		1,249,040	19,657		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	7,889	440,601				30.00
31.00	INTENSIVE CARE UNIT	1,130	155,646				31.00
41.00	SUBPROVIDER - IRF	1,936	127,931				41.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	10,955	724,178				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part II Date/Time Prepared: 2/27/2019 3:19 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,417,821	30,940,844	0.045824	5,632,998	258,127	50.00
51.00	05100	RECOVERY ROOM	91,262	5,374,929	0.016979	804,074	13,652	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	73,977	635,881	0.116338	1,243	145	52.00
53.00	05300	ANESTHESIOLOGY	33,645	9,046,613	0.003719	1,790,306	6,658	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	662,335	11,113,338	0.059598	1,489,048	88,744	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	675,604	5,532,526	0.122115	8,603	1,051	55.00
56.00	05600	RADIOISOTOPE	243,157	2,573,724	0.094477	311,765	29,455	56.00
57.00	05700	CT SCAN	113,122	20,457,265	0.005530	2,788,025	15,418	57.00
58.00	05800	MRI	187,116	6,593,743	0.028378	402,610	11,425	58.00
59.00	05900	CARDIAC CATHETERIZATION	91,222	8,342,847	0.010934	1,615,931	17,669	59.00
60.00	06000	LABORATORY	325,582	41,329,674	0.007878	6,833,417	53,834	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	11,944	1,253,417	0.009529	295,117	2,812	62.00
64.00	06400	INTRAVENOUS THERAPY	116,785	2,304,106	0.050686	25,719	1,304	64.00
65.00	06500	RESPIRATORY THERAPY	123,000	666,590	0.184521	138,196	25,500	65.00
66.00	06600	PHYSICAL THERAPY	61,586	1,452,461	0.042401	432,169	18,324	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,171	1,191,472	0.008536	157,929	1,348	67.00
68.00	06800	SPEECH PATHOLOGY	5,872	558,809	0.010508	35,926	378	68.00
69.00	06900	ELECTROCARDIOLOGY	20,897	2,110,922	0.009899	394,425	3,904	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	31,347	605,077	0.051807	4,917	255	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	183,516	116,614,813	0.001574	28,337,785	44,604	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	69,745	7,056,635	0.009884	520,452	5,144	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	368,585	71,464,621	0.005158	15,923,172	82,132	73.00
74.00	07400	RENAL DIALYSIS	1,351	37,525	0.036003	18,550	668	74.00
76.00	03950	DIABETES CENTER	3,982	20,437	0.194843	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	44,070	396,705	0.111090	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	4,109	10,520	0.390589	30	12	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	37,223	692,784	0.053730	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	145,153	685,265	0.211820	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	77,575	1,321,239	0.058714	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	77,545	977,400	0.079338	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	227,416	2,120,119	0.107266	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	25,509	192,828	0.132289	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	62,357	577,118	0.108049	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	13,991	490,423	0.028528	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	594,818	4,212,218	0.141213	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC X	26,690	826,168	0.032306	0	0	88.09
91.00	09100	EMERGENCY	422,667	2,970,257	0.142300	411,503	58,557	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	52,836	1,751,952	0.030158	271,170	8,178	92.00
200.00		Total (lines 50 through 199)	6,735,583	364,503,265		68,645,080	749,298	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part III Date/Time Prepared: 2/27/2019 3:19 pm

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	14,212	0.00	7,889	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,798	0.00	1,130	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	2,489	0.00	1,936	41.00
43.00	04300	NURSERY		0	1,158	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	19,657		10,955	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 10/01/2017 To 09/30/2018 | Worksheet D Part IV Date/Time Prepared: 2/27/2019 3:19 pm

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
88.09	08809	RURAL HEALTH CLINIC X	0	0	0	0	0	88.09
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	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 10/01/2017 To 09/30/2018 | Worksheet D Part IV Date/Time Prepared: 2/27/2019 3:19 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 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	30,940,844	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	5,374,929	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	635,881	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	9,046,613	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	11,113,338	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	5,532,526	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	2,573,724	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	20,457,265	0.000000	57.00
58.00	05800	MRI	0	0	0	6,593,743	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	8,342,847	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	41,329,674	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,253,417	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,304,106	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	666,590	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,452,461	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,191,472	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	558,809	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,110,922	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	605,077	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	116,614,813	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,056,635	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	71,464,621	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	37,525	0.000000	74.00
76.00	03950	DIABETES CENTER	0	0	0	20,437	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	396,705	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	10,520	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	692,784	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	685,265	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	1,321,239	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	977,400	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	2,120,119	0.000000	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	192,828	0.000000	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	0	0	577,118	0.000000	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	0	0	490,423	0.000000	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	0	0	4,212,218	0.000000	88.08
88.09	08809	RURAL HEALTH CLINIC X	0	0	0	826,168	0.000000	88.09
91.00	09100	EMERGENCY	0	0	0	2,970,257	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,751,952	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	364,503,265		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 2/27/2019 3:19 pm

Title XVIII | Hospital | 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	5,632,998	0	7,277,443	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	804,074	0	1,265,097	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	1,243	0	223	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,790,306	0	1,806,913	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,489,048	0	2,333,302	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	8,603	0	2,778,030	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	311,765	0	795,275	0	56.00
57.00	05700	CT SCAN	0.000000	2,788,025	0	5,011,819	0	57.00
58.00	05800	MRI	0.000000	402,610	0	2,033,124	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	1,615,931	0	2,370,117	0	59.00
60.00	06000	LABORATORY	0.000000	6,833,417	0	4,997,547	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	295,117	0	225,244	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	25,719	0	864,342	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	138,196	0	221,315	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	432,169	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	157,929	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	35,926	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	394,425	0	511,248	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	4,917	0	182,179	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	28,337,785	0	19,030,407	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	520,452	0	3,778,340	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	15,923,172	0	13,393,896	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	18,550	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	177,058	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	30	0	3,617	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
88.09	08809	RURAL HEALTH CLINIC X	0.000000	0	0	0	0	88.09
91.00	09100	EMERGENCY	0.000000	411,503	0	504,877	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	271,170	0	526,500	0	92.00
200.00		Total (lines 50 through 199)		68,645,080	0	70,087,913	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part V Date/Time Prepared: 2/27/2019 3:19 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.179258	7,277,443	0	0	1,304,540	50.00
51.00	05100	RECOVERY ROOM	0.374448	1,265,097	0	0	473,713	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.432488	223	0	0	542	52.00
53.00	05300	ANESTHESIOLOGY	0.052125	1,806,913	0	0	94,185	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.392110	2,333,302	0	0	914,911	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.611451	2,778,030	0	0	1,698,629	55.00
56.00	05600	RADIOISOTOPE	0.266328	795,275	0	0	211,804	56.00
57.00	05700	CT SCAN	0.034807	5,011,819	0	0	174,446	57.00
58.00	05800	MRI	0.089462	2,033,124	0	0	181,887	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.211298	2,370,117	0	0	500,801	59.00
60.00	06000	LABORATORY	0.150055	4,997,547	0	0	749,907	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.528801	225,244	0	0	119,109	62.00
64.00	06400	INTRAVENOUS THERAPY	0.488390	864,342	0	0	422,136	64.00
65.00	06500	RESPIRATORY THERAPY	2.785139	221,315	0	0	616,393	65.00
66.00	06600	PHYSICAL THERAPY	1.256799	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.470554	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.439393	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.089652	511,248	0	0	45,834	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.594795	182,179	0	0	108,359	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.095210	19,030,407	0	0	1,811,885	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.597948	3,778,340	0	0	2,259,251	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.173076	13,393,896	0	0	2,318,162	73.00
74.00	07400	RENAL DIALYSIS	2.419827	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	8.200617	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.124632	177,058	0	0	199,125	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	17.366255	3,617	0	0	62,814	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
88.09	08809	RURAL HEALTH CLINIC X	0.000000				0	88.09
91.00	09100	EMERGENCY	2.133838	504,877	0	0	1,077,326	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.629204	526,500	0	0	331,276	92.00
200.00		Subtotal (see instructions)		70,087,913	0	0	15,677,035	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		70,087,913	0	0	15,677,035	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part V Date/Time Prepared: 2/27/2019 3:19 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	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
88.09	08809	RURAL HEALTH CLINIC X	0	0	88.09
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 26-0025 | Component CCN: 26-T025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part II Date/Time Prepared: 2/27/2019 3:19 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,417,821	30,940,844	0.045824	335	15	50.00
51.00	05100	RECOVERY ROOM	91,262	5,374,929	0.016979	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	73,977	635,881	0.116338	0	0	52.00
53.00	05300	ANESTHESIOLOGY	33,645	9,046,613	0.003719	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	662,335	11,113,338	0.059598	35,957	2,143	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	675,604	5,532,526	0.122115	11	1	55.00
56.00	05600	RADIOISOTOPE	243,157	2,573,724	0.094477	1,506	142	56.00
57.00	05700	CT SCAN	113,122	20,457,265	0.005530	40,343	223	57.00
58.00	05800	MRI	187,116	6,593,743	0.028378	18,675	530	58.00
59.00	05900	CARDIAC CATHETERIZATION	91,222	8,342,847	0.010934	51	1	59.00
60.00	06000	LABORATORY	325,582	41,329,674	0.007878	229,642	1,809	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	11,944	1,253,417	0.009529	9,133	87	62.00
64.00	06400	INTRAVENOUS THERAPY	116,785	2,304,106	0.050686	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	123,000	666,590	0.184521	4,627	854	65.00
66.00	06600	PHYSICAL THERAPY	61,586	1,452,461	0.042401	470,715	19,959	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,171	1,191,472	0.008536	536,184	4,577	67.00
68.00	06800	SPEECH PATHOLOGY	5,872	558,809	0.010508	33,564	353	68.00
69.00	06900	ELECTROCARDIOLOGY	20,897	2,110,922	0.009899	7,250	72	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	31,347	605,077	0.051807	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	183,516	116,614,813	0.001574	220,862	348	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	69,745	7,056,635	0.009884	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	368,585	71,464,621	0.005158	191,202	986	73.00
74.00	07400	RENAL DIALYSIS	1,351	37,525	0.036003	1,750	63	74.00
76.00	03950	DIABETES CENTER	3,982	20,437	0.194843	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	44,070	396,705	0.111090	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	4,109	10,520	0.390589	18	7	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	37,223	692,784	0.053730	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	145,153	685,265	0.211820	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	77,575	1,321,239	0.058714	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	77,545	977,400	0.079338	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	227,416	2,120,119	0.107266	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	25,509	192,828	0.132289	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	62,357	577,118	0.108049	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	13,991	490,423	0.028528	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	594,818	4,212,218	0.141213	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC X	26,690	826,168	0.032306	0	0	88.09
91.00	09100	EMERGENCY	422,667	2,970,257	0.142300	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,751,952	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	6,682,747	364,503,265		1,801,825	32,170	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0025 | Component CCN: 26-T025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV Date/Time Prepared: 2/27/2019 3:19 pm

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
88.09	08809	RURAL HEALTH CLINIC X	0	0	0	0	0	88.09
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	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 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 2/27/2019 3:19 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 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	30,940,844	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	5,374,929	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	635,881	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	9,046,613	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	11,113,338	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	5,532,526	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	2,573,724	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	20,457,265	0.000000	57.00
58.00	05800	MRI	0	0	0	6,593,743	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	8,342,847	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	41,329,674	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,253,417	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,304,106	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	666,590	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,452,461	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,191,472	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	558,809	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,110,922	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	605,077	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	116,614,813	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,056,635	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	71,464,621	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	37,525	0.000000	74.00
76.00	03950	DIABETES CENTER	0	0	0	20,437	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	396,705	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	10,520	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	692,784	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	685,265	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	1,321,239	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	977,400	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	2,120,119	0.000000	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	192,828	0.000000	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	0	0	577,118	0.000000	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	0	0	490,423	0.000000	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	0	0	4,212,218	0.000000	88.08
88.09	08809	RURAL HEALTH CLINIC X	0	0	0	826,168	0.000000	88.09
91.00	09100	EMERGENCY	0	0	0	2,970,257	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,751,952	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	364,503,265		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0025 | Component CCN: 26-T025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV Date/Time Prepared: 2/27/2019 3:19 pm

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	335	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	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	35,957	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	11	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	1,506	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	40,343	0	0	0	57.00
58.00	05800	MRI	0.000000	18,675	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	51	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	229,642	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	9,133	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	4,627	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	470,715	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	536,184	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	33,564	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	7,250	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	220,862	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	191,202	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	1,750	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	18	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
88.09	08809	RURAL HEALTH CLINIC X	0.000000	0	0	0	0	88.09
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)		1,801,825	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part I Date/Time Prepared: 2/27/2019 3:19 pm

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	793,763	0	793,763	14,212	55.85	30.00
31.00	INTENSIVE CARE UNIT	247,651		247,651	1,798	137.74	31.00
41.00	SUBPROVIDER - IRF	164,461	0	164,461	2,489	66.08	41.00
43.00	NURSERY	43,165		43,165	1,158	37.28	43.00
200.00	Total (lines 30 through 199)	1,249,040		1,249,040	19,657		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	773	43,172				30.00
31.00	INTENSIVE CARE UNIT	206	28,374				31.00
41.00	SUBPROVIDER - IRF	0	0				41.00
43.00	NURSERY	93	3,467				43.00
200.00	Total (lines 30 through 199)	1,072	75,013				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part II Date/Time Prepared: 2/27/2019 3:19 pm

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	1,417,821	30,940,844	0.045824	0	0	50.00
51.00	05100	RECOVERY ROOM	91,262	5,374,929	0.016979	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	73,977	635,881	0.116338	0	0	52.00
53.00	05300	ANESTHESIOLOGY	33,645	9,046,613	0.003719	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	662,335	11,113,338	0.059598	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	675,604	5,532,526	0.122115	0	0	55.00
56.00	05600	RADIOISOTOPE	243,157	2,573,724	0.094477	0	0	56.00
57.00	05700	CT SCAN	113,122	20,457,265	0.005530	0	0	57.00
58.00	05800	MRI	187,116	6,593,743	0.028378	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	91,222	8,342,847	0.010934	0	0	59.00
60.00	06000	LABORATORY	325,582	41,329,674	0.007878	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	11,944	1,253,417	0.009529	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	116,785	2,304,106	0.050686	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	123,000	666,590	0.184521	0	0	65.00
66.00	06600	PHYSICAL THERAPY	61,586	1,452,461	0.042401	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,171	1,191,472	0.008536	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,872	558,809	0.010508	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	20,897	2,110,922	0.009899	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	31,347	605,077	0.051807	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	183,516	116,614,813	0.001574	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	69,745	7,056,635	0.009884	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	368,585	71,464,621	0.005158	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,351	37,525	0.036003	0	0	74.00
76.00	03950	DIABETES CENTER	3,982	20,437	0.194843	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	44,070	396,705	0.111090	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	4,109	10,520	0.390589	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	37,223	692,784	0.053730	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	145,153	685,265	0.211820	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	77,575	1,321,239	0.058714	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	77,545	977,400	0.079338	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	227,416	2,120,119	0.107266	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	25,509	192,828	0.132289	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	62,357	577,118	0.108049	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	13,991	490,423	0.028528	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	594,818	4,212,218	0.141213	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC X	26,690	826,168	0.032306	0	0	88.09
91.00	09100	EMERGENCY	422,667	2,970,257	0.142300	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	52,836	1,751,952	0.030158	0	0	92.00
200.00		Total (lines 50 through 199)	6,735,583	364,503,265		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part III Date/Time Prepared: 2/27/2019 3:19 pm

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	14,212	0.00	773	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,798	0.00	206	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	2,489	0.00	0	41.00
43.00	04300	NURSERY		0	1,158	0.00	93	43.00
200.00		Total (lines 30 through 199)		0	19,657		1,072	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 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 2/27/2019 3:19 pm

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
88.09	08809	RURAL HEALTH CLINIC X	0	0	0	0	0	88.09
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	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 10/01/2017 To 09/30/2018 | Worksheet D Part IV Date/Time Prepared: 2/27/2019 3:19 pm

Title XIX | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 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	30,940,844	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	5,374,929	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	635,881	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	9,046,613	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	11,113,338	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	5,532,526	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	2,573,724	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	20,457,265	0.000000	57.00
58.00	05800	MRI	0	0	0	6,593,743	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	8,342,847	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	41,329,674	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,253,417	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,304,106	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	666,590	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,452,461	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,191,472	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	558,809	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,110,922	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	605,077	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	116,614,813	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,056,635	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	71,464,621	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	37,525	0.000000	74.00
76.00	03950	DIABETES CENTER	0	0	0	20,437	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	396,705	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	10,520	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	692,784	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	685,265	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	1,321,239	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	977,400	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	2,120,119	0.000000	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	192,828	0.000000	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	0	0	577,118	0.000000	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	0	0	490,423	0.000000	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	0	0	4,212,218	0.000000	88.08
88.09	08809	RURAL HEALTH CLINIC X	0	0	0	826,168	0.000000	88.09
91.00	09100	EMERGENCY	0	0	0	2,970,257	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,751,952	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	364,503,265		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 2/27/2019 3:19 pm

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	0	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	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	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	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	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
88.09	08809	RURAL HEALTH CLINIC X	0.000000	0	0	0	0	88.09
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)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/27/2019 3:19 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14,212	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,212	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	13,266	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)	7,889	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)	16,560,690	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	16,560,690	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)	16,560,690	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)	1,165.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	9,192,736	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	9,192,736	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/27/2019 3:19 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,963,774	1,798	2,204.55	1,130	2,491,142	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)	11,678,217	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	23,362,095	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)	596,247	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	749,298	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,345,545	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	22,016,550	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)	946	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,165.26	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,102,336	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/27/2019 3:19 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	793,763	16,560,690	0.047931	1,102,336	52,836	90.00
91.00	Nursing School cost	0	16,560,690	0.000000	1,102,336	0	91.00
92.00	Allied health cost	0	16,560,690	0.000000	1,102,336	0	92.00
93.00	All other Medical Education	0	16,560,690	0.000000	1,102,336	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 26-0025 Component CCN: 26-T025	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/27/2019 3:19 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,489	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,489	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)	2,489	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)	1,936	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)	3,575,461	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)	3,575,461	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)	3,575,461	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)	1,436.51	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,781,083	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)	2,781,083	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1

Component CCN: 26-T025 | Date/Time Prepared: 2/27/2019 3:19 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	988,014	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,769,097	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)	127,931	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	32,170	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	160,101	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,608,996	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 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/27/2019 3:19 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	164,461	3,575,461	0.045997	0	0	90.00
91.00	Nursing School cost	0	3,575,461	0.000000	0	0	91.00
92.00	Allied health cost	0	3,575,461	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,575,461	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/27/2019 3:19 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14,212	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,212	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	13,266	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)	773	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)	1,158	15.00
16.00	Nursery days (title V or XIX only)	93	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	16,560,690	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	16,560,690	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)	16,560,690	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)	1,165.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	900,746	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)	900,746	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/27/2019 3:19 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	989,543	1,158	854.53	93	79,471	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,963,774	1,798	2,204.55	206	454,137	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)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,434,354	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)	946	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,165.26	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,102,336	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/27/2019 3:19 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	793,763	16,560,690	0.047931	1,102,336	52,836	90.00
91.00	Nursing School cost	0	16,560,690	0.000000	1,102,336	0	91.00
92.00	Allied health cost	0	16,560,690	0.000000	1,102,336	0	92.00
93.00	All other Medical Education	0	16,560,690	0.000000	1,102,336	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-3 | Date/Time Prepared: 2/27/2019 3:19 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,610,266		30.00
31.00	03100	INTENSIVE CARE UNIT		946,326		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	0.179258	5,632,998	1,009,760	50.00
51.00	05100	RECOVERY ROOM	0.374448	804,074	301,084	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.432488	1,243	3,024	52.00
53.00	05300	ANESTHESIOLOGY	0.056636	1,790,306	101,396	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.392110	1,489,048	583,871	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.611451	8,603	5,260	55.00
56.00	05600	RADIOISOTOPE	0.266328	311,765	83,032	56.00
57.00	05700	CT SCAN	0.034807	2,788,025	97,043	57.00
58.00	05800	MRI	0.089462	402,610	36,018	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.211298	1,615,931	341,443	59.00
60.00	06000	LABORATORY	0.151017	6,833,417	1,031,962	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.528801	295,117	156,058	62.00
64.00	06400	INTRAVENOUS THERAPY	0.488390	25,719	12,561	64.00
65.00	06500	RESPIRATORY THERAPY	2.785139	138,196	384,895	65.00
66.00	06600	PHYSICAL THERAPY	1.256799	432,169	543,150	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.470554	157,929	74,314	67.00
68.00	06800	SPEECH PATHOLOGY	0.439393	35,926	15,786	68.00
69.00	06900	ELECTROCARDIOLOGY	0.089652	394,425	35,361	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.594795	4,917	2,925	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.095210	28,337,785	2,698,041	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.597948	520,452	311,203	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.173076	15,923,172	2,755,919	73.00
74.00	07400	RENAL DIALYSIS	2.419827	18,550	44,888	74.00
76.00	03950	DIABETES CENTER	8.200617	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.124632	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	17.366255	30	521	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
88.09	08809	RURAL HEALTH CLINIC X	0.000000		0	88.09
91.00	09100	EMERGENCY	2.133838	411,503	878,081	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.629204	271,170	170,621	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		68,645,080	11,678,217	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)		68,645,080		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 26-0025 | Component CCN: 26-T025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-3 | Date/Time Prepared: 2/27/2019 3:19 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		1,743,300		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.179258	335	60	50.00
51.00	05100	RECOVERY ROOM	0.374448	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.432488	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.056636	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.392110	35,957	14,099	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.611451	11	7	55.00
56.00	05600	RADIOISOTOPE	0.266328	1,506	401	56.00
57.00	05700	CT SCAN	0.034807	40,343	1,404	57.00
58.00	05800	MRI	0.089462	18,675	1,671	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.211298	51	11	59.00
60.00	06000	LABORATORY	0.151017	229,642	34,680	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.528801	9,133	4,830	62.00
64.00	06400	INTRAVENOUS THERAPY	0.488390	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2.785139	4,627	12,887	65.00
66.00	06600	PHYSICAL THERAPY	1.256799	470,715	591,594	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.470554	536,184	252,304	67.00
68.00	06800	SPEECH PATHOLOGY	0.439393	33,564	14,748	68.00
69.00	06900	ELECTROCARDIOLOGY	0.089652	7,250	650	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.594795	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.095210	220,862	21,028	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.597948	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.173076	191,202	33,092	73.00
74.00	07400	RENAL DIALYSIS	2.419827	1,750	4,235	74.00
76.00	03950	DIABETES CENTER	8.200617	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.124632	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	17.366255	18	313	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
88.09	08809	RURAL HEALTH CLINIC X	0.000000		0	88.09
91.00	09100	EMERGENCY	2.133838	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.629204	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,801,825	988,014	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)		1,801,825		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 26-0025	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part A Date/Time Prepared: 2/27/2019 3:19 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	15,816,078	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)	314,169	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	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	83.41	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 that 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)	4.54	30.00
31.00	Percentage of Medicaid patient days (see instructions)	13.26	31.00
32.00	Sum of lines 30 and 31	17.80	32.00
33.00	Allowable disproportionate share percentage (see instructions)	4.32	33.00
34.00	Disproportionate share adjustment (see instructions)	170,814	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 26-0025	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part A Date/Time Prepared: 2/27/2019 3:19 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	6,766,695,164	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000136277	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	922,145	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	922,145	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	922,145		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)	17,223,206		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	21,250,173		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		21,250,173	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,300,042	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		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)		22,550,215	59.00
60.00	Primary payer payments		5,907	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		22,544,308	61.00
62.00	Deductibles billed to program beneficiaries		2,061,329	62.00
63.00	Coinsurance billed to program beneficiaries		52,511	63.00
64.00	Allowable bad debts (see instructions)		621,331	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		403,865	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		498,223	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		20,834,333	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)			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)		41,077	70.93
70.94	HRR adjustment amount (see instructions)		-393,820	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 26-0025	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part A Date/Time Prepared: 2/27/2019 3:19 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		223,882	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		20,257,708	71.00
71.01	Sequestration adjustment (see instructions)		405,154	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		19,965,196	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)		-112,642	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, or sum of 2.03 plus 2.04 (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 (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 10/01/2017 To 09/30/2018	Worksheet E Part B Date/Time Prepared: 2/27/2019 3:19 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	15,677,035	2.00
3.00	OPPS payments	13,048,796	3.00
4.00	Outlier payment (see instructions)	631,677	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a 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)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	0	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)	13,680,473	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2,216,226	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)	11,464,247	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)	11,464,247	30.00
31.00	Primary payer payments	95	31.00
32.00	Subtotal (line 30 minus line 31)	11,464,152	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)	235,063	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	152,791	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	100,552	36.00
37.00	Subtotal (see instructions)	11,616,943	37.00
38.00	MSP-LCC reconciliation amount from PS&R	323	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		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)	11,616,620	40.00
40.01	Sequestration adjustment (see instructions)	232,332	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	11,373,838	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	10,450	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 2/27/2019 3:19 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		19,965,196		11,373,838	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)		19,965,196		11,373,838	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		10,450	6.01
6.02	SETTLEMENT TO PROGRAM		112,642		0	6.02
7.00	Total Medicare program liability (see instructions)		19,852,554		11,384,288	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 10/01/2017 To 09/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 2/27/2019 3:19 pm

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,040,253		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)		3,040,253		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		10,094		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,050,347		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 10/01/2017 To 09/30/2018	Worksheet E-1 Part II Date/Time Prepared: 2/27/2019 3:19 pm
	Title XVIII	Hospital	PPS

			1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		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 10/01/2017 To 09/30/2018	Worksheet E-3 Part III Date/Time Prepared: 2/27/2019 3:19 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	3,010,671	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0220	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	20,774	3.00
4.00	Outlier Payments	147,513	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)	6.819178	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)	3,178,958	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)	3,178,958	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	3,178,958	19.00
20.00	Deductibles	65,372	20.00
21.00	Subtotal (line 19 minus line 20)	3,113,586	21.00
22.00	Coinsurance	987	22.00
23.00	Subtotal (line 21 minus line 22)	3,112,599	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)	3,112,599	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)	3,112,599	32.00
32.01	Sequestration adjustment (see instructions)	62,252	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	3,040,253	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)	10,094	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	147,513	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

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 10/01/2017 To 09/30/2018 | Worksheet G | Date/Time Prepared: 2/27/2019 3:19 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	12,516,835	0	0	0	1.00
2.00	Temporary investments	5,890,919	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	19,621,700	0	0	0	4.00
5.00	Other receivable	1,398,011	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	3,143,048	0	0	0	7.00
8.00	Prepaid expenses	1,152,306	0	0	0	8.00
9.00	Other current assets	761,121	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)	44,483,940	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,479,295	0	0	0	12.00
13.00	Land improvements	8,818,856	0	0	0	13.00
14.00	Accumulated depreciation	-6,483,355	0	0	0	14.00
15.00	Buildings	44,417,427	0	0	0	15.00
16.00	Accumulated depreciation	-29,226,834	0	0	0	16.00
17.00	Leasehold improvements	23,641,904	0	0	0	17.00
18.00	Accumulated depreciation	-13,974,463	0	0	0	18.00
19.00	Fixed equipment	1,544,761	0	0	0	19.00
20.00	Accumulated depreciation	-343,149	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	75,232,280	0	0	0	23.00
24.00	Accumulated depreciation	-63,264,977	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	22,617,870	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	65,459,615	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	79,898,410	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	5,735,320	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	85,633,730	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	195,577,285	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	12,384,937	0	0	0	37.00
38.00	Salaries, wages, and fees payable	9,554,388	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,742,276	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	1,815,773	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)	26,497,374	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	44,120,694	0	0	0	47.00
48.00	Unsecured loans	3,060,840	0	0	0	48.00
49.00	Other long term liabilities	1,939,563	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	49,121,097	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	75,618,471	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	119,958,814				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)	119,958,814	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	195,577,285	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet G-1 | Date/Time Prepared: 2/27/2019 3:19 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		109,889,431		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		9,934,563				2.00
3.00	Total (sum of line 1 and line 2)		119,823,994		0		3.00
4.00	FOUNDATION NET INCOME	33,228		0		0	4.00
5.00	RESTRICTED ASSETS	101,593		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)		134,821		0		10.00
11.00	Subtotal (line 3 plus line 10)		119,958,815		0		11.00
12.00	ROUNDING	1		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)		1		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		119,958,814		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	FOUNDATION NET INCOME		0			4.00
5.00	RESTRICTED ASSETS		0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	ROUNDING		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 2/27/2019 3:19 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,272,639		6,272,639	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	2,260,200		2,260,200	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)	8,532,839		8,532,839	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,491,612		1,491,612	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)	1,491,612		1,491,612	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	10,024,451		10,024,451	17.00
18.00	Ancillary services	140,552,510	207,132,984	347,685,494	18.00
19.00	Outpatient services	1,201,720	3,520,489	4,722,209	19.00
20.00	RURAL HEALTH CLINIC	0	692,784	692,784	20.00
20.01	RURAL HEALTH CLINIC II	0	685,265	685,265	20.01
20.02	RURAL HEALTH CLINIC III	0	1,321,239	1,321,239	20.02
20.03	RURAL HEALTH CLINIC IV	0	977,400	977,400	20.03
20.04	RURAL HEALTH CLINIC V	0	2,120,119	2,120,119	20.04
20.05	RURAL HEALTH CLINIC VI	0	192,828	192,828	20.05
20.06	RURAL HEALTH CLINIC VII	0	577,118	577,118	20.06
20.07	RURAL HEALTH CLINIC VIII	0	490,423	490,423	20.07
20.08	RURAL HEALTH CLINIC IX	0	4,212,218	4,212,218	20.08
20.09	RURAL HEALTH CLINIC X	0	826,168	826,168	20.09
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,258,763	2,258,763	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	3,380,171	7,997,334	11,377,505	27.00
27.01	PHYSICIAN REVENUE - NRCC	1,847,510	36,891,235	38,738,745	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	157,006,362	269,896,367	426,902,729	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		163,465,565		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)		163,465,565		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet G-3 | Date/Time Prepared: 2/27/2019 3:19 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	426,902,729	1.00
2.00	Less contractual allowances and discounts on patients' accounts	260,684,263	2.00
3.00	Net patient revenues (line 1 minus line 2)	166,218,466	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	163,465,565	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,752,901	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	735,026	6.00
7.00	Income from investments	5,305,242	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	647,899	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	26,361	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	387,385	22.00
23.00	Governmental appropriations	0	23.00
24.00	DAYCARE INCOME	754,132	24.00
24.01	OTHER (SPECIFY)	0	24.01
24.02	OTHER REVENUE	655,565	24.02
24.03	EHR MEANINGFUL USE	110,500	24.03
24.04	CONTRACTED SERVICES	233,574	24.04
25.00	Total other income (sum of lines 6-24)	8,855,684	25.00
26.00	Total (line 5 plus line 25)	11,608,585	26.00
27.00	NON OPERATING EXPENSE	1,674,022	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	1,674,022	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	9,934,563	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 26-0025 | HHA CCN: 26-7282 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H | Date/Time Prepared: 2/27/2019 3:19 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		3,000	3,000	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	1,212	1,212	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	207,917	23,602	0	0	114,045	345,564	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	559,262	63,484	0	0	7,541	630,287	6.00
7.00	Physical Therapy	244,459	27,750	0	0	0	272,209	7.00
8.00	Occupational Therapy	115,270	13,085	0	0	1,071	129,426	8.00
9.00	Speech Pathology	6,559	745	0	0	736	8,040	9.00
10.00	Medical Social Services	2,936	333	0	0	0	3,269	10.00
11.00	Home Health Aide	33,997	3,859	0	0	0	37,856	11.00
12.00	Supplies (see instructions)	0	0	0	0	578	578	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)	1,170,400	132,858	0	0	128,183	1,431,441	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	3,000	0	3,000			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	1,212	0	1,212			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	345,564	0	345,564			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	630,287	0	630,287			6.00
7.00	Physical Therapy	0	272,209	0	272,209			7.00
8.00	Occupational Therapy	0	129,426	0	129,426			8.00
9.00	Speech Pathology	0	8,040	0	8,040			9.00
10.00	Medical Social Services	0	3,269	0	3,269			10.00
11.00	Home Health Aide	0	37,856	0	37,856			11.00
12.00	Supplies (see instructions)	0	578	0	578			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	1,431,441	0	1,431,441			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 10/01/2017 To 09/30/2018 | Worksheet H-1 Part I | Date/Time Prepared: 2/27/2019 3:19 pm

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	3,000	3,000				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	1,212	0	0	1,212		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	345,564	3,000	0	1,212	0	349,776	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	630,287	0	0	0	0	630,287	6.00
7.00	Physical Therapy	272,209	0	0	0	0	272,209	7.00
8.00	Occupational Therapy	129,426	0	0	0	0	129,426	8.00
9.00	Speech Pathology	8,040	0	0	0	0	8,040	9.00
10.00	Medical Social Services	3,269	0	0	0	0	3,269	10.00
11.00	Home Health Aide	37,856	0	0	0	0	37,856	11.00
12.00	Supplies (see instructions)	578	0	0	0	0	578	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)	1,431,441	3,000	0	1,212	0	1,431,441	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	349,776			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	203,815	834,102		6.00
7.00	Physical Therapy	88,024	360,233		7.00
8.00	Occupational Therapy	41,852	171,278		8.00
9.00	Speech Pathology	2,600	10,640		9.00
10.00	Medical Social Services	1,057	4,326		10.00
11.00	Home Health Aide	12,241	50,097		11.00
12.00	Supplies (see instructions)	187	765		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)		1,431,441		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 26-0025 HHA CCN: 26-7282 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-1 Part II Date/Time Prepared: 2/27/2019 3:19 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	3,000				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	3,000		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	3,000	0	3,000	0	-349,776	1,081,665	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	630,287	6.00
7.00	Physical Therapy	0	0	0	0	0	272,209	7.00
8.00	Occupational Therapy	0	0	0	0	0	129,426	8.00
9.00	Speech Pathology	0	0	0	0	0	8,040	9.00
10.00	Medical Social Services	0	0	0	0	0	3,269	10.00
11.00	Home Health Aide	0	0	0	0	0	37,856	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	578	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)	3,000	0	3,000	0	-349,776	1,081,665	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	3,000	0	1,212	0		349,776	25.00
26.00	Unit Cost Multiplier	1.000000	0.000000	0.404000	0.000000		0.323368	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

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

Period: From 10/01/2017 To 09/30/2018

Worksheet H-2 Part I Date/Time Prepared: 2/27/2019 3:19 pm

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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	21,451	5,323	52,191	78,965	20,769	1.00
2.00	Skilled Nursing Care	834,102	0	0	140,386	974,488	256,300	2.00
3.00	Physical Therapy	360,233	0	0	61,364	421,597	110,885	3.00
4.00	Occupational Therapy	171,278	0	0	28,935	200,213	52,658	4.00
5.00	Speech Pathology	10,640	0	0	1,646	12,286	3,231	5.00
6.00	Medical Social Services	4,326	0	0	737	5,063	1,332	6.00
7.00	Home Health Aide	50,097	0	0	8,534	58,631	15,421	7.00
8.00	Supplies (see instructions)	765	0	0	0	765	201	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)	1,431,441	21,451	5,323	293,793	1,752,008	460,797	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	7,650	45,999	0	19,375	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)	7,650	45,999	0	19,375	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 10/01/2017 To 09/30/2018 | Worksheet H-2 Part I Date/Time Prepared: 2/27/2019 3:19 pm

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	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	14.00	15.00	16.00	24.00	25.00	
1.00	Administrative and General	192,222	0	0	0	364,980	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	1,230,788	0	2.00
3.00	Physical Therapy	0	0	0	0	532,482	0	3.00
4.00	Occupational Therapy	0	0	0	0	252,871	0	4.00
5.00	Speech Pathology	0	0	0	0	15,517	0	5.00
6.00	Medical Social Services	0	0	0	0	6,395	0	6.00
7.00	Home Health Aide	0	0	0	0	74,052	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	966	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)	192,222	0	0	0	2,478,051	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	364,980						1.00
2.00	Skilled Nursing Care	1,230,788	212,587	1,443,375				2.00
3.00	Physical Therapy	532,482	91,973	624,455				3.00
4.00	Occupational Therapy	252,871	43,677	296,548				4.00
5.00	Speech Pathology	15,517	2,680	18,197				5.00
6.00	Medical Social Services	6,395	1,105	7,500				6.00
7.00	Home Health Aide	74,052	12,791	86,843				7.00
8.00	Supplies (see instructions)	966	167	1,133				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)	2,478,051	364,980	2,478,051				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.		0.172725					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 10/01/2017 To 09/30/2018 | Worksheet H-2 Part II | Date/Time Prepared: 2/27/2019 3:19 pm

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	3,000	3,119	207,917	0	78,965	3,000	1.00
2.00	Skilled Nursing Care	0	0	559,262	0	974,488	0	2.00
3.00	Physical Therapy	0	0	244,459	0	421,597	0	3.00
4.00	Occupational Therapy	0	0	115,270	0	200,213	0	4.00
5.00	Speech Pathology	0	0	6,559	0	12,286	0	5.00
6.00	Medical Social Services	0	0	2,936	0	5,063	0	6.00
7.00	Home Health Aide	0	0	33,997	0	58,631	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	765	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	3,119	1,170,400		1,752,008	3,000	20.00
21.00	Total cost to be allocated	21,451	5,323	293,793		460,797	7,650	21.00
22.00	Unit cost multiplier	7.150333	1.706637	0.251019		0.263011	2.550000	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	33,539	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	33,539	20.00
21.00	Total cost to be allocated	45,999	0	19,375	0	0	192,222	21.00
22.00	Unit cost multiplier	15.333000	0.000000	6.458333	0.000000	0.000000	5.731298	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

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

Period: From 10/01/2017 To 09/30/2018

Worksheet H-2 Part II
Date/Time Prepared: 2/27/2019 3:19 pm

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	Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)			
		14.00	15.00	16.00			
1.00	Administrative and General	0	0	0			1.00
2.00	Skilled Nursing Care	0	0	0			2.00
3.00	Physical Therapy	0	0	0			3.00
4.00	Occupational Therapy	0	0	0			4.00
5.00	Speech Pathology	0	0	0			5.00
6.00	Medical Social Services	0	0	0			6.00
7.00	Home Health Aide	0	0	0			7.00
8.00	Supplies (see instructions)	0	0	0			8.00
9.00	Drugs	0	0	0			9.00
10.00	DME	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0			13.00
14.00	Clinic	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0			15.00
16.00	Day Care Program	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0			17.00
18.00	Homemaker Service	0	0	0			18.00
19.00	All Others (specify)	0	0	0			19.00
19.50	Telemedicine	0	0	0			19.50
20.00	Total (sum of lines 1-19)	0	0	0			20.00
21.00	Total cost to be allocated	0	0	0			21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 26-0025 | HHA CCN: 26-7282 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-3 Part I | Date/Time Prepared: 2/27/2019 3:19 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1,443,375		1,443,375	4,831	298.77	1.00
2.00	Physical Therapy	3.00	624,455	0	624,455	3,056	204.34	2.00
3.00	Occupational Therapy	4.00	296,548	0	296,548	1,441	205.79	3.00
4.00	Speech Pathology	5.00	18,197	0	18,197	82	221.91	4.00
5.00	Medical Social Services	6.00	7,500		7,500	132	56.82	5.00
6.00	Home Health Aide	7.00	86,843		86,843	777	111.77	6.00
7.00	Total (sum of lines 1-6)		2,476,918	0	2,476,918	10,319		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		99914	0	379			8.00
8.01	Skilled Nursing Care		99926	0	1,901			8.01
9.00	Physical Therapy		99914	0	344			9.00
9.01	Physical Therapy		99926	0	1,418			9.01
10.00	Occupational Therapy		99914	0	50			10.00
10.01	Occupational Therapy		99926	0	843			10.01
11.00	Speech Pathology		99914	0	3			11.00
11.01	Speech Pathology		99926	0	51			11.01
12.00	Medical Social Services		99914	0	1			12.00
12.01	Medical Social Services		99926	0	14			12.01
13.00	Home Health Aide		99914	0	1			13.00
13.01	Home Health Aide		99926	0	422			13.01
14.00	Total (sum of lines 8-13)			0	5,427			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	1,133	0	1,133	46,108	0.024573	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	2,280		0	681,196		1.00
2.00	Physical Therapy	0	1,762		0	360,047		2.00
3.00	Occupational Therapy	0	893		0	183,770		3.00
4.00	Speech Pathology	0	54		0	11,983		4.00
5.00	Medical Social Services	0	15		0	852		5.00
6.00	Home Health Aide	0	423		0	47,279		6.00
7.00	Total (sum of lines 1-6)	0	5,427		0	1,285,127		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 26-0025 | HHA CCN: 26-7282 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-3 Part I | Date/Time Prepared: 2/27/2019 3:19 pm

Title XVIII | Home Health Agency I | PPS

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

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	14,216	0	0	349	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	681,196						1.00
2.00	Physical Therapy	360,047						2.00
3.00	Occupational Therapy	183,770						3.00
4.00	Speech Pathology	11,983						4.00
5.00	Medical Social Services	852						5.00
6.00	Home Health Aide	47,279						6.00
7.00	Total (sum of lines 1-6)	1,285,127						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 10/01/2017 To 09/30/2018 | Worksheet H-3 Part II | Date/Time Prepared: 2/27/2019 3:19 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	1.256799	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.470554	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.439393	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.095210	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.173076	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 26-0025 | HHA CCN: 26-7282 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-4 Part I-II | Date/Time Prepared: 2/27/2019 3:19 pm

Title XVIII | Home Health Agency I | PPS

		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	790,862	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	13,849	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	6,885	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	54,949	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	866,545	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	866,545	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	866,545	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	866,545	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	866,545	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	866,545	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 10/01/2017 To 09/30/2018 | Worksheet H-5 | Date/Time Prepared: 2/27/2019 3:19 pm

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		866,545	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		866,545	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		866,545	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 10/01/2017 To 09/30/2018	Worksheet L Parts I-III Date/Time Prepared: 2/27/2019 3:19 pm
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		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,278,147	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	21,895	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)	41.75	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)	1,300,042	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 10/01/2017 To 09/30/2018 | Worksheet M-1 | Date/Time Prepared: 2/27/2019 3:19 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	12,448	0	12,448	92,003	104,451	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	103,143	0	103,143	0	103,143	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	115,355	0	115,355	0	115,355	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)	230,946	0	230,946	92,003	322,949	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	9,653	9,653	0	9,653	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	9,653	9,653	0	9,653	14.00
15.00	Medical Supplies	0	16,490	16,490	0	16,490	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	16,490	16,490	0	16,490	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	230,946	26,143	257,089	92,003	349,092	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	9,107	9,107	0	9,107	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	9,107	9,107	0	9,107	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	7,858	7,858	0	7,858	29.00
30.00	Administrative Costs	127,032	123,381	250,413	0	250,413	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	127,032	131,239	258,271	0	258,271	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	357,978	166,489	524,467	92,003	616,470	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Component CCN: 26-8512 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-1 | Date/Time Prepared: 2/27/2019 3:19 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	104,451		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	103,143		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	115,355		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	322,949		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	9,653		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	9,653		14.00
15.00	Medical Supplies	0	16,490		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	16,490		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	349,092		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	9,107		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	9,107		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	7,858		29.00
30.00	Administrative Costs	0	250,413		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	258,271		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	616,470		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Component CCN: 26-3984 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-1 | Date/Time Prepared: 2/27/2019 3:19 pm

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	249,741	0	249,741	-92,003	157,738	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	132,277	0	132,277	0	132,277	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	77,502	0	77,502	0	77,502	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)	459,520	0	459,520	-92,003	367,517	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	28,428	28,428	0	28,428	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	28,428	28,428	0	28,428	14.00
15.00	Medical Supplies	0	14,296	14,296	0	14,296	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	14,296	14,296	0	14,296	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	459,520	42,724	502,244	-92,003	410,241	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	12,635	12,635	0	12,635	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	12,635	12,635	0	12,635	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	15,972	15,972	0	15,972	29.00
30.00	Administrative Costs	102,873	166,206	269,079	25,400	294,479	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	102,873	182,178	285,051	25,400	310,451	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	562,393	237,537	799,930	-66,603	733,327	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-1

Component CCN: 26-3984 | Date/Time Prepared: 2/27/2019 3:19 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	157,738		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	132,277		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	77,502		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	367,517		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	28,428		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	28,428		14.00
15.00	Medical Supplies	0	14,296		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	14,296		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	410,241		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	12,635		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	12,635		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	15,972		29.00
30.00	Administrative Costs	-24	294,455		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-24	310,427		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-24	733,303		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Component CCN: 26-8513 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-1 | Date/Time Prepared: 2/27/2019 3:19 pm

RHC III | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	218,154	0	218,154	0	218,154	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	113,191	0	113,191	0	113,191	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	137,933	0	137,933	0	137,933	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)	469,278	0	469,278	0	469,278	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	8,434	8,434	0	8,434	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	8,434	8,434	0	8,434	14.00
15.00	Medical Supplies	0	28,428	28,428	0	28,428	15.00
16.00	Transportation (Health Care Staff)	0	550	550	0	550	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	28,978	28,978	0	28,978	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	469,278	37,412	506,690	0	506,690	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	46,535	46,535	0	46,535	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	46,535	46,535	0	46,535	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	3,301	3,301	0	3,301	29.00
30.00	Administrative Costs	141,586	154,528	296,114	0	296,114	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	141,586	157,829	299,415	0	299,415	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	610,864	241,776	852,640	0	852,640	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-1

Component CCN: 26-8513 | Date/Time Prepared: 2/27/2019 3:19 pm

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	218,154		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	113,191		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	137,933		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	469,278		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	8,434		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	8,434		14.00
15.00	Medical Supplies	0	28,428		15.00
16.00	Transportation (Health Care Staff)	0	550		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	28,978		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	506,690		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	46,535		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	46,535		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	3,301		29.00
30.00	Administrative Costs	0	296,114		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	299,415		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	852,640		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Component CCN: 26-8723 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-1 | Date/Time Prepared: 2/27/2019 3:19 pm

RHC IV | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	568,685	0	568,685	-284,343	284,342	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	104,864	104,864	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	184,308	0	184,308	-48,314	135,994	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	752,993	0	752,993	-227,793	525,200	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	34,765	34,765	-1,520	33,245	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	34,765	34,765	-1,520	33,245	14.00
15.00	Medical Supplies	0	22,647	22,647	-5,456	17,191	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	22,647	22,647	-5,456	17,191	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	752,993	57,412	810,405	-234,769	575,636	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	65,176	65,176	-32,000	33,176	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	65,176	65,176	-32,000	33,176	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	8,754	8,754	0	8,754	29.00
30.00	Administrative Costs	105,741	208,694	314,435	-2,304	312,131	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	105,741	217,448	323,189	-2,304	320,885	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	858,734	340,036	1,198,770	-269,073	929,697	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-1

Component CCN: 26-8723 | Date/Time Prepared: 2/27/2019 3:19 pm

RHC IV | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	284,342		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	104,864		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	135,994		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	525,200		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	33,245		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	33,245		14.00
15.00	Medical Supplies	0	17,191		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	17,191		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	575,636		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	33,176		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	33,176		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	8,754		29.00
30.00	Administrative Costs	-235	311,896		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-235	320,650		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-235	929,462		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Component CCN: 26-8724 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-1 | Date/Time Prepared: 2/27/2019 3:19 pm

RHC V | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	353,476	0	353,476	284,343	637,819	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	370,228	0	370,228	-104,864	265,364	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	160,752	0	160,752	48,314	209,066	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)	884,456	0	884,456	227,793	1,112,249	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	41,058	41,058	1,520	42,578	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	41,058	41,058	1,520	42,578	14.00
15.00	Medical Supplies	0	20,019	20,019	5,456	25,475	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	20,019	20,019	5,456	25,475	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	884,456	61,077	945,533	234,769	1,180,302	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	2,012	2,012	32,000	34,012	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	2,012	2,012	32,000	34,012	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	20,591	20,591	0	20,591	29.00
30.00	Administrative Costs	201,150	387,196	588,346	2,304	590,650	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	201,150	407,787	608,937	2,304	611,241	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,085,606	470,876	1,556,482	269,073	1,825,555	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Component CCN: 26-8724 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-1 | Date/Time Prepared: 2/27/2019 3:19 pm

RHC V | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	637,819		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	265,364		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	209,066		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	1,112,249		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	42,578		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	42,578		14.00
15.00	Medical Supplies	0	25,475		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	25,475		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,180,302		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	34,012		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	34,012		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	20,591		29.00
30.00	Administrative Costs	0	590,650		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	611,241		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,825,555		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Component CCN: 26-8756 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-1 | Date/Time Prepared: 2/27/2019 3:19 pm

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	49,884	0	49,884	0	49,884	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	30,977	0	30,977	0	30,977	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	50,236	0	50,236	0	50,236	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)	131,097	0	131,097	0	131,097	10.00
11.00	Physician Services Under Agreement	0	9,405	9,405	0	9,405	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	4,345	4,345	0	4,345	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	13,750	13,750	0	13,750	14.00
15.00	Medical Supplies	0	1,886	1,886	0	1,886	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	1,886	1,886	0	1,886	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	131,097	15,636	146,733	0	146,733	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	688	688	0	688	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	688	688	0	688	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	2,923	2,923	0	2,923	29.00
30.00	Administrative Costs	151	35,015	35,166	0	35,166	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	151	37,938	38,089	0	38,089	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	131,248	54,262	185,510	0	185,510	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-1

Component CCN: 26-8756 | Date/Time Prepared: 2/27/2019 3:19 pm

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	49,884		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	30,977		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	50,236		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	131,097		10.00
11.00	Physician Services Under Agreement	0	9,405		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	4,345		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	13,750		14.00
15.00	Medical Supplies	0	1,886		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	1,886		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	146,733		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	688		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	688		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	2,923		29.00
30.00	Administrative Costs	0	35,166		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	38,089		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	185,510		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Component CCN: 26-8757 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-1 | Date/Time Prepared: 2/27/2019 3:19 pm

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	50,942	0	50,942	0	50,942	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	87,879	31	87,910	0	87,910	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	115,730	0	115,730	0	115,730	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)	254,551	31	254,582	0	254,582	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	4,568	4,568	0	4,568	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	4,568	4,568	0	4,568	14.00
15.00	Medical Supplies	0	4,888	4,888	0	4,888	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	4,888	4,888	0	4,888	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	254,551	9,487	264,038	0	264,038	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	1,193	1,193	0	1,193	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	1,193	1,193	0	1,193	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	7,579	7,579	0	7,579	29.00
30.00	Administrative Costs	0	76,919	76,919	0	76,919	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	84,498	84,498	0	84,498	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	254,551	95,178	349,729	0	349,729	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-1

Component CCN: 26-8757 | Date/Time Prepared: 2/27/2019 3:19 pm

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	50,942		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	87,910		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	115,730		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	254,582		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	4,568		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	4,568		14.00
15.00	Medical Supplies	0	4,888		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	4,888		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	264,038		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	1,193		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	1,193		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	7,579		29.00
30.00	Administrative Costs	0	76,919		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	84,498		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	349,729		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Component CCN: 26-8758 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-1 | Date/Time Prepared: 2/27/2019 3:19 pm

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	104,013	0	104,013	0	104,013	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	61,110	0	61,110	0	61,110	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	31,613	0	31,613	0	31,613	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)	196,736	0	196,736	0	196,736	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	2,402	2,402	0	2,402	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	2,402	2,402	0	2,402	14.00
15.00	Medical Supplies	0	1,369	1,369	0	1,369	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	1,369	1,369	0	1,369	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	196,736	3,771	200,507	0	200,507	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	1,246	1,246	0	1,246	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	1,246	1,246	0	1,246	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	1,721	1,721	0	1,721	29.00
30.00	Administrative Costs	0	29,033	29,033	0	29,033	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	30,754	30,754	0	30,754	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	196,736	35,771	232,507	0	232,507	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-1

Component CCN: 26-8758 | Date/Time Prepared: 2/27/2019 3:19 pm

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	104,013		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	61,110		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	31,613		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	196,736		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	2,402		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	2,402		14.00
15.00	Medical Supplies	0	1,369		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	1,369		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	200,507		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	1,246		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	1,246		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	1,721		29.00
30.00	Administrative Costs	0	29,033		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	30,754		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	232,507		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Component CCN: 26-8754 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-1 | Date/Time Prepared: 2/27/2019 3:19 pm

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	2,543,832	0	2,543,832	-21,035	2,522,797	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	573,326	0	573,326	0	573,326	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	559,423	0	559,423	0	559,423	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)	3,676,581	0	3,676,581	-21,035	3,655,546	10.00
11.00	Physician Services Under Agreement	0	136,688	136,688	0	136,688	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	77	77	0	77	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	136,765	136,765	0	136,765	14.00
15.00	Medical Supplies	0	44,242	44,242	0	44,242	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	44,242	44,242	0	44,242	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,676,581	181,007	3,857,588	-21,035	3,836,553	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	260,346	260,346	0	260,346	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	260,346	260,346	0	260,346	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	382	382	0	382	29.00
30.00	Administrative Costs	174,290	554,321	728,611	0	728,611	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	174,290	554,703	728,993	0	728,993	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,850,871	996,056	4,846,927	-21,035	4,825,892	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-1

Component CCN: 26-8754 | Date/Time Prepared: 2/27/2019 3:19 pm

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	2,522,797		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	573,326		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	559,423		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	3,655,546		10.00
11.00	Physician Services Under Agreement	0	136,688		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	77		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	136,765		14.00
15.00	Medical Supplies	0	44,242		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	44,242		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	3,836,553		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	260,346		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	260,346		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	382		29.00
30.00	Administrative Costs	-3,770	724,841		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-3,770	725,223		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-3,770	4,822,122		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Component CCN: 26-8759 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-1 | Date/Time Prepared: 2/27/2019 3:19 pm

RHC X | 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	228,383	0	228,383	-23,284	205,099	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	92,468	0	92,468	-9,348	83,120	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)	320,851	0	320,851	-32,632	288,219	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	12,344	12,344	0	12,344	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	12,344	12,344	0	12,344	14.00
15.00	Medical Supplies	0	11,399	11,399	-1,760	9,639	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	11,399	11,399	-1,760	9,639	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	320,851	23,743	344,594	-34,392	310,202	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	2,764	2,764	-93	2,671	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	2,764	2,764	-93	2,671	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	191	191	-19	172	29.00
30.00	Administrative Costs	62,055	89,997	152,052	-15,701	136,351	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	62,055	90,188	152,243	-15,720	136,523	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	382,906	116,695	499,601	-50,205	449,396	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025 | Component CCN: 26-8759 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-1 | Date/Time Prepared: 2/27/2019 3:19 pm

RHC X | 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	205,099		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	83,120		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	288,219		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	12,344		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	12,344		14.00
15.00	Medical Supplies	0	9,639		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	9,639		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	310,202		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	2,671		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	2,671		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	172		29.00
30.00	Administrative Costs	0	136,351		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	136,523		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	449,396		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025 | Component CCN: 26-8512 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-2 | Date/Time Prepared: 2/27/2019 3:19 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.05	1,115	4,200	210		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.86	2,500	2,100	1,806		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.91	3,615		2,016	3,615	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)	0.91	3,615			3,615	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)					349,092	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					9,107	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					358,199	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.974576	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					258,271	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					315,125	15.00
16.00	Total overhead (sum of lines 14 and 15)					573,396	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					573,396	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					558,818	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					907,910	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025 | Component CCN: 26-3984 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-2 | Date/Time Prepared: 2/27/2019 3:19 pm

RHC II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.95	628	4,200	3,990		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.88	2,481	2,100	1,848		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.83	3,109		5,838	5,838	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)	1.83	3,109			5,838	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)					410,241	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					12,635	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					422,876	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.970121	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					310,427	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					401,277	15.00
16.00	Total overhead (sum of lines 14 and 15)					711,704	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					711,704	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					690,439	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,100,680	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025 | Component CCN: 26-8513 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-2 | Date/Time Prepared: 2/27/2019 3:19 pm

RHC III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.92	2,940	4,200	3,864		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.00	2,353	2,100	2,100		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.92	5,293		5,964	5,964	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	5,293			5,964	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)					506,690	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					46,535	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					553,225	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.915884	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					299,415	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					615,512	15.00
16.00	Total overhead (sum of lines 14 and 15)					914,927	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					914,927	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					837,967	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,344,657	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025 | Component CCN: 26-8723 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-2 | Date/Time Prepared: 2/27/2019 3:19 pm

RHC IV | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.20	3,894	4,200	5,040		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.90	2,869	2,100	1,890		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.10	6,763		6,930	6,930	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)	2.10	6,763			6,930	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)					575,636	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					33,176	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					608,812	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.945507	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					320,650	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					453,009	15.00
16.00	Total overhead (sum of lines 14 and 15)					773,659	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					773,659	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					731,500	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,307,136	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025 | Component CCN: 26-8724 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-2 | Date/Time Prepared: 2/27/2019 3:19 pm

RHC V | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.93	3,898	4,200	8,106		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	2.84	6,275	2,100	5,964		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.77	10,173		14,070	14,070	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)	4.77	10,173			14,070	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)					1,180,302	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					34,012	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,214,314	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.971991	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					611,241	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					894,188	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,505,429	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,505,429	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,463,263	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,643,565	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025 | Component CCN: 26-8756 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-2 | Date/Time Prepared: 2/27/2019 3:19 pm

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	0.20	393	4,200	840		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.32	483	2,100	672		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.52	876		1,512	1,512	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)	0.52	876			1,512	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)					146,733	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					688	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					147,421	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.995333	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					38,089	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					130,448	15.00
16.00	Total overhead (sum of lines 14 and 15)					168,537	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					168,537	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					167,750	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					314,483	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025 | Component CCN: 26-8757 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-2 | Date/Time Prepared: 2/27/2019 3:19 pm

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	0.20	603	4,200	840		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.00	2,405	2,100	2,100		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.20	3,008		2,940	3,008	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)	1.20	3,008			3,008	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)					264,038	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					1,193	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					265,231	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.995502	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					84,498	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					287,986	15.00
16.00	Total overhead (sum of lines 14 and 15)					372,484	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					372,484	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					370,809	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					634,847	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025 | Component CCN: 26-8758 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-2 | Date/Time Prepared: 2/27/2019 3:19 pm

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	0.42	1,004	4,200	1,764		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.66	1,305	2,100	1,386		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.08	2,309		3,150	3,150	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)	1.08	2,309			3,150	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)					200,507	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					1,246	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					201,753	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.993824	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					30,754	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					148,920	15.00
16.00	Total overhead (sum of lines 14 and 15)					179,674	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					179,674	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					178,564	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					379,071	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025 | Component CCN: 26-8754 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-2 | Date/Time Prepared: 2/27/2019 3:19 pm

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	9.52	14,047	4,200	39,984		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	5.31	5,414	2,100	11,151		3.00
4.00	Subtotal (sum of lines 1 through 3)	14.83	19,461		51,135	51,135	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)	14.83	19,461			51,135	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)					3,836,553	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					260,346	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					4,096,899	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.936453	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					725,223	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					4,354,183	15.00
16.00	Total overhead (sum of lines 14 and 15)					5,079,406	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					5,079,406	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					4,756,625	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					8,593,178	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025 | Component CCN: 26-8759 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-2 | Date/Time Prepared: 2/27/2019 3:19 pm

RHC X | 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	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.81	5,133	2,100	3,801		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.81	5,133		3,801	5,133	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)	1.81	5,133			5,133	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)					310,202	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					2,671	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					312,873	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.991463	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					136,523	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					241,458	15.00
16.00	Total overhead (sum of lines 14 and 15)					377,981	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					377,981	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					374,754	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					684,956	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 26-0025 Component CCN: 26-8512	Period: From 10/01/2017 To 09/30/2018	Worksheet M-3 Date/Time Prepared: 2/27/2019 3:19 pm
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		907,910	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		28,747	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		879,163	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		3,615	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)		3,615	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		243.20	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)	82.30	83.45	8.00
9.00	Rate for Program covered visits (see instructions)	82.30	83.45	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	796	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	66,426	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	66,426	16.00
16.01	Total program charges (see instructions)(from contractor's records)		127,878	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		808	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		420	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		41,754	16.04
16.05	Total program cost (see instructions)	0	42,174	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		13,813	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		22,652	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		42,174	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		17,213	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		59,387	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)		59,387	26.00
26.01	Sequestration adjustment (see instructions)		1,188	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		39,983	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)		18,216	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 10/01/2017 To 09/30/2018	Worksheet M-3 Date/Time Prepared: 2/27/2019 3:19 pm
	Title XVIII	RHC II	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,100,680	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		33,057	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,067,623	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		5,838	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)		5,838	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		182.87	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)	82.30	83.45	8.00
9.00	Rate for Program covered visits (see instructions)	82.30	83.45	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	911	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	76,023	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	76,023	16.00
16.01	Total program charges (see instructions)(from contractor's records)		161,868	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		675	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		317	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.)		46,396	16.04
16.05	Total program cost (see instructions)	0	46,713	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		17,711	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		28,697	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		46,713	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		18,866	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		65,579	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)		65,579	26.00
26.01	Sequestration adjustment (see instructions)		1,312	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		44,000	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)		20,267	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 10/01/2017 To 09/30/2018	Worksheet M-3 Date/Time Prepared: 2/27/2019 3:19 pm
	Title XVIII	RHC III	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,344,657	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		91,767	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,252,890	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		5,964	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)		5,964	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		210.08	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)	82.30	83.45	8.00
9.00	Rate for Program covered visits (see instructions)	82.30	83.45	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,581	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	131,934	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	131,934	16.00
16.01	Total program charges (see instructions)(from contractor's records)		298,000	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		908	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		402	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.)		82,830	16.04
16.05	Total program cost (see instructions)	0	83,232	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		27,995	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		53,820	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		83,232	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		47,561	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		130,793	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)		130,793	26.00
26.01	Sequestration adjustment (see instructions)		2,616	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		78,622	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)		49,555	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 10/01/2017 To 09/30/2018	Worksheet M-3 Date/Time Prepared: 2/27/2019 3:19 pm
	Title XVIII	RHC IV	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,307,136	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		40,607	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,266,529	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		6,930	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		6,930	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		182.76	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)	82.30	83.45	8.00
9.00	Rate for Program covered visits (see instructions)	82.30	83.45	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,987	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	165,815	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	165,815	16.00
16.01	Total program charges (see instructions)(from contractor's records)		301,454	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		4,536	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		2,495	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.)		110,901	16.04
16.05	Total program cost (see instructions)	0	113,396	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		24,694	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		54,445	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		113,396	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		16,107	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		129,503	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)		129,503	26.00
26.01	Sequestration adjustment (see instructions)		2,590	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		108,762	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)		18,151	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 10/01/2017 To 09/30/2018	Worksheet M-3 Date/Time Prepared: 2/27/2019 3:19 pm
	Title XVIII	RHC V	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		2,643,565	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		47,676	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,595,889	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		14,070	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		14,070	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		184.50	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)	82.30	83.45	8.00
9.00	Rate for Program covered visits (see instructions)	82.30	83.45	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,814	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	151,378	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	151,378	16.00
16.01	Total program charges (see instructions)(from contractor's records)		281,855	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		4,902	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		2,633	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.)		98,382	16.04
16.05	Total program cost (see instructions)	0	101,015	16.05
17.00	Primary payer amounts		44	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		25,768	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		50,237	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		100,971	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		23,770	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		124,741	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)		124,741	26.00
26.01	Sequestration adjustment (see instructions)		2,495	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		96,778	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)		25,468	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 10/01/2017 To 09/30/2018	Worksheet M-3 Date/Time Prepared: 2/27/2019 3:19 pm
	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)		314,483	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		1,866	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		312,617	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		1,512	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)		1,512	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		206.76	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)	82.30	83.45	8.00
9.00	Rate for Program covered visits (see instructions)	82.30	83.45	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	121	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	10,097	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	10,097	16.00
16.01	Total program charges (see instructions)(from contractor's records)		31,791	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		71	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		23	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.)		6,045	16.04
16.05	Total program cost (see instructions)	0	6,068	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		2,518	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		5,840	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		6,068	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		962	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		7,030	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)		7,030	26.00
26.01	Sequestration adjustment (see instructions)		141	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		5,710	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)		1,179	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 10/01/2017 To 09/30/2018	Worksheet M-3 Date/Time Prepared: 2/27/2019 3:19 pm
	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)		634,847	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		5,196	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		629,651	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		3,008	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)		3,008	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		209.33	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)	82.30	83.45	8.00
9.00	Rate for Program covered visits (see instructions)	82.30	83.45	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	677	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	56,496	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	56,496	16.00
16.01	Total program charges (see instructions)(from contractor's records)		131,393	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		459	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		197	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.)		31,726	16.04
16.05	Total program cost (see instructions)	0	31,923	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		16,642	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		22,858	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		31,923	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,379	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		33,302	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)		33,302	26.00
26.01	Sequestration adjustment (see instructions)		666	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		29,504	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)		3,132	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 10/01/2017 To 09/30/2018	Worksheet M-3 Date/Time Prepared: 2/27/2019 3:19 pm
	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)		379,071	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		4,564	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		374,507	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		3,150	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)		3,150	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		118.89	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)	82.30	83.45	8.00
9.00	Rate for Program covered visits (see instructions)	82.30	83.45	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	251	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	20,946	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	20,946	16.00
16.01	Total program charges (see instructions)(from contractor's records)		56,177	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.)		12,946	16.04
16.05	Total program cost (see instructions)	0	12,946	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		4,763	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		10,283	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		12,946	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		3,275	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		16,221	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)		16,221	26.00
26.01	Sequestration adjustment (see instructions)		324	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		12,171	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)		3,726	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 10/01/2017 To 09/30/2018	Worksheet M-3 Date/Time Prepared: 2/27/2019 3:19 pm
	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)		8,593,178	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		370,949	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		8,222,229	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		51,135	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)		51,135	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		160.79	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)	82.30	83.45	8.00
9.00	Rate for Program covered visits (see instructions)	82.30	83.45	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	3,550	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	296,248	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	296,248	16.00
16.01	Total program charges (see instructions)(from contractor's records)		624,714	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		250	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		118	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.)		210,054	16.04
16.05	Total program cost (see instructions)	0	210,172	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		33,563	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		118,180	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		210,172	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		43,464	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		253,636	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)		253,636	26.00
26.01	Sequestration adjustment (see instructions)		5,073	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		202,238	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)		46,325	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: 26-8759	Period: From 10/01/2017 To 09/30/2018	Worksheet M-3 Date/Time Prepared: 2/27/2019 3:19 pm
	Title XVIII	RHC X	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)		684,956	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		7,424	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		677,532	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		5,133	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)		5,133	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		132.00	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)	82.30	83.45	8.00
9.00	Rate for Program covered visits (see instructions)	82.30	83.45	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	306	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	25,536	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	25,536	16.00
16.01	Total program charges (see instructions)(from contractor's records)		38,032	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.)		17,225	16.04
16.05	Total program cost (see instructions)	0	17,225	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		4,005	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		6,805	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		17,225	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		2,011	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		19,236	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)		19,236	26.00
26.01	Sequestration adjustment (see instructions)		385	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		16,576	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)		2,275	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 10/01/2017 To 09/30/2018	Worksheet M-4 Date/Time Prepared: 2/27/2019 3:19 pm
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	322,949	322,949	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001233	0.013120	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	398	4,237	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,920	4,498	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	2,318	8,735	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	349,092	349,092	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	558,818	558,818	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.006640	0.025022	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	3,711	13,983	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	6,029	22,718	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	14	149	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	430.64	152.47	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	12	79	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	5,168	12,045	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)		28,747	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)		17,213	16.00

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

Provider CCN: 26-0025 | Component CCN: 26-3984 | Period: From 10/01/2017 To 09/30/2018 | Worksheet M-4 | Date/Time Prepared: 2/27/2019 3:19 pm

Title XVIII | RHC II | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	367,517	367,517	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001007	0.008580	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	370	3,153	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	3,254	5,544	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	3,624	8,697	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	410,241	410,241	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	690,439	690,439	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.008834	0.021200	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	6,099	14,637	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	9,723	23,334	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	23	196	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	422.74	119.05	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	19	91	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	8,032	10,834	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)		33,057	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)		18,866	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 26-0025 Component CCN: 26-8513	Period: From 10/01/2017 To 09/30/2018	Worksheet M-4 Date/Time Prepared: 2/27/2019 3:19 pm
	Title XVIII	RHC III	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	469,278	469,278	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.003923	0.014900	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,841	6,992	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	15,144	10,603	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	16,985	17,595	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	506,690	506,690	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	837,967	837,967	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.033521	0.034725	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	28,089	29,098	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	45,074	46,693	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	94	357	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	479.51	130.79	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	49	184	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	23,496	24,065	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		91,767	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)		47,561	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 26-0025 Component CCN: 26-8723	Period: From 10/01/2017 To 09/30/2018	Worksheet M-4 Date/Time Prepared: 2/27/2019 3:19 pm
	Title XVIII	RHC IV	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	525,200	525,200	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001641	0.010379	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	862	5,451	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	6,090	5,480	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	6,952	10,931	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	575,636	575,636	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	731,500	731,500	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.012077	0.018989	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	8,834	13,890	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	15,786	24,821	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	43	272	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	367.12	91.25	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	22	88	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	8,077	8,030	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)		40,607	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)		16,107	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 26-0025 Component CCN: 26-8724	Period: From 10/01/2017 To 09/30/2018	Worksheet M-4 Date/Time Prepared: 2/27/2019 3:19 pm
	Title XVIII	RHC V	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,112,249	1,112,249	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001092	0.005191	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,215	5,774	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	8,361	5,937	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	9,576	11,711	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,180,302	1,180,302	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,463,263	1,463,263	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.008113	0.009922	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	11,871	14,518	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	21,447	26,229	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	65	309	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	329.95	84.88	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	44	109	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	14,518	9,252	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)		47,676	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		23,770	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 26-0025 Component CCN: 26-8756	Period: From 10/01/2017 To 09/30/2018	Worksheet M-4 Date/Time Prepared: 2/27/2019 3:19 pm
	Title XVIII	RHC VI	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	131,097	131,097	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000308	0.001695	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	40	222	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	367	242	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	407	464	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	146,733	146,733	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	167,750	167,750	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002774	0.003162	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	465	530	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	872	994	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	2	11	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	436.00	90.36	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	2	1	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	872	90	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)		1,866	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)		962	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 26-0025 Component CCN: 26-8757	Period: From 10/01/2017 To 09/30/2018	Worksheet M-4 Date/Time Prepared: 2/27/2019 3:19 pm
	Title XVIII	RHC VII	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	254,582	254,582	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000601	0.001135	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	153	289	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,295	424	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,448	713	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	264,038	264,038	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	370,809	370,809	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.005484	0.002700	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	2,034	1,001	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	3,482	1,714	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	9	17	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	386.89	100.82	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	2	6	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	774	605	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)		5,196	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)		1,379	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 26-0025 Component CCN: 26-8758	Period: From 10/01/2017 To 09/30/2018	Worksheet M-4 Date/Time Prepared: 2/27/2019 3:19 pm
	Title XVIII	RHC VIII	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	196,736	196,736	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000668	0.001410	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	131	277	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,563	443	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,694	720	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	200,507	200,507	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	178,564	178,564	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.008449	0.003591	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,509	641	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	3,203	1,361	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	9	19	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	355.89	71.63	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	9	1	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	3,203	72	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)		4,564	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)		3,275	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 26-0025 Component CCN: 26-8754	Period: From 10/01/2017 To 09/30/2018	Worksheet M-4 Date/Time Prepared: 2/27/2019 3:19 pm
	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)	3,655,546	3,655,546	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.003550	0.007121	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	12,977	26,031	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	105,026	21,581	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	118,003	47,612	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3,836,553	3,836,553	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	4,756,625	4,756,625	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.030758	0.012410	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	146,304	59,030	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	264,307	106,642	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	657	1,318	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	402.29	80.91	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	65	214	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	26,149	17,315	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)		370,949	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)		43,464	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 26-0025 Component CCN: 26-8759	Period: From 10/01/2017 To 09/30/2018	Worksheet M-4 Date/Time Prepared: 2/27/2019 3:19 pm
	Title XVIII	RHC X	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	288,219	288,219	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000266	0.003638	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	77	1,049	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	753	1,483	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	830	2,532	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	310,202	310,202	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	374,754	374,754	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002676	0.008162	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,003	3,059	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,833	5,591	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	6	82	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	305.50	68.18	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	1	25	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	306	1,705	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)		7,424	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)		2,011	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 10/01/2017 To 09/30/2018	Worksheet M-5 Date/Time Prepared: 2/27/2019 3:19 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		39,983	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)		39,983	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		18,216	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		58,199	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 10/01/2017 To 09/30/2018	Worksheet M-5 Date/Time Prepared: 2/27/2019 3:19 pm
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		44,000	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)		44,000	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		20,267	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		64,267	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 26-0025 Component CCN: 26-8513	Period: From 10/01/2017 To 09/30/2018	Worksheet M-5 Date/Time Prepared: 2/27/2019 3:19 pm
		RHC III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		78,622	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)		78,622	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		49,555	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		128,177	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 10/01/2017 To 09/30/2018	Worksheet M-5 Date/Time Prepared: 2/27/2019 3:19 pm
		RHC IV	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		108,762	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)		108,762	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		18,151	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		126,913	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 10/01/2017 To 09/30/2018	Worksheet M-5 Date/Time Prepared: 2/27/2019 3:19 pm
		RHC V	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		96,778	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)		96,778	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		25,468	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		122,246	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: 26-8756	Period: From 10/01/2017 To 09/30/2018	Worksheet M-5 Date/Time Prepared: 2/27/2019 3:19 pm
		RHC VI	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		5,710	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)		5,710	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		1,179	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		6,889	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: 26-8757	Period: From 10/01/2017 To 09/30/2018	Worksheet M-5 Date/Time Prepared: 2/27/2019 3:19 pm
		RHC VII	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		29,504	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)		29,504	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		3,132	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		32,636	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: 26-8758	Period: From 10/01/2017 To 09/30/2018	Worksheet M-5 Date/Time Prepared: 2/27/2019 3:19 pm
		RHC VIII	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		12,171	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)		12,171	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		3,726	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		15,897	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 10/01/2017 To 09/30/2018	Worksheet M-5 Date/Time Prepared: 2/27/2019 3:19 pm
		RHC IX	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		202,238	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)		202,238	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		46,325	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		248,563	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: 26-8759	Period: From 10/01/2017 To 09/30/2018	Worksheet M-5 Date/Time Prepared: 2/27/2019 3:19 pm
		RHC X	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		16,576	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)		16,576	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		2,275	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		18,851	7.00

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