

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 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 26-0025	Period: From 10/01/2019 To 09/30/2020	Worksheet S Parts I-III Date/Time Prepared: 4/28/2021 2:10 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 4/28/2021	Time: 2:10 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY 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 10/01/2019 and ending 09/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) ROB 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		HIT	Title XIX	
		1.00	Part A 2.00	Part B 3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY							
1.00	Hospital	0	-294,615	107	0	0	1.00
2.00	Subprovider - IPF	0	0	0			2.00
3.00	Subprovider - IRF	0	2,426	0			3.00
5.00	Swing Bed - SNF	0	0	0			5.00
6.00	Swing Bed - NF	0					6.00
9.00	HOME HEALTH AGENCY I	0	0	0			9.00
10.00	RURAL HEALTH CLINIC I	0		21,702			10.00
10.01	RURAL HEALTH CLINIC II	0		31,182			10.01
10.02	RURAL HEALTH CLINIC III	0		31,132			10.02
10.03	RURAL HEALTH CLINIC IV	0		29,148			10.03
10.04	RURAL HEALTH CLINIC V	0		45,929			10.04
10.05	RURAL HEALTH CLINIC VI	0		823			10.05
10.06	RURAL HEALTH CLINIC VII	0		2,802			10.06
10.07	RURAL HEALTH CLINIC VIII	0		1,192			10.07
10.08	RURAL HEALTH CLINIC IX	0		55,011			10.08
10.09	RURAL HEALTH CLINIC X	0		6,474			10.09
200.00	Total	0	-292,189	225,502	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 26-0025		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 4/28/2021 2:10 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		
		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
4.00	Subprovider - IPF									
5.00	Subprovider - IRF		HANNIBAL REGIONAL HOSPITAL	26T025	99926	5	10/01/2015	N	P	O
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF									
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA		HANNIBAL REGIONAL - HHA	267282	99926		04/10/1990	N	P	N
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		HANNIBAL REG - SHELBYNA	268512	99926		06/11/1997	N	O	O
15.01	Hospital-Based Health Clinic - RHC		HANNIBAL REG - LAGRANGE	263984	99926		04/03/1992	N	O	O
15.02	Hospital-Based Health Clinic - RHC		HANNIBAL REG - MONROE CITY	268513	99926		06/11/1997	N	O	O
15.03	Hospital-Based Health Clinic - RHC		HANNIBAL REG - LOUISIANA	268723	99926		04/01/2014	N	O	O
15.04	Hospital-Based Health Clinic - RHC		HANNIBAL REG - BOWLING GREEN	268724	99926		04/01/2014	N	O	O
15.05	Hospital-Based Health Clinic - RHC		HANNIBAL REG - LA PLATA	268756	99926		07/03/2017	N	O	O
15.06	Hospital-Based Health Clinic - RHC		HANNIBAL REG - LANCASTER	268757	99926		07/03/2017	N	O	O
15.07	Hospital-Based Health Clinic - RHC		HANNIBAL REG - KIRKSVILLE	268758	99926		07/03/2017	N	O	O
15.08	Hospital-Based Health Clinic - RHC		HANNIBAL REG - HRMG 2ND FLOOR	268754	99926		07/24/2017	N	O	O
15.09	Hospital-Based Health Clinic - RHC		HANNIBAL REG - WALMART	268759	99926		11/07/2017	N	O	O
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2019	09/30/2020		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 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 4/28/2021 2:10 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.	1,176	0	62	0	1,031	15
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	
		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.	10/01/2019				09/30/2020	
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 OPSS 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	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N				N	
		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	
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	
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	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N				N	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.	N					
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.						
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					
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N					

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-0025		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 4/28/2021 2:10 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 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	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			
64.00	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. 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 10/01/2019
To 09/30/2020Worksheet S-2
Part I
Date/Time Prepared:
4/28/2021 2:10 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			
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
	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		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
			1.00	2.00	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			
70.00	Inpatient Psychiatric Facility PPS							
	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

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			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital 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	Y	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	Y	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	Y	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	Y	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	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	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
					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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-0025	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part I Date/Time Prepared: 4/28/2021 2:10 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
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
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:	427,795	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	Removed and reserved			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 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 4/28/2021 2:10 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)								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)								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 10/01/2019 To 09/30/2020	Worksheet S-2 Part II Date/Time Prepared: 4/28/2021 2:10 pm
			Y/N 1.00	Date 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 1.00	Date 2.00	V/I 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 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	12/18/2019
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 1.00	Legal Oper. 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 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	02/02/2021	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 26-0025

Period:
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Part II
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4/28/2021 2:10 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:
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		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 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/28/2021 2:10 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	78	28,548	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		78	28,548	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,928	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		86	31,476	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	13	4,758		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.02 RURAL HEALTH CLINIC III	88.02				0	26.02
26.03 RURAL HEALTH CLINIC IV	88.03				0	26.03
26.04 RURAL HEALTH CLINIC V	88.04				0	26.04
26.05 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:
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To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/28/2021 2:10 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)	6,129	955	11,801			1.00
2.00	HMO and other (see instructions)	1,617	1,093				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	225	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)	6,129	955	11,801			7.00
8.00	INTENSIVE CARE UNIT	1,327	116	2,227			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		105	1,018			13.00
14.00	Total (see instructions)	7,456	1,176	15,046	0.00	941.81	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	2,122	0	2,810	0.00	18.21	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	6,578	460	11,323	0.00	19.32	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	1,168	143	4,903	0.00	8.25	26.00
26.01	RURAL HEALTH CLINIC II	691	60	2,762	0.00	5.02	26.01
26.02	RURAL HEALTH CLINIC III	1,101	253	4,290	0.00	6.84	26.02
26.03	RURAL HEALTH CLINIC IV	1,364	313	5,919	0.00	17.43	26.03
26.04	RURAL HEALTH CLINIC V	1,653	478	11,506	0.00	10.07	26.04
26.05	RURAL HEALTH CLINIC VI	244	88	1,123	0.00	1.94	26.05
26.06	RURAL HEALTH CLINIC VII	1,038	69	2,364	0.00	3.32	26.06
26.07	RURAL HEALTH CLINIC VIII	510	107	2,545	0.00	3.03	26.07
26.08	RURAL HEALTH CLINIC IX	3,753	1,126	23,087	0.00	35.77	26.08
26.09	RURAL HEALTH CLINIC X	239	66	3,035	0.00	5.86	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	1,076.87	27.00
28.00	Observation Bed Days		0	821			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	15	162			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 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/28/2021 2:10 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	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	1,768	327	4,042	1.00
2.00 HMO and other (see instructions)			415	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,768	327	4,042	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	216	0	273	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 10/01/2019
To 09/30/2020Worksheet S-3
Part II
Date/Time Prepared:
4/28/2021 2:10 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	82,296,605	0	82,296,605	2,243,738.31	36.68
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		285,126	0	285,126	1,618.56	176.16
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		10,630,498	0	10,630,498	92,220.73	115.27
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		2,675,772	0	2,675,772	140,217.96	19.08
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		22,171,458	-135,889	22,035,569	409,200.11	53.85
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,300,934	0	2,300,934	26,042.88	88.35
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		309,687	0	309,687	1,342.08	230.75
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		16,578,295	0	16,578,295		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		4,661,308	0	4,661,308		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		32,902	0	32,902		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		1,769,731	0	1,769,731		
24.00	Wage-related costs (RHC/FQHC)		1,294,355	0	1,294,355		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part II
Date/Time Prepared:
4/28/2021 2:10 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on 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	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	523,542	349,657	873,199	35,996.03	24.26	26.00
27.00	Administrative & General	5.00	14,811,459	-392,537	14,418,922	453,046.08	31.83	27.00
28.00	Administrative & General under contract (see inst.)		706,809	0	706,809	3,051.11	231.66	28.00
29.00	Maintenance & Repairs	6.00	538,327	0	538,327	31,725.06	16.97	29.00
30.00	Operation of Plant	7.00	1,014,751	0	1,014,751	47,931.53	21.17	30.00
31.00	Laundry & Linen Service	8.00	32,996	0	32,996	3,113.53	10.60	31.00
32.00	Housekeeping	9.00	813,815	0	813,815	59,047.79	13.78	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,172,964	0	1,172,964	69,356.66	16.91	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	1,223,747	0	1,223,747	32,313.49	37.87	38.00
39.00	Central Services and Supply	14.00	195,253	0	195,253	10,704.98	18.24	39.00
40.00	Pharmacy	15.00	1,781,315	-1,781,315	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	842,692	0	842,692	37,673.07	22.37	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 10/01/2019
To 09/30/2020Worksheet S-3
Part III
Date/Time Prepared:
4/28/2021 2:10 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on 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)	69,697,144	0	69,697,144	2,014,350.73	34.60	1.00
2.00	Excluded area salaries (see instructions)	22,171,458	-135,889	22,035,569	409,200.11	53.85	2.00
3.00	Subtotal salaries (line 1 minus line 2)	47,525,686	135,889	47,661,575	1,605,150.62	29.69	3.00
4.00	Subtotal other wages & related costs (see inst.)	2,610,621	0	2,610,621	27,384.96	95.33	4.00
5.00	Subtotal wage-related costs (see inst.)	16,611,197	0	16,611,197	0.00	34.85	5.00
6.00	Total (sum of lines 3 thru 5)	66,747,504	135,889	66,883,393	1,632,535.58	40.97	6.00
7.00	Total overhead cost (see instructions)	23,657,670	-1,824,195	21,833,475	783,959.33	27.85	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 26-0025	Period: From 10/01/2019 To 09/30/2020	Worksheet S-3 Part IV Date/Time Prepared: 4/28/2021 2:10 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			2,961,393 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)			0 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			23,276 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)			14,596,075 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			-22,464 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			70,001 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)			205,169 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			20,873 14.00
15.00	'Workers' Compensation Insurance			924,355 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			5,056,064 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			46,592 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))			338,757 21.00
22.00	Day Care Cost and Allowances			81,165 22.00
23.00	Tuition Reimbursement			35,335 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			24,336,591 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part V
Date/Time Prepared:
4/28/2021 2:10 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	2,446,096	24,336,591	1.00
2.00	Hospital	2,300,934	20,990,311	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	145,162	321,243	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	411,288	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	182,524	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	77,877	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	136,285	14.02
14.03	Hospital-Based Health Clinic RHC 3	0	520,803	14.03
14.04	Hospital-Based Health Clinic RHC 4	0	194,693	14.04
14.05	Hospital-Based Health Clinic RHC 5	0	41,372	14.05
14.06	Hospital-Based Health Clinic RHC 6	0	65,709	14.06
14.07	Hospital-Based Health Clinic RHC 7	0	53,540	14.07
14.08	Hospital-Based Health Clinic RHC 8	0	1,221,697	14.08
14.09	Hospital-Based Health Clinic RHC 9	0	119,249	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

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL			In Lieu of Form CMS-2552-10		
HOME HEALTH AGENCY STATISTICAL DATA				Provider CCN: 26-0025 Component CCN: 26-7282		Period: From 10/01/2019 To 09/30/2020	
				Home Health Agency I		Worksheet S-4 Date/Time Prepared: 4/28/2021 2:10 pm	
						PPS	
				1.00			
0.00 County				MARION		0.00	
				Title V	Title XVIII	Title XIX	Other
				1.00	2.00	3.00	4.00
				Total		5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	1,294	5	447	1,746	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	383.00	44.00	362.00	789.00	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			3.52	0.00	3.52	5.00
6.00	Direct Nursing Service			6.50	0.00	6.50	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			3.39	0.00	3.39	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			1.98	0.00	1.98	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.17	0.00	0.17	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			1.22	0.00	1.22	14.00
15.00	Medical Social Service Supervisor			0.70	0.00	0.70	15.00
16.00	Home Health Aide			0.84	0.00	0.84	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		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	2,340	604	85	7	3,036	21.00
22.00	Skilled Nursing Visit Charges	515,405	133,100	18,700	1,540	668,745	22.00
23.00	Physical Therapy Visits	1,377	447	25	3	1,852	23.00
24.00	Physical Therapy Visit Charges	309,825	100,575	5,625	675	416,700	24.00
25.00	Occupational Therapy Visits	582	419	9	0	1,010	25.00
26.00	Occupational Therapy Visit Charges	130,950	94,275	2,025	0	227,250	26.00
27.00	Speech Pathology Visits	83	111	0	6	200	27.00
28.00	Speech Pathology Visit Charges	18,675	24,975	0	1,350	45,000	28.00
29.00	Medical Social Service Visits	7	0	0	0	7	29.00
30.00	Medical Social Service Visit Charges	1,575	0	0	0	1,575	30.00
31.00	Home Health Aide Visits	267	190	2	7	466	31.00
32.00	Home Health Aide Visit Charges	32,040	22,800	240	840	55,920	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,656	1,771	121	23	6,571	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)	1,008,470	375,725	26,590	4,405	1,415,190	35.00
36.00	Total Number of Episodes (standard/non outlier)	424		48	3	475	36.00
37.00	Total Number of Outlier Episodes		71		0	71	37.00
38.00	Total Non-Routine Medical Supply Charges	22,885	4,895	485	27	28,292	38.00

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 26-0025 Component CCN: 26-8512		Period: From 10/01/2019 To 09/30/2020 Worksheet S-8 Date/Time Prepared: 4/28/2021 2:10 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	SHELBY		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	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
				5.00	
11.00	Facility hours of operations (1)				
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
		1.00	2.00	3.00	4.00
				Total Visits	
				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
		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	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 26-0025

Period:

Worksheet S-8

Component CCN: 26-8512

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 pm

RHC I

Cost

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

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 26-0025 Component CCN: 26-3984		Period: From 10/01/2019 To 09/30/2020 Worksheet S-8 Date/Time Prepared: 4/28/2021 2:10 pm	
		RHC II		Cost	
		1.00			
Clinic Address and Identification		1802 ELM STREET		1.00	
1.00	Street	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
		1.00	2.00	3.00	4.00
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			Total Visits	14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
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
		6.00	7.00	8.00	9.00
Facility hours of operations (1)					
11.00	CLINIC	17:00	08:00	17:00	08:00
		17:00		17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 26-0025

Period:

Worksheet S-8

Component CCN: 26-3984

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 pm

RHC II

Cost

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

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 26-0025 Component CCN: 26-8513		Period: From 10/01/2019 To 09/30/2020 Worksheet S-8 Date/Time Prepared: 4/28/2021 2:10 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	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
				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
		1.00	2.00	3.00	4.00
				Total Visits	
				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
		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

Period:

Worksheet S-8

Component CCN: 26-8513

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 pm

RHC III

Cost

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

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 26-0025 Component CCN: 26-8723		Period: From 10/01/2019 To 09/30/2020 Worksheet S-8 Date/Time Prepared: 4/28/2021 2:10 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	
		from	to	from	to
		1.00	2.00	3.00	4.00
				Tuesday	
				from	
				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
		1.00	2.00	3.00	4.00
				Total Visits	
				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
		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

Period:

Worksheet S-8

Component CCN: 26-8723

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 pm

RHC IV

Cost

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

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 26-0025 Component CCN: 26-8724		Period: From 10/01/2019 To 09/30/2020 Worksheet S-8 Date/Time Prepared: 4/28/2021 2:10 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	
		from	to	from	to
		1.00	2.00	3.00	4.00
				Tuesday	
				from	
				5.00	
Facility hours of operations (1)					
11.00	CLINIC	07:00	17:00	07:00	19:00
				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
		1.00	2.00	3.00	4.00
				Total Visits	
				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
		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

Period:

Worksheet S-8

Component CCN: 26-8724

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 pm

RHC V

Cost

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

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 26-0025 Component CCN: 26-8756		Period: From 10/01/2019 To 09/30/2020
			Worksheet S-8		Date/Time Prepared: 4/28/2021 2:10 pm
			RHC VI		Cost
			1.00		
1.00	Clinic Address and Identification				
	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
			from to		from to
			1.00 2.00		3.00 4.00
			Tuesday		from
			1.00		5.00
11.00	Facility hours of operations (1)				
	CLINIC		08:00 17:00		08:00
			1.00		2.00
12.00	Have you received an approval for an exception to the productivity standard?		N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N 0		13.00
			Provider name		CCN number
			1.00		2.00
14.00	RHC/FQHC name, CCN number				
			Y/N		V
			1.00		2.00
			XVIII		XIX
			3.00		4.00
			Total Visits		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)				
			County		4.00
2.00	City, State, ZIP Code, County		MACON		2.00
			Tuesday		Wednesday
			to from to		from to
			6.00 7.00		8.00 9.00
			Thursday		10.00
Facility hours of operations (1)					
11.00	CLINIC		17:00 08:00		17:00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 26-0025

Period:

Worksheet S-8

Component CCN: 26-8756

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 pm

RHC VI

Cost

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

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 26-0025 Component CCN: 26-8757		Period: From 10/01/2019 To 09/30/2020
			Worksheet S-8		Date/Time Prepared: 4/28/2021 2:10 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
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	CLINIC		08:00	17:00	08:00
			1.00		2.00
12.00	Have you received an approval for an exception to the productivity standard?		N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N		0 13.00
			Provider name		CCN number
			1.00		2.00
14.00	RHC/FQHC name, CCN number				14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
		Total Visits			
		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)				
		County			
		4.00			
2.00	City, State, ZIP Code, County		SCHUYLER		
		Tuesday	Wednesday		Thursday
		to	from	to	from
		6.00	7.00	8.00	9.00
Facility hours of operations (1)					
11.00	CLINIC	17:00	08:00	17:00	08:00
		17:00		17:00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 26-0025

Period:

Worksheet S-8

Component CCN: 26-8757

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 pm

RHC VII

Cost

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

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 26-0025 Component CCN: 26-8758		Period: From 10/01/2019 To 09/30/2020 Worksheet S-8 Date/Time Prepared: 4/28/2021 2:10 pm		
		RHC VIII		Cost		
		1.00				
1.00	Clinic Address and Identification					
	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
		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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 26-0025 Component CCN: 26-8758	Period: From 10/01/2019 To 09/30/2020	Worksheet S-8 Date/Time Prepared: 4/28/2021 2:10 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

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 26-0025 Component CCN: 26-8754		Period: From 10/01/2019 To 09/30/2020 Worksheet S-8 Date/Time Prepared: 4/28/2021 2:10 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
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	CLINIC	08:00		17:00	08:00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			Total Visits	14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
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
		6.00	7.00	8.00	9.00
Facility hours of operations (1)					
11.00	CLINIC	17:00	08:00	17:00	08:00
		17:00		17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 26-0025

Period:

Worksheet S-8

Component CCN: 26-8754

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 pm

RHC IX

Cost

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

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 26-0025 Component CCN: 26-8759		Period: From 10/01/2019 To 09/30/2020 Worksheet S-8 Date/Time Prepared: 4/28/2021 2:10 pm		
		RHC X		Cost		
		1.00				
1.00	Clinic Address and Identification	3650 STARDUST DRIVE				1.00
	Street					
		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		
4.00	Source of Federal Funds					4.00
5.00	Community Health Center (Section 330(d), PHS Act)					5.00
6.00	Migrant Health Center (Section 329(d), PHS Act)					6.00
7.00	Health Services for the Homeless (Section 340(d), PHS Act)					7.00
8.00	Appalachian Regional Commission					8.00
9.00	Look-Alikes					9.00
	OTHER (SPECIFY)					
		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
11.00	Facility hours of operations (1)					
	CLINIC	11:00	18:00	08:00	20:00	08:00
		1.00		2.00		
12.00	Have you received an approval for an exception to the productivity standard?	N		0		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.					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
11.00	Facility hours of operations (1)					
	CLINIC	20:00	08:00	20:00	08:00	20:00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 26-0025

Period:

Worksheet S-8

Component CCN: 26-8759

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 pm

RHC X

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC	08:00	20:00	08:00	19:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020

Worksheet S-10

Date/Time Prepared:
4/28/2021 2:10 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)		0.300612	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		6,863,698	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		46,475,930	6.00
7.00	Medicaid cost (line 1 times line 6)		13,971,222	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)		7,107,524	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)		7,107,524	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	7,129,750	1,810,714	8,940,464
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,143,288	1,810,714	3,954,002
22.00	Payments received from patients for amounts previously written off as charity care	69,090	55,139	124,229
23.00	Cost of charity care (line 21 minus line 22)	2,074,198	1,755,575	3,829,773
			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)		14,753,389	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		561,005	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		863,084	27.01
28.00	Non-Medicare bad debt expense (see instructions)		13,890,305	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		4,477,671	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		8,307,444	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		15,414,968	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 26-0025		Period: From 10/01/2019 To 09/30/2020		Worksheet A Date/Time Prepared: 4/28/2021 2:10 pm	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (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		4,847,560	4,847,560	1,916,687	6,764,247	1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP		5,325,660	5,325,660	-917,442	4,408,218	2.00	
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	523,542	16,644,018	17,167,560	430,822	17,598,382	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	14,811,459	12,482,232	27,293,691	-761,522	26,532,169	5.00	
6.00	00600	MAINTENANCE & REPAIRS	538,327	100,891	639,218	0	639,218	6.00	
7.00	00700	OPERATION OF PLANT	1,014,751	3,522,586	4,537,337	-344,175	4,193,162	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	32,996	323,014	356,010	0	356,010	8.00	
9.00	00900	HOUSEKEEPING	813,815	184,554	998,369	344,175	1,342,544	9.00	
10.00	01000	DIETARY	1,172,964	999,011	2,171,975	0	2,171,975	10.00	
11.00	01100	CAFETERIA	0	0	0	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	1,223,747	329,831	1,553,578	123,934	1,677,512	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	195,253	158,284	353,537	0	353,537	14.00	
15.00	01500	PHARMACY	1,781,315	780,300	2,561,615	-1,781,315	780,300	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	842,692	1,620,956	2,463,648	0	2,463,648	16.00	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,055,418	3,975,031	12,030,449	-27,825	12,002,624	30.00	
31.00	03100	INTENSIVE CARE UNIT	1,842,202	366,175	2,208,377	0	2,208,377	31.00	
41.00	04100	SUBPROVIDER - IRF	1,093,225	1,312,386	2,405,611	0	2,405,611	41.00	
43.00	04300	NURSERY	227,811	113,219	341,030	0	341,030	43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,665,865	2,346,120	4,011,985	115,280	4,127,265	50.00	
51.00	05100	RECOVERY ROOM	1,319,926	213,588	1,533,514	0	1,533,514	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	962,245	167,314	1,129,559	0	1,129,559	52.00	
53.00	05300	ANESTHESIOLOGY	1,700,548	1,510,395	3,210,943	0	3,210,943	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,542,053	842,922	2,384,975	280,760	2,665,735	54.00	
55.00	05500	RADIOLOGY - THERAPEUTIC	781,138	666,581	1,447,719	53,903	1,501,622	55.00	
56.00	05600	RADIOISOTOPE	123,391	162,581	285,972	0	285,972	56.00	
57.00	05700	CT SCAN	298,462	272,766	571,228	206,360	777,588	57.00	
58.00	05800	MRI	131,346	178,842	310,188	157,930	468,118	58.00	
59.00	05900	CARDIAC CATHETERIZATION	766,097	1,517,598	2,283,695	0	2,283,695	59.00	
60.00	06000	LABORATORY	2,435,581	2,837,797	5,273,378	16,504	5,289,882	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	115,484	393,931	509,415	0	509,415	62.00	
64.00	06400	INTRAVENOUS THERAPY	1,240,277	237,915	1,478,192	0	1,478,192	64.00	
65.00	06500	RESPIRATORY THERAPY	851,410	391,110	1,242,520	0	1,242,520	65.00	
66.00	06600	PHYSICAL THERAPY	552,536	810,046	1,362,582	0	1,362,582	66.00	
67.00	06700	OCCUPATIONAL THERAPY	60,180	542,484	602,664	0	602,664	67.00	
68.00	06800	SPEECH PATHOLOGY	225,854	35,940	261,794	0	261,794	68.00	
69.00	06900	ELECTROCARDIOLOGY	69,381	39,676	109,057	0	109,057	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	163,230	37,003	200,233	0	200,233	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,591,549	3,591,549	3,280,464	6,872,013	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,387,018	8,387,018	-3,280,464	5,106,554	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,454,018	7,454,018	1,781,315	9,235,333	73.00	
74.00	07400	RENAL DIALYSIS	0	155,605	155,605	0	155,605	74.00	
76.00	03950	DIABETES CENTER	100,480	15,032	115,512	0	115,512	76.00	
76.97	07697	CARDIAC REHABILITATION	195,682	35,004	230,686	0	230,686	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	84,810	10,783	95,593	0	95,593	76.98	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	621,598	185,253	806,851	0	806,851	88.00	
88.01	08801	RURAL HEALTH CLINIC II	263,511	193,503	457,014	30,348	487,362	88.01	
88.02	08802	RURAL HEALTH CLINIC III	438,536	156,590	595,126	22,982	618,108	88.02	
88.03	08803	RURAL HEALTH CLINIC IV	45,034	182,863	227,897	1,895,396	2,123,293	88.03	
88.04	08804	RURAL HEALTH CLINIC V	2,414,329	821,756	3,236,085	-1,924,214	1,311,871	88.04	
88.05	08805	RURAL HEALTH CLINIC VI	142,924	44,737	187,661	0	187,661	88.05	
88.06	08806	RURAL HEALTH CLINIC VII	225,046	80,143	305,189	0	305,189	88.06	
88.07	08807	RURAL HEALTH CLINIC VIII	183,645	25,441	209,086	0	209,086	88.07	
88.08	08808	RURAL HEALTH CLINIC IX	4,061,531	1,073,972	5,135,503	75,164	5,210,667	88.08	
88.09	08809	RURAL HEALTH CLINIC X	267,929	75,397	343,326	137,266	480,592	88.09	
91.00	09100	EMERGENCY	2,998,796	4,411,421	7,410,217	0	7,410,217	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00	
	OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,398,102	335,602	1,733,704	0	1,733,704	101.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		1,842,182	1,842,182	-1,842,182	0	113.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	62,616,474	95,368,186	157,984,660	-9,849	157,974,811	118.00	
	NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,659,042	5,207,529	23,866,571	-32,148	23,834,423	192.00	
194.00	07950	FOUNDATION	118,487	97,985	216,472	0	216,472	194.00	
194.01	07951	CHILD DEVELOPMENT CENTER	902,602	209,518	1,112,120	-430,822	681,298	194.01	
194.02	07952	HWY 61 BUILDING	0	0	0	0	0	194.02	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020

Worksheet A

Date/Time Prepared:
4/28/2021 2:10 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
194.03	07953	MARKETING	0	0	0	472,819	472,819	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	82,296,605	100,883,218	183,179,823	0	183,179,823	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020

Worksheet A

Date/Time Prepared:
4/28/2021 2:10 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	-1,905,513	4,858,734	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-14,014	4,394,204	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,155,579	16,442,803	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,836,484	31,368,653	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	639,218	6.00
7.00	00700	OPERATION OF PLANT	-29,270	4,163,892	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	356,010	8.00
9.00	00900	HOUSEKEEPING	0	1,342,544	9.00
10.00	01000	DIETARY	-704,955	1,467,020	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,677,512	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	353,537	14.00
15.00	01500	PHARMACY	0	780,300	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-25,139	2,438,509	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-3,091,496	8,911,128	30.00
31.00	03100	INTENSIVE CARE UNIT	-1,226	2,207,151	31.00
41.00	04100	SUBPROVIDER - IRF	-74,505	2,331,106	41.00
43.00	04300	NURSERY	-2	341,028	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-568,668	3,558,597	50.00
51.00	05100	RECOVERY ROOM	-736	1,532,778	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,129,559	52.00
53.00	05300	ANESTHESIOLOGY	-2,885,410	325,533	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,665,735	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	1,501,622	55.00
56.00	05600	RADIOISOTOPE	0	285,972	56.00
57.00	05700	CT SCAN	0	777,588	57.00
58.00	05800	MRI	0	468,118	58.00
59.00	05900	CARDIAC CATHETERIZATION	-1,017,580	1,266,115	59.00
60.00	06000	LABORATORY	-838,837	4,451,045	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	509,415	62.00
64.00	06400	INTRAVENOUS THERAPY	0	1,478,192	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,242,520	65.00
66.00	06600	PHYSICAL THERAPY	0	1,362,582	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	602,664	67.00
68.00	06800	SPEECH PATHOLOGY	0	261,794	68.00
69.00	06900	ELECTROCARDIOLOGY	-5,189	103,868	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	200,233	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,872,013	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,106,554	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-173,767	9,061,566	73.00
74.00	07400	RENAL DIALYSIS	0	155,605	74.00
76.00	03950	DIABETES CENTER	0	115,512	76.00
76.97	07697	CARDIAC REHABILITATION	0	230,686	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	95,593	76.98
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	806,851	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	487,362	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	618,108	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	2,123,293	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	1,311,871	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	187,661	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	305,189	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	209,086	88.07
88.08	08808	RURAL HEALTH CLINIC IX	-7,500	5,203,167	88.08
88.09	08809	RURAL HEALTH CLINIC X	0	480,592	88.09
91.00	09100	EMERGENCY	-4,283,499	3,126,718	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	1,733,704	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-11,946,401	146,028,410	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	23,834,423	192.00
194.00	07950	FOUNDATION	0	216,472	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	681,298	194.01
194.02	07952	HWY 61 BUILDING	0	0	194.02
194.03	07953	MARKETING	0	472,819	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-11,946,401	171,233,422	200.00

RECLASSIFICATIONS

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-6

Date/Time Prepared:
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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - MARKETING					
1.00	MARKETING	194.03	245,916	226,903		1.00
	TOTALS		245,916	226,903		
	B - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,842,182		1.00
	TOTALS		0	1,842,182		
	C - CAPITAL LEASE EXP					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	7,742		1.00
2.00	NURSING ADMINISTRATION	13.00	0	123,934		2.00
3.00	OPERATING ROOM	50.00	0	115,280		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	280,760		4.00
5.00	RADIOLOGY - THERAPEUTIC	55.00	0	53,903		5.00
6.00	CT SCAN	57.00	0	206,360		6.00
7.00	MRI	58.00	0	157,930		7.00
8.00	LABORATORY	60.00	0	16,504		8.00
9.00	RURAL HEALTH CLINIC II	88.01	0	30,348		9.00
	0		0	992,761		
	D - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	149,824		1.00
	0		0	149,824		
	E - IMPLANTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	3,280,464		1.00
	0		0	3,280,464		
	F - CHILDREN'S CENTER					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	349,657	81,165		1.00
	0		349,657	81,165		
	G - OUTSIDE CLEANING SERVICE					
1.00	HOUSEKEEPING	9.00	0	344,175		1.00
	0		0	344,175		
	H - PHARMACY SALARIES					
1.00	DRUGS CHARGED TO PATIENTS	73.00	1,781,315	0		1.00
	0		1,781,315	0		
	I - MEDICAL DIRECTORSHIPS					
1.00	ADMINISTRATIVE & GENERAL	5.00	149,571	0		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		149,571	0		
	J - RHC SALARIES					
1.00	RURAL HEALTH CLINIC III	88.02	22,982	0		1.00
2.00	RURAL HEALTH CLINIC IV	88.03	37,024	0		2.00
3.00	RURAL HEALTH CLINIC IX	88.08	90,714	0		3.00
4.00	RURAL HEALTH CLINIC X	88.09	137,266	0		4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	74,048	0		5.00
	0		362,034	0		
	K - BOWLING GREEN & LOUISIANA CLINICS					
1.00	RURAL HEALTH CLINIC IV	88.03	1,686,598	171,774		1.00
	0		1,686,598	171,774		
500.00	Grand Total: Increases		4,575,091	7,089,248		500.00

RECLASSIFICATIONS

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-6

Date/Time Prepared:
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	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - MARKETING						
1.00	ADMINISTRATIVE & GENERAL	5.00	245,916	226,903	0		1.00
	TOTALS		245,916	226,903			
	B - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1,842,182	11		1.00
	TOTALS		0	1,842,182			
	C - CAPITAL LEASE EXP						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	992,761	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	992,761			
	D - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	149,824	5		1.00
	0		0	149,824			
	E - IMPLANTS						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,280,464	0		1.00
	0		0	3,280,464			
	F - CHILDREN'S CENTER						
1.00	CHILD DEVELOPMENT CENTER	194.01	349,657	81,165	0		1.00
	0		349,657	81,165			
	G - OUTSIDE CLEANING SERVICE						
1.00	OPERATION OF PLANT	7.00	0	344,175	0		1.00
	0		0	344,175			
	H - PHARMACY SALARIES						
1.00	PHARMACY	15.00	1,781,315	0	0		1.00
	0		1,781,315	0			
	I - MEDICAL DIRECTORSHIPS						
1.00	ADULTS & PEDIATRICS	30.00	27,825	0	0		1.00
2.00	RURAL HEALTH CLINIC IX	88.08	15,550	0	0		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	106,196	0	0		3.00
	0		149,571	0			
	J - RHC SALARIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	296,192	0	0		1.00
2.00	RURAL HEALTH CLINIC V	88.04	65,842	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
	0		362,034	0			
	K - BOWLING GREEN & LOUISIANA CLINICS						
1.00	RURAL HEALTH CLINIC V	88.04	1,686,598	171,774	0		1.00
	0		1,686,598	171,774			
500.00	Grand Total: Decreases		4,575,091	7,089,248			500.00

500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part I
Date/Time Prepared:
4/28/2021 2:10 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,712,256	0	0	0	0	1.00
2.00	Land Improvements	9,123,178	952,561	0	952,561	0	2.00
3.00	Buildings and Fixtures	81,344,058	5,396,313	0	5,396,313	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	23,083,223	2,424,239	0	2,424,239	0	5.00
6.00	Movable Equipment	72,494,255	6,738,631	0	6,738,631	83,918	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	189,756,970	15,511,744	0	15,511,744	83,918	8.00
9.00	Reconciling Items	-3,316,339	-9,322,423	0	-9,322,423	-11,713,604	9.00
10.00	Total (line 8 minus line 9)	193,073,309	24,834,167	0	24,834,167	11,797,522	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,712,256	0				1.00
2.00	Land Improvements	10,075,739	0				2.00
3.00	Buildings and Fixtures	86,740,371	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	25,507,462	0				5.00
6.00	Movable Equipment	79,148,968	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	205,184,796	0				8.00
9.00	Reconciling Items	-925,158	0				9.00
10.00	Total (line 8 minus line 9)	206,109,954	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part II
Date/Time Prepared:
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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	4,847,560	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,325,660	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	10,173,220	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	4,847,560				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,325,660				2.00
3.00	Total (sum of lines 1-2)	0	10,173,220				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part III
Date/Time Prepared:
4/28/2021 2:10 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	100,528,366	0	100,528,366	0.497286	74,505	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	104,656,430	3,030,722	101,625,708	0.502714	75,319	2.00
3.00	Total (sum of lines 1-2)	205,184,796	3,030,722	202,154,074	1.000000	149,824	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	74,505	4,684,854	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	75,319	4,318,885	0	2.00
3.00	Total (sum of lines 1-2)	0	0	149,824	9,003,739	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	99,375	74,505	0	0	4,858,734	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	75,319	0	0	4,394,204	2.00
3.00	Total (sum of lines 1-2)	99,375	149,824	0	0	9,252,938	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8

Date/Time Prepared:
4/28/2021 2:10 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		B	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-1,742,807	CAP REL COSTS-BLDG & FIXT	1.00	11	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)		0		0.00	0	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	-9,072	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	-13,064,101			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	-704,955	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	-25,139	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	-759,487	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8

Date/Time Prepared:
4/28/2021 2:10 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	MISC INCOME - A&P	B	-3,941	ADULTS & PEDIATRICS	30.00	0	33.01
33.02	MISC INCOME - ICU	B	-1,226	INTENSIVE CARE UNIT	31.00	0	33.02
33.03	MISC INCOME - NURSERY	B	-2	NURSERY	43.00	0	33.03
33.04	MISC INCOME - REHAB	B	-698	SUBPROVIDER - IRF	41.00	0	33.04
33.05	MISC INCOME - RECOVERY ROOM	B	-736	RECOVERY ROOM	51.00	0	33.05
33.06	MISC INCOME - EKG	B	-5,189	ELECTROCARDIOLOGY	69.00	0	33.06
33.07	MISC INCOME - DRUGS	B	-173,767	DRUGS CHARGED TO PATIENTS	73.00	0	33.07
33.08	MISC INCOME - LABORATORY	B	-5,557	LABORATORY	60.00	0	33.08
33.09	MISC INCOME - ER	B	-1,266	EMERGENCY	91.00	0	33.09
33.10	MISC INCOME - RHC IX	B	-7,500	RURAL HEALTH CLINIC IX	88.08	0	33.10
33.11	MISC INCOME - PLANT	B	-20,198	OPERATION OF PLANT	7.00	0	33.11
34.00	ADVERTISING	A	-519,866	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	LOBBYING EXPENSE	A	-27,883	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	ALCOHOLIC BEVERAGE EXPENSE	A	-397	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	CONTRIBUTIONS	A	-51,932	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	RECRUITMENT FEES	A	-655,160	ADMINISTRATIVE & GENERAL	5.00	0	38.00
38.01	RECRUITMENT FEES	A	-36,791	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.01
39.00	PATIENT TELEPHONE EXPENSE OPERATING	A	-36,507	ADMINISTRATIVE & GENERAL	5.00	0	39.00
39.01	PATIENT TELEPHONE EXPENSE CAPITAL	A	-14,014	CAP REL COSTS-MVBLE EQUIP	2.00	9	39.01
40.00	MEDICAID/FRA	A	7,358,994	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	DAYCARE REVENUE	B	-287,886	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	41.00
42.00	BUILDING RENTAL INCOME	B	-162,706	CAP REL COSTS-BLDG & FIXT	1.00	9	42.00
43.00	EMPLOYED PHYSICIAN BENEFITS	A	-830,902	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	43.00
44.00	PHYSICIAN PENSION EXPENSE	A	-933	ADMINISTRATIVE & GENERAL	5.00	0	44.00
44.01	PHYSICIAN PENSION EXPENSE	A	-41,960	ADULTS & PEDIATRICS	30.00	0	44.01
44.02	PHYSICIAN PENSION EXPENSE	A	-2,858	SUBPROVIDER - IRF	41.00	0	44.02
44.03	PHYSICIAN PENSION EXPENSE	A	-866	OPERATING ROOM	50.00	0	44.03
44.04	PHYSICIAN PENSION EXPENSE	A	-67,648	ANESTHESIOLOGY	53.00	0	44.04
44.05	PHYSICIAN PENSION EXPENSE	A	-22,917	LABORATORY	60.00	0	44.05
44.06	PHYSICIAN PENSION EXPENSE	A	-18,528	EMERGENCY	91.00	0	44.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-11,946,401				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020

Worksheet A-8-2

Date/Time Prepared:
4/28/2021 2:10 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	664,681	247,844	416,837	211,500	1,906	1.00
2.00	30.00	ADULTS & PEDIATRICS	3,045,595	3,045,595	0	211,500	0	2.00
3.00	41.00	SUBPROVIDER - IRF	70,949	70,949	0	211,500	0	3.00
4.00	50.00	OPERATING ROOM	567,802	567,802	0	246,400	0	4.00
5.00	53.00	ANESTHESIOLOGY	2,860,183	2,817,762	42,421	239,400	409	5.00
6.00	59.00	CARDIAC CATHETERIZATION	1,017,580	1,017,580	0	211,500	0	6.00
7.00	60.00	LABORATORY	893,230	757,675	135,555	260,300	646	7.00
8.00	91.00	EMERGENCY	4,263,705	4,263,705	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			13,383,725	12,788,912	594,813		2,961	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	193,807	9,690	844	529	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	16,424	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	3,900	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	47,074	2,354	42,929	637	0	5.00
6.00	59.00	CARDIAC CATHETERIZATION	0	0	7,292	0	0	6.00
7.00	60.00	LABORATORY	80,843	4,042	13,340	2,024	0	7.00
8.00	91.00	EMERGENCY	0	0	13,231	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			321,724	16,086	97,960	3,190	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	194,336	222,501	470,345		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	3,045,595		2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	70,949		3.00
4.00	50.00	OPERATING ROOM	0	0	0	567,802		4.00
5.00	53.00	ANESTHESIOLOGY	0	47,711	0	2,817,762		5.00
6.00	59.00	CARDIAC CATHETERIZATION	0	0	0	1,017,580		6.00
7.00	60.00	LABORATORY	0	82,867	52,688	810,363		7.00
8.00	91.00	EMERGENCY	0	0	0	4,263,705		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	324,914	275,189	13,064,101		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/28/2021 2:10 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	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,858,734	4,858,734				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,394,204		4,394,204			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	16,442,803	62,231	23,794	16,528,828		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	31,368,653	800,073	1,456,869	3,079,114	36,704,709	5.00
6.00	00600	MAINTENANCE & REPAIRS	639,218	0	0	115,783	755,001	6.00
7.00	00700	OPERATION OF PLANT	4,163,892	381,378	38,415	218,253	4,801,938	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	356,010	9,223	0	7,097	372,330	8.00
9.00	00900	HOUSEKEEPING	1,342,544	9,638	6,370	175,035	1,533,587	9.00
10.00	01000	DIETARY	1,467,020	55,982	4,603	252,281	1,779,886	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,677,512	4,674	408,782	263,204	2,354,172	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	353,537	14,135	8,218	41,995	417,885	14.00
15.00	01500	PHARMACY	780,300	17,400	162,710	0	960,410	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,438,509	47,329	102,393	181,246	2,769,477	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,911,128	450,024	99,347	1,436,825	10,897,324	30.00
31.00	03100	INTENSIVE CARE UNIT	2,207,151	186,756	89,124	396,221	2,879,252	31.00
41.00	04100	SUBPROVIDER - IRF	2,331,106	77,724	10,866	220,058	2,639,754	41.00
43.00	04300	NURSERY	341,028	4,311	9,888	48,998	404,225	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,558,597	140,111	659,601	347,410	4,705,719	50.00
51.00	05100	RECOVERY ROOM	1,532,778	112,939	0	283,890	1,929,607	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,129,559	32,333	26,924	206,960	1,395,776	52.00
53.00	05300	ANESTHESIOLOGY	325,533	3,886	56,589	19,820	405,828	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,665,735	110,192	365,624	331,665	3,473,216	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1,501,622	199,389	226,390	168,007	2,095,408	55.00
56.00	05600	RADIOISOTOPE	285,972	12,861	77,615	26,539	402,987	56.00
57.00	05700	CT SCAN	777,588	5,928	0	64,193	847,709	57.00
58.00	05800	MRI	468,118	8,747	41,164	28,250	546,279	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,266,115	37,774	47,332	164,772	1,515,993	59.00
60.00	06000	LABORATORY	4,451,045	62,159	152,335	349,552	5,015,091	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	509,415	1,399	644	24,838	536,296	62.00
64.00	06400	INTRAVENOUS THERAPY	1,478,192	72,232	22,350	266,759	1,839,533	64.00
65.00	06500	RESPIRATORY THERAPY	1,242,520	25,442	13,126	183,121	1,464,209	65.00
66.00	06600	PHYSICAL THERAPY	1,362,582	34,738	0	118,839	1,516,159	66.00
67.00	06700	OCCUPATIONAL THERAPY	602,664	1,814	0	12,944	617,422	67.00
68.00	06800	SPEECH PATHOLOGY	261,794	663	0	48,577	311,034	68.00
69.00	06900	ELECTROCARDIOLOGY	103,868	5,130	17,518	14,922	141,438	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	200,233	1,606	14,082	35,108	251,029	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,872,013	0	0	0	6,872,013	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,106,554	0	0	0	5,106,554	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,061,566	0	0	383,125	9,444,691	73.00
74.00	07400	RENAL DIALYSIS	155,605	0	0	0	155,605	74.00
76.00	03950	DIABETES CENTER	115,512	2,156	0	21,611	139,279	76.00
76.97	07697	CARDIAC REHABILITATION	230,686	22,302	4,478	42,087	299,553	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	95,593	0	0	18,241	113,834	76.98
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	806,851	0	3,724	133,693	944,268	88.00
88.01	08801	RURAL HEALTH CLINIC II	487,362	0	19,437	56,676	563,475	88.01
88.02	08802	RURAL HEALTH CLINIC III	618,108	59,454	0	99,263	776,825	88.02
88.03	08803	RURAL HEALTH CLINIC IV	2,123,293	0	3,400	380,403	2,507,096	88.03
88.04	08804	RURAL HEALTH CLINIC V	1,311,871	0	47,504	142,359	1,501,734	88.04
88.05	08805	RURAL HEALTH CLINIC VI	187,661	0	0	30,740	218,401	88.05
88.06	08806	RURAL HEALTH CLINIC VII	305,189	0	0	48,403	353,592	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	209,086	7,886	0	39,498	256,470	88.07
88.08	08808	RURAL HEALTH CLINIC IX	5,203,167	227,981	0	889,720	6,320,868	88.08
88.09	08809	RURAL HEALTH CLINIC X	480,592	0	490	87,149	568,231	88.09
91.00	09100	EMERGENCY	3,126,718	304,296	48,065	519,314	3,998,393	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,733,704	31,090	5,191	300,704	2,070,689	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	146,028,410	3,645,386	4,274,962	12,325,262	140,492,254	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	10,985	0	0	10,985	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	23,834,423	957,521	118,245	4,006,263	28,916,452	192.00
194.00	07950	FOUNDATION	216,472	5,493	78	25,484	247,527	194.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/28/2021 2:10 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	
194.01	07951	CHILD DEVELOPMENT CENTER	681,298	98,409	919	118,927	899,553	194.01
194.02	07952	HWY 61 BUILDING	0	104,669	0	0	104,669	194.02
194.03	07953	MARKETING	472,819	36,271	0	52,892	561,982	194.03
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)	171,233,422	4,858,734	4,394,204	16,528,828	171,233,422	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/28/2021 2:10 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	36,704,709					5.00
6.00	00600	MAINTENANCE & REPAIRS	205,994	960,995				6.00
7.00	00700	OPERATION OF PLANT	1,310,156	91,707	6,203,801			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	101,586	2,218	15,828	491,962		8.00
9.00	00900	HOUSEKEEPING	418,422	2,318	16,539	0	1,970,866	9.00
10.00	01000	DIETARY	485,622	13,462	96,071	0	30,681	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	642,310	1,124	8,021	0	2,561	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	114,015	3,399	24,258	0	7,747	14.00
15.00	01500	PHARMACY	262,037	4,184	29,860	0	9,536	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	755,621	11,381	81,221	0	25,938	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,973,215	108,214	772,287	170,645	246,632	30.00
31.00	03100	INTENSIVE CARE UNIT	785,572	44,908	320,493	29,697	102,350	31.00
41.00	04100	SUBPROVIDER - IRF	720,228	18,690	133,383	32,425	42,596	41.00
43.00	04300	NURSERY	110,288	1,037	7,398	0	2,363	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,283,904	33,692	240,445	58,616	76,787	50.00
51.00	05100	RECOVERY ROOM	526,472	27,158	193,814	21,472	61,895	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	380,822	7,775	55,487	0	17,720	52.00
53.00	05300	ANESTHESIOLOGY	110,726	934	6,669	0	2,130	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	947,629	26,497	189,101	34,561	60,390	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	571,709	47,946	342,172	8,972	109,274	55.00
56.00	05600	RADIOISOTOPE	109,951	3,093	22,070	0	7,048	56.00
57.00	05700	CT SCAN	231,288	1,425	10,173	0	3,249	57.00
58.00	05800	MRI	149,046	2,103	15,010	3,200	4,793	58.00
59.00	05900	CARDIAC CATHETERIZATION	413,622	9,083	64,824	8,551	20,702	59.00
60.00	06000	LABORATORY	1,368,312	14,947	106,671	26	34,066	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	146,322	336	2,401	0	767	62.00
64.00	06400	INTRAVENOUS THERAPY	501,896	17,369	123,957	6,816	39,586	64.00
65.00	06500	RESPIRATORY THERAPY	399,493	6,118	43,661	0	13,943	65.00
66.00	06600	PHYSICAL THERAPY	413,667	8,353	59,613	1,618	19,038	66.00
67.00	06700	OCCUPATIONAL THERAPY	168,457	436	3,112	0	994	67.00
68.00	06800	SPEECH PATHOLOGY	84,862	159	1,138	0	363	68.00
69.00	06900	ELECTROCARDIOLOGY	38,590	1,234	8,803	0	2,811	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	68,491	386	2,757	2,121	880	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,874,953	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,393,267	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,576,880	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	42,455	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	38,001	518	3,699	0	1,181	76.00
76.97	07697	CARDIAC REHABILITATION	81,730	5,363	38,272	0	12,222	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	31,058	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	257,633	0	0	274	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	153,738	0	0	173	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	211,948	14,296	102,029	415	32,583	88.02
88.03	08803	RURAL HEALTH CLINIC IV	684,034	0	0	1,939	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	409,732	0	0	830	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	59,588	0	0	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	96,474	0	0	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	69,975	1,896	13,534	0	4,322	88.07
88.08	08808	RURAL HEALTH CLINIC IX	1,724,579	54,821	391,239	0	124,943	88.08
88.09	08809	RURAL HEALTH CLINIC X	155,036	0	0	11	0	88.09
91.00	09100	EMERGENCY	1,090,918	73,172	522,203	109,600	166,767	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	564,965	7,476	53,353	0	17,039	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,317,289	669,228	4,121,566	491,962	1,305,897	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	2,997	2,641	18,851	0	6,020	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,889,566	230,250	1,643,210	0	524,765	192.00
194.00	07950	FOUNDATION	67,535	1,321	9,426	0	3,010	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	245,433	23,664	168,881	0	53,933	194.01
194.02	07952	HWY 61 BUILDING	28,558	25,169	179,622	0	57,363	194.02
194.03	07953	MARKETING	153,331	8,722	62,245	0	19,878	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/28/2021 2:10 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	
202.00	TOTAL (sum lines 118 through 201)	36,704,709	960,995	6,203,801	491,962	1,970,866	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
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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	2,405,722					10.00
11.00	01100	CAFETERIA	1,708,963	1,708,963				11.00
13.00	01300	NURSING ADMINISTRATION	0	44,368	3,052,556			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,703	0	582,007		14.00
15.00	01500	PHARMACY	0	66,666	0	0	1,332,693	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	37,747	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	494,612	350,417	1,349,014	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	91,279	72,255	301,033	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	110,868	55,087	217,411	0	0	41.00
43.00	04300	NURSERY	0	8,140	33,965	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	77,586	305,419	0	0	50.00
51.00	05100	RECOVERY ROOM	0	53,138	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	37,403	155,789	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	28,919	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	62,195	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	20,206	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	4,414	0	0	0	56.00
57.00	05700	CT SCAN	0	11,551	0	0	0	57.00
58.00	05800	MRI	0	5,417	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	26,082	0	0	0	59.00
60.00	06000	LABORATORY	0	107,079	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	5,474	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	43,565	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	38,148	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	33,992	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,942	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	8,083	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,009	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,681	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	333,895	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	248,112	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,332,693	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	0	4,958	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	7,194	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	2,923	12,193	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	97,678	0	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC X	0	13,328	0	0	0	88.09
91.00	09100	EMERGENCY	0	132,817	447,025	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	230,707	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,405,722	1,491,165	3,052,556	582,007	1,332,693	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	217,798	0	0	0	192.00
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	0	0	0	0	194.01
194.02	07952	HWY 61 BUILDING	0	0	0	0	0	194.02
194.03	07953	MARKETING	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet B
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2,405,722	1,708,963	3,052,556	582,007	1,332,693	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
Date/Time Prepared:
4/28/2021 2:10 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	3,681,385				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,721,696	19,084,056	181,059	19,265,115	30.00
31.00	03100	INTENSIVE CARE UNIT	242,210	4,869,049	-123,317	4,745,732	31.00
41.00	04100	SUBPROVIDER - IRF	394,020	4,364,462	0	4,364,462	41.00
43.00	04300	NURSERY	48,890	616,306	0	616,306	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	6,782,168	0	6,782,168	50.00
51.00	05100	RECOVERY ROOM	0	2,813,556	0	2,813,556	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	61,146	2,111,918	0	2,111,918	52.00
53.00	05300	ANESTHESIOLOGY	0	555,206	0	555,206	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,793,589	0	4,793,589	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	3,195,687	0	3,195,687	55.00
56.00	05600	RADIOISOTOPE	0	549,563	0	549,563	56.00
57.00	05700	CT SCAN	0	1,105,395	0	1,105,395	57.00
58.00	05800	MRI	0	725,848	0	725,848	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,058,857	0	2,058,857	59.00
60.00	06000	LABORATORY	0	6,646,192	0	6,646,192	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	691,596	0	691,596	62.00
64.00	06400	INTRAVENOUS THERAPY	0	2,572,722	-57,742	2,514,980	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,965,572	0	1,965,572	65.00
66.00	06600	PHYSICAL THERAPY	0	2,052,440	0	2,052,440	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	799,363	0	799,363	67.00
68.00	06800	SPEECH PATHOLOGY	0	405,639	0	405,639	68.00
69.00	06900	ELECTROCARDIOLOGY	0	195,885	0	195,885	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	333,345	0	333,345	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,080,861	0	9,080,861	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,747,933	0	6,747,933	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,354,264	0	13,354,264	73.00
74.00	07400	RENAL DIALYSIS	0	198,060	0	198,060	74.00
76.00	03950	DIABETES CENTER	0	187,636	0	187,636	76.00
76.97	07697	CARDIAC REHABILITATION	0	444,334	0	444,334	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	160,008	0	160,008	76.98
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,202,175	0	1,202,175	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	717,386	0	717,386	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,138,096	0	1,138,096	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	3,193,069	0	3,193,069	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	1,912,296	0	1,912,296	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	277,989	0	277,989	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	450,066	0	450,066	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	346,197	0	346,197	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	8,714,128	0	8,714,128	88.08
88.09	08809	RURAL HEALTH CLINIC X	0	736,606	0	736,606	88.09
91.00	09100	EMERGENCY	1,213,423	7,754,318	0	7,754,318	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	2,944,229	0	2,944,229	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,681,385	128,848,065	0	128,848,065	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	41,494	0	41,494	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	39,422,041	0	39,422,041	192.00
194.00	07950	FOUNDATION	0	328,819	0	328,819	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	1,391,464	0	1,391,464	194.01
194.02	07952	HWY 61 BUILDING	0	395,381	0	395,381	194.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0025

Period:
From 10/01/2019
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Cost Center Description			MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
194.03	07953	MARKETING	0	806,158	0	806,158		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	3,681,385	171,233,422	0	171,233,422		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/28/2021 2:10 pm

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			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	0	62,231	23,794	86,025	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,506	800,073	1,456,869	2,272,448	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	602	6.00
7.00	00700	OPERATION OF PLANT	352,234	381,378	38,415	772,027	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	9,223	0	9,223	8.00
9.00	00900	HOUSEKEEPING	2,965	9,638	6,370	18,973	9.00
10.00	01000	DIETARY	0	55,982	4,603	60,585	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	16,828	4,674	408,782	430,284	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,135	8,218	22,353	14.00
15.00	01500	PHARMACY	124,155	17,400	162,710	304,265	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	47,329	102,393	149,722	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	65,614	450,024	99,347	614,985	30.00
31.00	03100	INTENSIVE CARE UNIT	20,238	186,756	89,124	296,118	31.00
41.00	04100	SUBPROVIDER - IRF	3,118	77,724	10,866	91,708	41.00
43.00	04300	NURSERY	0	4,311	9,888	14,199	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	414,954	140,111	659,601	1,214,666	50.00
51.00	05100	RECOVERY ROOM	0	112,939	0	112,939	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	32,333	26,924	59,257	52.00
53.00	05300	ANESTHESIOLOGY	628	3,886	56,589	61,103	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	280,982	110,192	365,624	756,798	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	53,903	199,389	226,390	479,682	55.00
56.00	05600	RADIOISOTOPE	0	12,861	77,615	90,476	56.00
57.00	05700	CT SCAN	206,360	5,928	0	212,288	57.00
58.00	05800	MRI	157,930	8,747	41,164	207,841	58.00
59.00	05900	CARDIAC CATHETERIZATION	943	37,774	47,332	86,049	59.00
60.00	06000	LABORATORY	16,844	62,159	152,335	231,338	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,399	644	2,043	62.00
64.00	06400	INTRAVENOUS THERAPY	550	72,232	22,350	95,132	64.00
65.00	06500	RESPIRATORY THERAPY	72,965	25,442	13,126	111,533	65.00
66.00	06600	PHYSICAL THERAPY	96	34,738	0	34,834	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,814	0	1,814	67.00
68.00	06800	SPEECH PATHOLOGY	1,024	663	0	1,687	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,130	17,518	22,648	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,546	1,606	14,082	18,234	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	0	2,156	0	2,156	76.00
76.97	07697	CARDIAC REHABILITATION	83	22,302	4,478	26,863	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	14,603	0	3,724	18,327	88.00
88.01	08801	RURAL HEALTH CLINIC II	83,902	0	19,437	103,339	88.01
88.02	08802	RURAL HEALTH CLINIC III	203	59,454	0	59,657	88.02
88.03	08803	RURAL HEALTH CLINIC IV	47,564	0	3,400	50,964	88.03
88.04	08804	RURAL HEALTH CLINIC V	255,321	0	47,504	302,825	88.04
88.05	08805	RURAL HEALTH CLINIC VI	10,800	0	0	10,800	88.05
88.06	08806	RURAL HEALTH CLINIC VII	24,000	0	0	24,000	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	7,886	0	7,886	88.07
88.08	08808	RURAL HEALTH CLINIC IX	824	227,981	0	228,805	88.08
88.09	08809	RURAL HEALTH CLINIC X	8,890	0	490	9,380	88.09
91.00	09100	EMERGENCY	113	304,296	48,065	352,474	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	3,103	31,090	5,191	39,384	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,259,789	3,645,386	4,274,962	10,180,137	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	10,985	0	10,985	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	67,525	957,521	118,245	1,143,291	192.00
194.00	07950	FOUNDATION	0	5,493	78	5,571	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	98,409	919	99,328	194.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0025

Period:
From 10/01/2019
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Part II
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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
194.02	07952	HWY 61 BUILDING	0	104,669	0	104,669	0	194.02
194.03	07953	MARKETING	0	36,271	0	36,271	275	194.03
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)	2,327,314	4,858,734	4,394,204	11,580,252	86,025	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/28/2021 2:10 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	2,288,468					5.00
6.00	00600	MAINTENANCE & REPAIRS	12,843	13,445				6.00
7.00	00700	OPERATION OF PLANT	81,686	1,283	856,132			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,334	31	2,184	17,809		8.00
9.00	00900	HOUSEKEEPING	26,088	32	2,282	0	48,286	9.00
10.00	01000	DIETARY	30,278	188	13,258	0	752	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	40,047	16	1,107	0	63	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,109	48	3,348	0	190	14.00
15.00	01500	PHARMACY	16,338	59	4,121	0	234	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	47,112	159	11,209	0	635	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	185,374	1,514	106,577	6,176	6,042	30.00
31.00	03100	INTENSIVE CARE UNIT	48,979	628	44,228	1,075	2,508	31.00
41.00	04100	SUBPROVIDER - IRF	44,905	261	18,407	1,174	1,044	41.00
43.00	04300	NURSERY	6,876	15	1,021	0	58	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	80,049	471	33,182	2,122	1,881	50.00
51.00	05100	RECOVERY ROOM	32,825	380	26,747	777	1,516	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,744	109	7,657	0	434	52.00
53.00	05300	ANESTHESIOLOGY	6,904	13	920	0	52	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	59,083	371	26,096	1,251	1,480	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	35,645	671	47,220	325	2,677	55.00
56.00	05600	RADIOISOTOPE	6,855	43	3,046	0	173	56.00
57.00	05700	CT SCAN	14,420	20	1,404	0	80	57.00
58.00	05800	MRI	9,293	29	2,071	116	117	58.00
59.00	05900	CARDIAC CATHETERIZATION	25,789	127	8,946	310	507	59.00
60.00	06000	LABORATORY	85,312	209	14,721	1	835	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	9,123	5	331	0	19	62.00
64.00	06400	INTRAVENOUS THERAPY	31,292	243	17,106	247	970	64.00
65.00	06500	RESPIRATORY THERAPY	24,908	86	6,025	0	342	65.00
66.00	06600	PHYSICAL THERAPY	25,791	117	8,227	59	466	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,503	6	429	0	24	67.00
68.00	06800	SPEECH PATHOLOGY	5,291	2	157	0	9	68.00
69.00	06900	ELECTROCARDIOLOGY	2,406	17	1,215	0	69	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,270	5	380	77	22	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	116,900	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	86,868	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	160,664	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,647	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	2,369	7	510	0	29	76.00
76.97	07697	CARDIAC REHABILITATION	5,096	75	5,282	0	299	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,936	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	16,063	0	0	10	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	9,585	0	0	6	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	13,215	200	14,080	15	798	88.02
88.03	08803	RURAL HEALTH CLINIC IV	42,648	0	0	70	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	25,546	0	0	30	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	3,715	0	0	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	6,015	0	0	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	4,363	27	1,868	0	106	88.07
88.08	08808	RURAL HEALTH CLINIC IX	107,524	767	53,991	0	3,061	88.08
88.09	08809	RURAL HEALTH CLINIC X	9,666	0	0	0	0	88.09
91.00	09100	EMERGENCY	68,017	1,024	72,065	3,968	4,086	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	35,224	105	7,363	0	417	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,765,533	9,363	568,781	17,809	31,995	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	187	37	2,602	0	147	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	491,894	3,222	226,764	0	12,857	192.00
194.00	07950	FOUNDATION	4,211	18	1,301	0	74	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	15,302	331	23,306	0	1,321	194.01
194.02	07952	HWY 61 BUILDING	1,781	352	24,788	0	1,405	194.02
194.03	07953	MARKETING	9,560	122	8,590	0	487	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/28/2021 2:10 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	
202.00	TOTAL (sum lines 118 through 201)	2,288,468	13,445	856,132	17,809	48,286	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/28/2021 2:10 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	106,374					10.00
11.00	01100	CAFETERIA	75,566	75,566				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,962	474,848			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	650	0	33,916		14.00
15.00	01500	PHARMACY	0	2,948	0	0	327,965	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,669	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	21,870	15,495	209,850	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,036	3,195	46,828	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	4,902	2,436	33,820	0	0	41.00
43.00	04300	NURSERY	0	360	5,283	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	3,431	47,510	0	0	50.00
51.00	05100	RECOVERY ROOM	0	2,350	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,654	24,234	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,279	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,750	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	893	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	195	0	0	0	56.00
57.00	05700	CT SCAN	0	511	0	0	0	57.00
58.00	05800	MRI	0	240	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,153	0	0	0	59.00
60.00	06000	LABORATORY	0	4,735	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	242	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	1,926	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,687	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,503	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	395	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	357	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	133	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	340	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	19,459	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,457	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	327,965	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	0	219	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	318	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	129	1,897	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	4,319	0	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC X	0	589	0	0	0	88.09
91.00	09100	EMERGENCY	0	5,873	69,538	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	35,888	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	106,374	65,936	474,848	33,916	327,965	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	9,630	0	0	0	192.00
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	0	0	0	0	194.01
194.02	07952	HWY 61 BUILDING	0	0	0	0	0	194.02
194.03	07953	MARKETING	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/28/2021 2:10 pm

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	106,374	75,566	474,848	33,916	327,965	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/28/2021 2:10 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	211,449				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	98,890	1,274,248	0	1,274,248	30.00
31.00	03100	INTENSIVE CARE UNIT	13,912	463,568	0	463,568	31.00
41.00	04100	SUBPROVIDER - IRF	22,631	222,433	0	222,433	41.00
43.00	04300	NURSERY	2,808	30,875	0	30,875	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,385,119	0	1,385,119	50.00
51.00	05100	RECOVERY ROOM	0	179,011	0	179,011	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,512	121,678	0	121,678	52.00
53.00	05300	ANESTHESIOLOGY	0	70,374	0	70,374	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	849,555	0	849,555	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	567,987	0	567,987	55.00
56.00	05600	RADIOISOTOPE	0	100,926	0	100,926	56.00
57.00	05700	CT SCAN	0	229,057	0	229,057	57.00
58.00	05800	MRI	0	219,854	0	219,854	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	123,738	0	123,738	59.00
60.00	06000	LABORATORY	0	338,970	0	338,970	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	11,892	0	11,892	62.00
64.00	06400	INTRAVENOUS THERAPY	0	148,304	0	148,304	64.00
65.00	06500	RESPIRATORY THERAPY	0	145,534	0	145,534	65.00
66.00	06600	PHYSICAL THERAPY	0	71,615	0	71,615	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	13,238	0	13,238	67.00
68.00	06800	SPEECH PATHOLOGY	0	7,756	0	7,756	68.00
69.00	06900	ELECTROCARDIOLOGY	0	26,566	0	26,566	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	23,511	0	23,511	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	136,359	0	136,359	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	101,325	0	101,325	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	490,622	0	490,622	73.00
74.00	07400	RENAL DIALYSIS	0	2,647	0	2,647	74.00
76.00	03950	DIABETES CENTER	0	5,402	0	5,402	76.00
76.97	07697	CARDIAC REHABILITATION	0	38,152	0	38,152	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	4,057	0	4,057	76.98
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	35,096	0	35,096	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	113,225	0	113,225	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	88,481	0	88,481	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	95,661	0	95,661	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	329,142	0	329,142	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	14,675	0	14,675	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	30,267	0	30,267	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	14,455	0	14,455	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	403,096	0	403,096	88.08
88.09	08809	RURAL HEALTH CLINIC X	0	20,088	0	20,088	88.09
91.00	09100	EMERGENCY	69,696	649,443	0	649,443	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	119,945	0	119,945	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	211,449	9,317,947	0	9,317,947	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	13,958	0	13,958	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,908,532	0	1,908,532	192.00
194.00	07950	FOUNDATION	0	11,308	0	11,308	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	140,207	0	140,207	194.01
194.02	07952	HWY 61 BUILDING	0	132,995	0	132,995	194.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
194.03	07953	MARKETING	0	55,305	0	55,305		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	211,449	11,580,252	0	11,580,252		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/28/2021 2:10 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	468,843					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,318,885				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,005	23,386	76,849,716			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	77,203	1,431,895	14,316,135	-36,704,709	134,528,713	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	538,327	0	755,001	6.00
7.00	00700	OPERATION OF PLANT	36,801	37,757	1,014,751	0	4,801,938	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	890	0	32,996	0	372,330	8.00
9.00	00900	HOUSEKEEPING	930	6,261	813,815	0	1,533,587	9.00
10.00	01000	DIETARY	5,402	4,524	1,172,964	0	1,779,886	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	451	401,775	1,223,747	0	2,354,172	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,364	8,077	195,253	0	417,885	14.00
15.00	01500	PHARMACY	1,679	159,921	0	0	960,410	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,567	100,638	842,692	0	2,769,477	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	43,425	97,644	6,680,421	0	10,897,324	30.00
31.00	03100	INTENSIVE CARE UNIT	18,021	87,596	1,842,202	0	2,879,252	31.00
41.00	04100	SUBPROVIDER - IRF	7,500	10,680	1,023,143	0	2,639,754	41.00
43.00	04300	NURSERY	416	9,719	227,811	0	404,225	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,520	648,295	1,615,258	0	4,705,719	50.00
51.00	05100	RECOVERY ROOM	10,898	0	1,319,926	0	1,929,607	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,120	26,463	962,245	0	1,395,776	52.00
53.00	05300	ANESTHESIOLOGY	375	55,619	92,151	0	405,828	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,633	359,357	1,542,053	0	3,473,216	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	19,240	222,510	781,138	0	2,095,408	55.00
56.00	05600	RADIOISOTOPE	1,241	76,285	123,391	0	402,987	56.00
57.00	05700	CT SCAN	572	0	298,462	0	847,709	57.00
58.00	05800	MRI	844	40,458	131,346	0	546,279	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,645	46,521	766,097	0	1,515,993	59.00
60.00	06000	LABORATORY	5,998	149,724	1,625,218	0	5,015,091	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	135	633	115,484	0	536,296	62.00
64.00	06400	INTRAVENOUS THERAPY	6,970	21,967	1,240,277	0	1,839,533	64.00
65.00	06500	RESPIRATORY THERAPY	2,455	12,901	851,410	0	1,464,209	65.00
66.00	06600	PHYSICAL THERAPY	3,352	0	552,536	0	1,516,159	66.00
67.00	06700	OCCUPATIONAL THERAPY	175	0	60,180	0	617,422	67.00
68.00	06800	SPEECH PATHOLOGY	64	0	225,854	0	311,034	68.00
69.00	06900	ELECTROCARDIOLOGY	495	17,218	69,381	0	141,438	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	155	13,841	163,230	0	251,029	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	6,872,013	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5,106,554	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,781,315	0	9,444,691	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	155,605	74.00
76.00	03950	DIABETES CENTER	208	0	100,480	0	139,279	76.00
76.97	07697	CARDIAC REHABILITATION	2,152	4,401	195,682	0	299,553	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	84,810	0	113,834	76.98
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	3,660	621,598	0	944,268	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	19,104	263,511	0	563,475	88.01
88.02	08802	RURAL HEALTH CLINIC III	5,737	0	461,518	0	776,825	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	3,342	1,768,656	0	2,507,096	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	46,690	661,889	0	1,501,734	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	142,924	0	218,401	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	0	225,046	0	353,592	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	761	0	183,645	0	256,470	88.07
88.08	08808	RURAL HEALTH CLINIC IX	21,999	0	4,136,695	0	6,320,868	88.08
88.09	08809	RURAL HEALTH CLINIC X	0	482	405,195	0	568,231	88.09
91.00	09100	EMERGENCY	29,363	47,241	2,414,514	0	3,998,393	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	3,000	5,102	1,398,102	0	2,070,689	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	351,761	4,201,687	57,305,474	-36,704,709	103,787,545	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,060	0	0	0	10,985	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	92,396	116,218	18,626,894	0	28,916,452	192.00
194.00	07950	FOUNDATION	530	77	118,487	0	247,527	194.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/28/2021 2:10 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
194.01	07951	CHILD DEVELOPMENT CENTER	9,496	903	552,945	0	899,553	194.01
194.02	07952	HWY 61 BUILDING	10,100	0	0	0	104,669	194.02
194.03	07953	MARKETING	3,500	0	245,916	0	561,982	194.03
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)	4,858,734	4,394,204	16,528,828		36,704,709	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.363243	1.017439	0.215080		0.272839	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			86,025		2,288,468	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001119		0.017011	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 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/28/2021 2:10 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	385,635					6.00
7.00	00700	OPERATION OF PLANT	36,801	348,834				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	890	890	503,626			8.00
9.00	00900	HOUSEKEEPING	930	930	0	347,014		9.00
10.00	01000	DIETARY	5,402	5,402	0	5,402	305,066	10.00
11.00	01100	CAFETERIA	0	0	0	0	216,711	11.00
13.00	01300	NURSING ADMINISTRATION	451	451	0	451	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	43,425	43,425	174,690	43,425	62,721	30.00
31.00	03100	INTENSIVE CARE UNIT	18,021	18,021	30,401	18,021	11,575	31.00
41.00	04100	SUBPROVIDER - IRF	7,500	7,500	33,194	7,500	14,059	41.00
43.00	04300	NURSERY	416	416	0	416	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,520	13,520	60,006	13,520	0	50.00
51.00	05100	RECOVERY ROOM	10,898	10,898	21,981	10,898	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,120	3,120	0	3,120	0	52.00
53.00	05300	ANESTHESIOLOGY	375	375	0	375	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,633	10,633	35,380	10,633	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	19,240	19,240	9,185	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	3,276	844	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,645	3,645	8,754	3,645	0	59.00
60.00	06000	LABORATORY	5,998	5,998	27	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	6,978	6,970	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,455	2,455	0	2,455	0	65.00
66.00	06600	PHYSICAL THERAPY	3,352	3,352	1,656	3,352	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	175	175	0	175	0	67.00
68.00	06800	SPEECH PATHOLOGY	64	64	0	64	0	68.00
69.00	06900	ELECTROCARDIOLOGY	495	495	0	495	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	155	155	2,171	155	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	208	208	0	208	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,152	2,152	0	2,152	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	280	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	177	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	5,737	5,737	425	5,737	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	1,985	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	850	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	761	761	0	761	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	21,999	21,999	0	21,999	0	88.08
88.09	08809	RURAL HEALTH CLINIC X	0	0	11	0	0	88.09
91.00	09100	EMERGENCY	29,363	29,363	112,199	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)	268,553	231,752	503,626	229,932	305,066	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,060	1,060	0	1,060	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	92,396	92,396	0	92,396	0	192.00
194.00	07950	FOUNDATION	530	530	0	530	0	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	9,496	9,496	0	9,496	0	194.01
194.02	07952	HWY 61 BUILDING	10,100	10,100	0	10,100	0	194.02
194.03	07953	MARKETING	3,500	3,500	0	3,500	0	194.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/28/2021 2:10 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	
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)	960,995	6,203,801	491,962	1,970,866	2,405,722	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	2.491981	17.784393	0.976840	5.679500	7.885907	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	13,445	856,132	17,809	48,286	106,374	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.034865	2.454268	0.035362	0.139147	0.348692	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 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/28/2021 2:10 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	59,626					11.00
13.00	01300	NURSING ADMINISTRATION	1,548	533,764				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	513	0	11,978,567			14.00
15.00	01500	PHARMACY	2,326	0	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,317	0	0	0	27,936	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,226	235,886	0	0	13,065	30.00
31.00	03100	INTENSIVE CARE UNIT	2,521	52,638	0	0	1,838	31.00
41.00	04100	SUBPROVIDER - IRF	1,922	38,016	0	0	2,990	41.00
43.00	04300	NURSERY	284	5,939	0	0	371	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,707	53,405	0	0	0	50.00
51.00	05100	RECOVERY ROOM	1,854	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,305	27,241	0	0	464	52.00
53.00	05300	ANESTHESIOLOGY	1,009	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,170	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	705	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	154	0	0	0	0	56.00
57.00	05700	CT SCAN	403	0	0	0	0	57.00
58.00	05800	MRI	189	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	910	0	0	0	0	59.00
60.00	06000	LABORATORY	3,736	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	191	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	1,520	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,331	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,186	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	312	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	282	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	105	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	268	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	6,872,013	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	5,106,554	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	173	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	251	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	102	2,132	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	3,408	0	0	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC X	465	0	0	0	0	88.09
91.00	09100	EMERGENCY	4,634	78,166	0	0	9,208	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	40,341	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)	52,027	533,764	11,978,567	100	27,936	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,599	0	0	0	0	192.00
194.00	07950	FOUNDATION	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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-1

Date/Time Prepared:
4/28/2021 2:10 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	
194.03	07953	MARKETING	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,708,963	3,052,556	582,007	1,332,693	3,681,385	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.661373	5.718924	0.048587	13,326.930000	131.779245	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	75,566	474,848	33,916	327,965	211,449	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.267333	0.889622	0.002831	3,279.650000	7.569051	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

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020

Worksheet B-2

Date/Time Prepared:
4/28/2021 2:10 pm

		Description	Worksheet		Amount	
			CODE	Line No.		
			1.00	2.00	3.00	4.00
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS		1	74.00	0
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM		1	94.00	0
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1	74.00	0
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM		1	94.00	0
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS		1	74.00	0
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM		1	94.00	0
7.00		ICU OBSERVATION & IV THERAPY		1	30.00	181,059
8.00		ICU OBSERVATION		1	31.00	-123,317
9.00		IV THERAPY		1	64.00	-57,742

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/28/2021 2:10 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	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	19,265,115		19,265,115	0	19,265,115	30.00
31.00	03100	INTENSIVE CARE UNIT	4,745,732		4,745,732	0	4,745,732	31.00
41.00	04100	SUBPROVIDER - IRF	4,364,462		4,364,462	0	4,364,462	41.00
43.00	04300	NURSERY	616,306		616,306	0	616,306	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,782,168		6,782,168	0	6,782,168	50.00
51.00	05100	RECOVERY ROOM	2,813,556		2,813,556	0	2,813,556	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,111,918		2,111,918	0	2,111,918	52.00
53.00	05300	ANESTHESIOLOGY	555,206		555,206	0	555,206	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,793,589		4,793,589	0	4,793,589	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	3,195,687		3,195,687	0	3,195,687	55.00
56.00	05600	RADIOISOTOPE	549,563		549,563	0	549,563	56.00
57.00	05700	CT SCAN	1,105,395		1,105,395	0	1,105,395	57.00
58.00	05800	MRI	725,848		725,848	0	725,848	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,058,857		2,058,857	0	2,058,857	59.00
60.00	06000	LABORATORY	6,646,192		6,646,192	52,688	6,698,880	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	691,596		691,596	0	691,596	62.00
64.00	06400	INTRAVENOUS THERAPY	2,514,980		2,514,980	0	2,514,980	64.00
65.00	06500	RESPIRATORY THERAPY	1,965,572	0	1,965,572	0	1,965,572	65.00
66.00	06600	PHYSICAL THERAPY	2,052,440	0	2,052,440	0	2,052,440	66.00
67.00	06700	OCCUPATIONAL THERAPY	799,363	0	799,363	0	799,363	67.00
68.00	06800	SPEECH PATHOLOGY	405,639	0	405,639	0	405,639	68.00
69.00	06900	ELECTROCARDIOLOGY	195,885		195,885	0	195,885	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	333,345		333,345	0	333,345	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,080,861		9,080,861	0	9,080,861	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,747,933		6,747,933	0	6,747,933	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,354,264		13,354,264	0	13,354,264	73.00
74.00	07400	RENAL DIALYSIS	198,060		198,060	0	198,060	74.00
76.00	03950	DIABETES CENTER	187,636		187,636	0	187,636	76.00
76.97	07697	CARDIAC REHABILITATION	444,334		444,334	0	444,334	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	160,008		160,008	0	160,008	76.98
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,202,175		1,202,175	0	1,202,175	88.00
88.01	08801	RURAL HEALTH CLINIC II	717,386		717,386	0	717,386	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,138,096		1,138,096	0	1,138,096	88.02
88.03	08803	RURAL HEALTH CLINIC IV	3,193,069		3,193,069	0	3,193,069	88.03
88.04	08804	RURAL HEALTH CLINIC V	1,912,296		1,912,296	0	1,912,296	88.04
88.05	08805	RURAL HEALTH CLINIC VI	277,989		277,989	0	277,989	88.05
88.06	08806	RURAL HEALTH CLINIC VII	450,066		450,066	0	450,066	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	346,197		346,197	0	346,197	88.07
88.08	08808	RURAL HEALTH CLINIC IX	8,714,128		8,714,128	0	8,714,128	88.08
88.09	08809	RURAL HEALTH CLINIC X	736,606		736,606	0	736,606	88.09
91.00	09100	EMERGENCY	7,754,318		7,754,318	0	7,754,318	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,253,101		1,253,101		1,253,101	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	2,944,229		2,944,229		2,944,229	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	130,101,166	0	130,101,166	52,688	130,153,854	200.00
201.00		Less Observation Beds	1,253,101		1,253,101		1,253,101	201.00
202.00		Total (see instructions)	128,848,065	0	128,848,065	52,688	128,900,753	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/28/2021 2:10 pm

			Title XVIII			Hospital	PPS
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,608,785		8,608,785		30.00
31.00	03100	INTENSIVE CARE UNIT	1,642,106		1,642,106		31.00
41.00	04100	SUBPROVIDER - IRF	2,503,372		2,503,372		41.00
43.00	04300	NURSERY	305,287		305,287		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	23,909,092	54,493,005	78,402,097	0.086505	50.00
51.00	05100	RECOVERY ROOM	1,397,275	4,639,120	6,036,395	0.466099	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,379,970	265,146	1,645,116	1.283750	52.00
53.00	05300	ANESTHESIOLOGY	7,014,685	13,914,876	20,929,561	0.026527	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,649,589	9,734,500	14,384,089	0.333256	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	64,044	6,691,147	6,755,191	0.473071	55.00
56.00	05600	RADIOISOTOPE	338,512	2,048,504	2,387,016	0.230230	56.00
57.00	05700	CT SCAN	5,749,890	18,310,978	24,060,868	0.045942	57.00
58.00	05800	MRI	492,139	4,729,807	5,221,946	0.139000	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,375,889	6,129,172	11,505,061	0.178952	59.00
60.00	06000	LABORATORY	12,789,974	28,914,159	41,704,133	0.159365	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	880,948	677,212	1,558,160	0.443854	62.00
64.00	06400	INTRAVENOUS THERAPY	24,255	3,550,800	3,575,055	0.703480	64.00
65.00	06500	RESPIRATORY THERAPY	4,209,902	960,157	5,170,059	0.380184	65.00
66.00	06600	PHYSICAL THERAPY	1,970,542	559,385	2,529,927	0.811265	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,433,979	535,729	1,969,708	0.405828	67.00
68.00	06800	SPEECH PATHOLOGY	267,344	887,103	1,154,447	0.351371	68.00
69.00	06900	ELECTROCARDIOLOGY	1,018,856	2,383,769	3,402,625	0.057569	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	714	640,714	641,428	0.519692	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	30,999,050	25,303,256	56,302,306	0.161288	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,917,631	7,968,283	11,885,914	0.567725	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,952,881	42,907,348	70,860,229	0.188459	73.00
74.00	07400	RENAL DIALYSIS	142,991	0	142,991	1.385122	74.00
76.00	03950	DIABETES CENTER	0	33,575	33,575	5.588563	76.00
76.97	07697	CARDIAC REHABILITATION	5,150	541,465	546,615	0.812883	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	2,789	2,789	57.371101	76.98
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,070,403	1,070,403		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	507,545	507,545		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	767,206	767,206		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	966,363	966,363		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	1,711,974	1,711,974		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	243,183	243,183		88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	506,562	506,562		88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	531,767	531,767		88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	4,935,792	4,935,792		88.08
88.09	08809	RURAL HEALTH CLINIC X	0	511,280	511,280		88.09
91.00	09100	EMERGENCY	6,154,418	19,213,348	25,367,766	0.305676	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	733,580	2,532,245	3,265,825	0.383701	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	2,365,943	2,365,943		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	155,932,850	272,685,610	428,618,460		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	155,932,850	272,685,610	428,618,460		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 26-0025	Period: From 10/01/2019 To 09/30/2020	Worksheet C Part I Date/Time Prepared: 4/28/2021 2:10 pm
			Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
			11.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.086505		50.00
51.00	05100	RECOVERY ROOM	0.466099		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.283750		52.00
53.00	05300	ANESTHESIOLOGY	0.026527		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.333256		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.473071		55.00
56.00	05600	RADIOISOTOPE	0.230230		56.00
57.00	05700	CT SCAN	0.045942		57.00
58.00	05800	MRI	0.139000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.178952		59.00
60.00	06000	LABORATORY	0.160629		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.443854		62.00
64.00	06400	INTRAVENOUS THERAPY	0.703480		64.00
65.00	06500	RESPIRATORY THERAPY	0.380184		65.00
66.00	06600	PHYSICAL THERAPY	0.811265		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.405828		67.00
68.00	06800	SPEECH PATHOLOGY	0.351371		68.00
69.00	06900	ELECTROCARDIOLOGY	0.057569		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.519692		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.161288		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.567725		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.188459		73.00
74.00	07400	RENAL DIALYSIS	1.385122		74.00
76.00	03950	DIABETES CENTER	5.588563		76.00
76.97	07697	CARDIAC REHABILITATION	0.812883		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	57.371101		76.98
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
88.03	08803	RURAL HEALTH CLINIC IV			88.03
88.04	08804	RURAL HEALTH CLINIC V			88.04
88.05	08805	RURAL HEALTH CLINIC VI			88.05
88.06	08806	RURAL HEALTH CLINIC VII			88.06
88.07	08807	RURAL HEALTH CLINIC VIII			88.07
88.08	08808	RURAL HEALTH CLINIC IX			88.08
88.09	08809	RURAL HEALTH CLINIC X			88.09
91.00	09100	EMERGENCY	0.305676		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.383701		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/28/2021 2:10 pm

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	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	19,265,115		19,265,115	0	19,265,115	30.00
31.00	03100	INTENSIVE CARE UNIT	4,745,732		4,745,732	0	4,745,732	31.00
41.00	04100	SUBPROVIDER - IRF	4,364,462		4,364,462	0	4,364,462	41.00
43.00	04300	NURSERY	616,306		616,306	0	616,306	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,782,168		6,782,168	0	6,782,168	50.00
51.00	05100	RECOVERY ROOM	2,813,556		2,813,556	0	2,813,556	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,111,918		2,111,918	0	2,111,918	52.00
53.00	05300	ANESTHESIOLOGY	555,206		555,206	0	555,206	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,793,589		4,793,589	0	4,793,589	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	3,195,687		3,195,687	0	3,195,687	55.00
56.00	05600	RADIOISOTOPE	549,563		549,563	0	549,563	56.00
57.00	05700	CT SCAN	1,105,395		1,105,395	0	1,105,395	57.00
58.00	05800	MRI	725,848		725,848	0	725,848	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,058,857		2,058,857	0	2,058,857	59.00
60.00	06000	LABORATORY	6,646,192		6,646,192	52,688	6,698,880	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	691,596		691,596	0	691,596	62.00
64.00	06400	INTRAVENOUS THERAPY	2,514,980		2,514,980	0	2,514,980	64.00
65.00	06500	RESPIRATORY THERAPY	1,965,572	0	1,965,572	0	1,965,572	65.00
66.00	06600	PHYSICAL THERAPY	2,052,440	0	2,052,440	0	2,052,440	66.00
67.00	06700	OCCUPATIONAL THERAPY	799,363	0	799,363	0	799,363	67.00
68.00	06800	SPEECH PATHOLOGY	405,639	0	405,639	0	405,639	68.00
69.00	06900	ELECTROCARDIOLOGY	195,885		195,885	0	195,885	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	333,345		333,345	0	333,345	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,080,861		9,080,861	0	9,080,861	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,747,933		6,747,933	0	6,747,933	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,354,264		13,354,264	0	13,354,264	73.00
74.00	07400	RENAL DIALYSIS	198,060		198,060	0	198,060	74.00
76.00	03950	DIABETES CENTER	187,636		187,636	0	187,636	76.00
76.97	07697	CARDIAC REHABILITATION	444,334		444,334	0	444,334	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	160,008		160,008	0	160,008	76.98
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,202,175		1,202,175	0	1,202,175	88.00
88.01	08801	RURAL HEALTH CLINIC II	717,386		717,386	0	717,386	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,138,096		1,138,096	0	1,138,096	88.02
88.03	08803	RURAL HEALTH CLINIC IV	3,193,069		3,193,069	0	3,193,069	88.03
88.04	08804	RURAL HEALTH CLINIC V	1,912,296		1,912,296	0	1,912,296	88.04
88.05	08805	RURAL HEALTH CLINIC VI	277,989		277,989	0	277,989	88.05
88.06	08806	RURAL HEALTH CLINIC VII	450,066		450,066	0	450,066	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	346,197		346,197	0	346,197	88.07
88.08	08808	RURAL HEALTH CLINIC IX	8,714,128		8,714,128	0	8,714,128	88.08
88.09	08809	RURAL HEALTH CLINIC X	736,606		736,606	0	736,606	88.09
91.00	09100	EMERGENCY	7,754,318		7,754,318	0	7,754,318	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,253,101		1,253,101		1,253,101	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	2,944,229		2,944,229		2,944,229	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	130,101,166	0	130,101,166	52,688	130,153,854	200.00
201.00		Less Observation Beds	1,253,101		1,253,101		1,253,101	201.00
202.00		Total (see instructions)	128,848,065	0	128,848,065	52,688	128,900,753	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/28/2021 2:10 pm

			Title XIX			Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,608,785		8,608,785			30.00	
31.00	03100	INTENSIVE CARE UNIT	1,642,106		1,642,106			31.00	
41.00	04100	SUBPROVIDER - IRF	2,503,372		2,503,372			41.00	
43.00	04300	NURSERY	305,287		305,287			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	23,909,092	54,493,005	78,402,097	0.086505	0.000000	50.00	
51.00	05100	RECOVERY ROOM	1,397,275	4,639,120	6,036,395	0.466099	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,379,970	265,146	1,645,116	1.283750	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	7,014,685	13,914,876	20,929,561	0.026527	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,649,589	9,734,500	14,384,089	0.333256	0.000000	54.00	
55.00	05500	RADIOLOGY - THERAPEUTIC	64,044	6,691,147	6,755,191	0.473071	0.000000	55.00	
56.00	05600	RADIOISOTOPE	338,512	2,048,504	2,387,016	0.230230	0.000000	56.00	
57.00	05700	CT SCAN	5,749,890	18,310,978	24,060,868	0.045942	0.000000	57.00	
58.00	05800	MRI	492,139	4,729,807	5,221,946	0.139000	0.000000	58.00	
59.00	05900	CARDIAC CATHETERIZATION	5,375,889	6,129,172	11,505,061	0.178952	0.000000	59.00	
60.00	06000	LABORATORY	12,789,974	28,914,159	41,704,133	0.159365	0.000000	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	880,948	677,212	1,558,160	0.443854	0.000000	62.00	
64.00	06400	INTRAVENOUS THERAPY	24,255	3,550,800	3,575,055	0.703480	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY	4,209,902	960,157	5,170,059	0.380184	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	1,970,542	559,385	2,529,927	0.811265	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	1,433,979	535,729	1,969,708	0.405828	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	267,344	887,103	1,154,447	0.351371	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	1,018,856	2,383,769	3,402,625	0.057569	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	714	640,714	641,428	0.519692	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	30,999,050	25,303,256	56,302,306	0.161288	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,917,631	7,968,283	11,885,914	0.567725	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	27,952,881	42,907,348	70,860,229	0.188459	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	142,991	0	142,991	1.385122	0.000000	74.00	
76.00	03950	DIABETES CENTER	0	33,575	33,575	5.588563	0.000000	76.00	
76.97	07697	CARDIAC REHABILITATION	5,150	541,465	546,615	0.812883	0.000000	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	2,789	2,789	57.371101	0.000000	76.98	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,070,403	1,070,403	1.123105	0.000000	88.00	
88.01	08801	RURAL HEALTH CLINIC II	0	507,545	507,545	1.413443	0.000000	88.01	
88.02	08802	RURAL HEALTH CLINIC III	0	767,206	767,206	1.483429	0.000000	88.02	
88.03	08803	RURAL HEALTH CLINIC IV	0	966,363	966,363	3.304213	0.000000	88.03	
88.04	08804	RURAL HEALTH CLINIC V	0	1,711,974	1,711,974	1.117012	0.000000	88.04	
88.05	08805	RURAL HEALTH CLINIC VI	0	243,183	243,183	1.143127	0.000000	88.05	
88.06	08806	RURAL HEALTH CLINIC VII	0	506,562	506,562	0.888472	0.000000	88.06	
88.07	08807	RURAL HEALTH CLINIC VIII	0	531,767	531,767	0.651031	0.000000	88.07	
88.08	08808	RURAL HEALTH CLINIC IX	0	4,935,792	4,935,792	1.765497	0.000000	88.08	
88.09	08809	RURAL HEALTH CLINIC X	0	511,280	511,280	1.440710	0.000000	88.09	
91.00	09100	EMERGENCY	6,154,418	19,213,348	25,367,766	0.305676	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	733,580	2,532,245	3,265,825	0.383701	0.000000	92.00	
	OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	2,365,943	2,365,943			101.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	155,932,850	272,685,610	428,618,460			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	155,932,850	272,685,610	428,618,460			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/28/2021 2:10 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			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 10/01/2019
To 09/30/2020Worksheet D
Part I
Date/Time Prepared:
4/28/2021 2:10 pm

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,274,248	0	1,274,248	12,622	100.95	30.00
31.00	INTENSIVE CARE UNIT	463,568		463,568	2,227	208.16	31.00
41.00	SUBPROVIDER - IRF	222,433	0	222,433	2,810	79.16	41.00
43.00	NURSERY	30,875		30,875	1,018	30.33	43.00
200.00	Total (lines 30 through 199)	1,991,124		1,991,124	18,677		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	6,129	618,723				
31.00	INTENSIVE CARE UNIT	1,327	276,228				
41.00	SUBPROVIDER - IRF	2,122	167,978				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	9,578	1,062,929				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part II
Date/Time Prepared:
4/28/2021 2:10 pm

Cost Center Description			Title XVIII		Hospital	PPS		
			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	1,385,119	78,402,097	0.017667	10,603,613	187,334	50.00
51.00	05100	RECOVERY ROOM	179,011	6,036,395	0.029655	591,136	17,530	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	121,678	1,645,116	0.073963	2,072	153	52.00
53.00	05300	ANESTHESIOLOGY	70,374	20,929,561	0.003362	2,403,790	8,082	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	849,555	14,384,089	0.059062	2,564,931	151,490	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	567,987	6,755,191	0.084082	3,633	305	55.00
56.00	05600	RADIOISOTOPE	100,926	2,387,016	0.042281	178,091	7,530	56.00
57.00	05700	CT SCAN	229,057	24,060,868	0.009520	2,993,643	28,499	57.00
58.00	05800	MRI	219,854	5,221,946	0.042102	202,235	8,514	58.00
59.00	05900	CARDIAC CATHETERIZATION	123,738	11,505,061	0.010755	2,206,455	23,730	59.00
60.00	06000	LABORATORY	338,970	41,704,133	0.008128	6,252,003	50,816	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	11,892	1,558,160	0.007632	440,376	3,361	62.00
64.00	06400	INTRAVENOUS THERAPY	148,304	3,575,055	0.041483	24,237	1,005	64.00
65.00	06500	RESPIRATORY THERAPY	145,534	5,170,059	0.028149	2,298,544	64,702	65.00
66.00	06600	PHYSICAL THERAPY	71,615	2,529,927	0.028307	538,743	15,250	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,238	1,969,708	0.006721	229,746	1,544	67.00
68.00	06800	SPEECH PATHOLOGY	7,756	1,154,447	0.006718	70,432	473	68.00
69.00	06900	ELECTROCARDIOLOGY	26,566	3,402,625	0.007808	550,670	4,300	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	23,511	641,428	0.036654	365	13	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	136,359	56,302,306	0.002422	13,895,201	33,654	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	101,325	11,885,914	0.008525	1,589,914	13,554	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	490,622	70,860,229	0.006924	11,836,400	81,955	73.00
74.00	07400	RENAL DIALYSIS	2,647	142,991	0.018512	93,256	1,726	74.00
76.00	03950	DIABETES CENTER	5,402	33,575	0.160894	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	38,152	546,615	0.069797	450	31	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	4,057	2,789	1.454643	0	0	76.98
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	35,096	1,070,403	0.032788	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	113,225	507,545	0.223084	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	88,481	767,206	0.115329	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	95,661	966,363	0.098991	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	329,142	1,711,974	0.192259	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	14,675	243,183	0.060346	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	30,267	506,562	0.059750	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	14,455	531,767	0.027183	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	403,096	4,935,792	0.081668	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC X	20,088	511,280	0.039290	0	0	88.09
91.00	09100	EMERGENCY	649,443	25,367,766	0.025601	3,020,090	77,317	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	82,884	3,265,825	0.025379	352,480	8,946	92.00
200.00		Total (lines 50 through 199)	7,289,762	413,192,967		62,942,506	791,814	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 26-0025		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part III Date/Time Prepared: 4/28/2021 2:10 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	0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF		0	0	0	0	0	0	41.00
43.00	04300	NURSERY		0	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)		0	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	12,622	0.00	6,129		30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	2,227	0.00	1,327		31.00
41.00	04100	SUBPROVIDER - IRF		0	0	2,810	0.00	2,122		41.00
43.00	04300	NURSERY		0	0	1,018	0.00	0		43.00
200.00		Total (lines 30 through 199)		0	0	18,677		9,578		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 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/28/2021 2:10 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	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 10/01/2019
To 09/30/2020Worksheet D
Part IV
Date/Time Prepared:
4/28/2021 2:10 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) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	78,402,097	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	6,036,395	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,645,116	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	20,929,561	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,384,089	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	6,755,191	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	2,387,016	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	24,060,868	0.000000	57.00
58.00	05800	MRI	0	0	0	5,221,946	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	11,505,061	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	41,704,133	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,558,160	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,575,055	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,170,059	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,529,927	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,969,708	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,154,447	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,402,625	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	641,428	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	56,302,306	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,885,914	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	70,860,229	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	142,991	0.000000	74.00
76.00	03950	DIABETES CENTER	0	0	0	33,575	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	546,615	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	2,789	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,070,403	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	507,545	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	767,206	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	966,363	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	1,711,974	0.000000	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	243,183	0.000000	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	0	0	506,562	0.000000	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	0	0	531,767	0.000000	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	0	0	4,935,792	0.000000	88.08
88.09	08809	RURAL HEALTH CLINIC X	0	0	0	511,280	0.000000	88.09
91.00	09100	EMERGENCY	0	0	0	25,367,766	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,265,825	0.000000	92.00
200.00	Total (lines 50 through 199)		0	0	0	413,192,967		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part IV
Date/Time Prepared:
4/28/2021 2:10 pm

Cost Center Description			Title XVIII		Hospital		PPS
			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	10,603,613	0	19,360,760	0
51.00	05100	RECOVERY ROOM	0.000000	591,136	0	1,563,814	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	2,072	0	610	0
53.00	05300	ANESTHESIOLOGY	0.000000	2,403,790	0	3,714,680	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,564,931	0	2,748,450	0
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	3,633	0	2,958,437	0
56.00	05600	RADIOISOTOPE	0.000000	178,091	0	879,515	0
57.00	05700	CT SCAN	0.000000	2,993,643	0	5,754,460	0
58.00	05800	MRI	0.000000	202,235	0	1,596,093	0
59.00	05900	CARDIAC CATHETERIZATION	0.000000	2,206,455	0	2,998,189	0
60.00	06000	LABORATORY	0.000000	6,252,003	0	3,875,406	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	440,376	0	149,833	0
64.00	06400	INTRAVENOUS THERAPY	0.000000	24,237	0	1,089,791	0
65.00	06500	RESPIRATORY THERAPY	0.000000	2,298,544	0	397,823	0
66.00	06600	PHYSICAL THERAPY	0.000000	538,743	0	52,978	0
67.00	06700	OCCUPATIONAL THERAPY	0.000000	229,746	0	36,945	0
68.00	06800	SPEECH PATHOLOGY	0.000000	70,432	0	1,010	0
69.00	06900	ELECTROCARDIOLOGY	0.000000	550,670	0	784,921	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	365	0	112,423	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	13,895,201	0	10,174,005	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,589,914	0	3,838,388	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	11,836,400	0	14,982,701	0
74.00	07400	RENAL DIALYSIS	0.000000	93,256	0	0	0
76.00	03950	DIABETES CENTER	0.000000	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0.000000	450	0	255,168	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	637	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0
88.04	08804	RURAL HEALTH CLINIC V	0.000000	0	0	0	0
88.05	08805	RURAL HEALTH CLINIC VI	0.000000	0	0	0	0
88.06	08806	RURAL HEALTH CLINIC VII	0.000000	0	0	0	0
88.07	08807	RURAL HEALTH CLINIC VIII	0.000000	0	0	0	0
88.08	08808	RURAL HEALTH CLINIC IX	0.000000	0	0	0	0
88.09	08809	RURAL HEALTH CLINIC X	0.000000	0	0	0	0
91.00	09100	EMERGENCY	0.000000	3,020,090	0	4,113,012	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	352,480	0	1,023,189	0
200.00		Total (lines 50 through 199)		62,942,506	0	82,463,238	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part V
Date/Time Prepared:
4/28/2021 2:10 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.086505	19,360,760	0	0	1,674,803	50.00
51.00	05100	RECOVERY ROOM	0.466099	1,563,814	479	0	728,892	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.283750	610	0	0	783	52.00
53.00	05300	ANESTHESIOLOGY	0.026527	3,714,680	0	0	98,539	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.333256	2,748,450	0	0	915,937	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.473071	2,958,437	927	0	1,399,551	55.00
56.00	05600	RADIOISOTOPE	0.230230	879,515	0	0	202,491	56.00
57.00	05700	CT SCAN	0.045942	5,754,460	0	0	264,371	57.00
58.00	05800	MRI	0.139000	1,596,093	0	0	221,857	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.178952	2,998,189	0	0	536,532	59.00
60.00	06000	LABORATORY	0.159365	3,875,406	174	0	617,604	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.443854	149,833	3	0	66,504	62.00
64.00	06400	INTRAVENOUS THERAPY	0.703480	1,089,791	293	0	766,646	64.00
65.00	06500	RESPIRATORY THERAPY	0.380184	397,823	0	0	151,246	65.00
66.00	06600	PHYSICAL THERAPY	0.811265	52,978	0	0	42,979	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.405828	36,945	0	0	14,993	67.00
68.00	06800	SPEECH PATHOLOGY	0.351371	1,010	0	0	355	68.00
69.00	06900	ELECTROCARDIOLOGY	0.057569	784,921	420	0	45,187	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.519692	112,423	0	0	58,425	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.161288	10,174,005	72	0	1,640,945	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.567725	3,838,388	0	0	2,179,149	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.188459	14,982,701	32	210	2,823,625	73.00
74.00	07400	RENAL DIALYSIS	1.385122	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	5.588563	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.812883	255,168	0	0	207,422	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	57.371101	637	26	0	36,545	76.98
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
88.03	08803	RURAL HEALTH CLINIC IV						88.03
88.04	08804	RURAL HEALTH CLINIC V						88.04
88.05	08805	RURAL HEALTH CLINIC VI						88.05
88.06	08806	RURAL HEALTH CLINIC VII						88.06
88.07	08807	RURAL HEALTH CLINIC VIII						88.07
88.08	08808	RURAL HEALTH CLINIC IX						88.08
88.09	08809	RURAL HEALTH CLINIC X						88.09
91.00	09100	EMERGENCY	0.305676	4,113,012	0	0	1,257,249	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.383701	1,023,189	0	0	392,599	92.00
200.00		Subtotal (see instructions)		82,463,238	2,426	210	16,345,229	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00
		Only Charges						
202.00		Net Charges (line 200 - line 201)		82,463,238	2,426	210	16,345,229	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part V
Date/Time Prepared:
4/28/2021 2:10 pm

			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	223	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	439	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	28	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1	0		62.00
64.00	06400	INTRAVENOUS THERAPY	206	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	24	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6	40		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	1,492	0		76.98
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
88.04	08804	RURAL HEALTH CLINIC V				88.04
88.05	08805	RURAL HEALTH CLINIC VI				88.05
88.06	08806	RURAL HEALTH CLINIC VII				88.06
88.07	08807	RURAL HEALTH CLINIC VIII				88.07
88.08	08808	RURAL HEALTH CLINIC IX				88.08
88.09	08809	RURAL HEALTH CLINIC X				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)	2,431	40		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	2,431	40		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 26-0025

Period:

Worksheet D

Component CCN: 26-T025

From 10/01/2019
To 09/30/2020Part II
Date/Time Prepared:
4/28/2021 2:10 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	1,385,119	78,402,097	0.017667	16,736	296 50.00
51.00	05100	RECOVERY ROOM	179,011	6,036,395	0.029655	1,535	46 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	121,678	1,645,116	0.073963	1	0 52.00
53.00	05300	ANESTHESIOLOGY	70,374	20,929,561	0.003362	1,140	4 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	849,555	14,384,089	0.059062	49,058	2,897 54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	567,987	6,755,191	0.084082	14,199	1,194 55.00
56.00	05600	RADIOISOTOPE	100,926	2,387,016	0.042281	0	0 56.00
57.00	05700	CT SCAN	229,057	24,060,868	0.009520	44,596	425 57.00
58.00	05800	MRI	219,854	5,221,946	0.042102	17,404	733 58.00
59.00	05900	CARDIAC CATHETERIZATION	123,738	11,505,061	0.010755	822	9 59.00
60.00	06000	LABORATORY	338,970	41,704,133	0.008128	285,047	2,317 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	11,892	1,558,160	0.007632	12,277	94 62.00
64.00	06400	INTRAVENOUS THERAPY	148,304	3,575,055	0.041483	18	1 64.00
65.00	06500	RESPIRATORY THERAPY	145,534	5,170,059	0.028149	226,795	6,384 65.00
66.00	06600	PHYSICAL THERAPY	71,615	2,529,927	0.028307	848,233	24,011 66.00
67.00	06700	OCCUPATIONAL THERAPY	13,238	1,969,708	0.006721	802,885	5,396 67.00
68.00	06800	SPEECH PATHOLOGY	7,756	1,154,447	0.006718	82,117	552 68.00
69.00	06900	ELECTROCARDIOLOGY	26,566	3,402,625	0.007808	10,560	82 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	23,511	641,428	0.036654	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	136,359	56,302,306	0.002422	197,040	477 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	101,325	11,885,914	0.008525	708	6 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	490,622	70,860,229	0.006924	230,362	1,595 73.00
74.00	07400	RENAL DIALYSIS	2,647	142,991	0.018512	10,842	201 74.00
76.00	03950	DIABETES CENTER	5,402	33,575	0.160894	0	0 76.00
76.97	07697	CARDIAC REHABILITATION	38,152	546,615	0.069797	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	4,057	2,789	1.454643	0	0 76.98
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	35,096	1,070,403	0.032788	0	0 88.00
88.01	08801	RURAL HEALTH CLINIC II	113,225	507,545	0.223084	0	0 88.01
88.02	08802	RURAL HEALTH CLINIC III	88,481	767,206	0.115329	0	0 88.02
88.03	08803	RURAL HEALTH CLINIC IV	95,661	966,363	0.098991	0	0 88.03
88.04	08804	RURAL HEALTH CLINIC V	329,142	1,711,974	0.192259	0	0 88.04
88.05	08805	RURAL HEALTH CLINIC VI	14,675	243,183	0.060346	0	0 88.05
88.06	08806	RURAL HEALTH CLINIC VII	30,267	506,562	0.059750	0	0 88.06
88.07	08807	RURAL HEALTH CLINIC VIII	14,455	531,767	0.027183	0	0 88.07
88.08	08808	RURAL HEALTH CLINIC IX	403,096	4,935,792	0.081668	0	0 88.08
88.09	08809	RURAL HEALTH CLINIC X	20,088	511,280	0.039290	0	0 88.09
91.00	09100	EMERGENCY	649,443	25,367,766	0.025601	3,600	92 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,265,825	0.000000	0	0 92.00
200.00		Total (lines 50 through 199)	7,206,878	413,192,967		2,855,975	46,812 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0025 Component CCN: 26-T025		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/28/2021 2:10 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	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 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/28/2021 2:10 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) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	78,402,097	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	6,036,395	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	1,645,116	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	20,929,561	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	14,384,089	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC		0	0	0	6,755,191	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	2,387,016	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	24,060,868	0.000000	57.00
58.00	05800	MRI		0	0	0	5,221,946	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	11,505,061	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	41,704,133	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	1,558,160	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	3,575,055	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	5,170,059	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	2,529,927	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	1,969,708	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	1,154,447	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	3,402,625	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	641,428	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	56,302,306	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	11,885,914	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	70,860,229	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	142,991	0.000000	74.00
76.00	03950	DIABETES CENTER		0	0	0	33,575	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	546,615	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	2,789	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	1,070,403	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II		0	0	0	507,545	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III		0	0	0	767,206	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV		0	0	0	966,363	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V		0	0	0	1,711,974	0.000000	88.04
88.05	08805	RURAL HEALTH CLINIC VI		0	0	0	243,183	0.000000	88.05
88.06	08806	RURAL HEALTH CLINIC VII		0	0	0	506,562	0.000000	88.06
88.07	08807	RURAL HEALTH CLINIC VIII		0	0	0	531,767	0.000000	88.07
88.08	08808	RURAL HEALTH CLINIC IX		0	0	0	4,935,792	0.000000	88.08
88.09	08809	RURAL HEALTH CLINIC X		0	0	0	511,280	0.000000	88.09
91.00	09100	EMERGENCY		0	0	0	25,367,766	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	3,265,825	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	413,192,967		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0025 Component CCN: 26-T025		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/28/2021 2:10 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		16,736	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000		1,535	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		1	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000		1,140	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		49,058	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000		14,199	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000		0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000		44,596	0	0	0	57.00
58.00	05800	MRI	0.000000		17,404	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		822	0	0	0	59.00
60.00	06000	LABORATORY	0.000000		285,047	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		12,277	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		18	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		226,795	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000		848,233	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		802,885	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		82,117	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		10,560	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		197,040	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		708	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		230,362	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000		10,842	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		3,600	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)			2,855,975	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part I
Date/Time Prepared:
4/28/2021 2:10 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	1,274,248	0	1,274,248	12,622	100.95	30.00	
31.00	INTENSIVE CARE UNIT	463,568		463,568	2,227	208.16	31.00	
41.00	SUBPROVIDER - IRF	222,433	0	222,433	2,810	79.16	41.00	
43.00	NURSERY	30,875		30,875	1,018	30.33	43.00	
200.00	Total (lines 30 through 199)	1,991,124		1,991,124	18,677		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	955	96,407					30.00
31.00	INTENSIVE CARE UNIT	116	24,147					31.00
41.00	SUBPROVIDER - IRF	0	0					41.00
43.00	NURSERY	105	3,185					43.00
200.00	Total (lines 30 through 199)	1,176	123,739					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part II
Date/Time Prepared:
4/28/2021 2:10 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	1,385,119	78,402,097	0.017667	94,065	1,662
51.00	05100	RECOVERY ROOM	179,011	6,036,395	0.029655	61,479	1,823
52.00	05200	DELIVERY ROOM & LABOR ROOM	121,678	1,645,116	0.073963	13,105	969
53.00	05300	ANESTHESIOLOGY	70,374	20,929,561	0.003362	175,670	591
54.00	05400	RADIOLOGY-DIAGNOSTIC	849,555	14,384,089	0.059062	342,518	20,230
55.00	05500	RADIOLOGY - THERAPEUTIC	567,987	6,755,191	0.084082	2,290	193
56.00	05600	RADIOISOTOPE	100,926	2,387,016	0.042281	38,001	1,607
57.00	05700	CT SCAN	229,057	24,060,868	0.009520	575,908	5,483
58.00	05800	MRI	219,854	5,221,946	0.042102	44,069	1,855
59.00	05900	CARDIAC CATHETERIZATION	123,738	11,505,061	0.010755	380,681	4,094
60.00	06000	LABORATORY	338,970	41,704,133	0.008128	1,019,242	8,284
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	11,892	1,558,160	0.007632	19,545	149
64.00	06400	INTRAVENOUS THERAPY	148,304	3,575,055	0.041483	0	0
65.00	06500	RESPIRATORY THERAPY	145,534	5,170,059	0.028149	298,921	8,414
66.00	06600	PHYSICAL THERAPY	71,615	2,529,927	0.028307	35,464	1,004
67.00	06700	OCCUPATIONAL THERAPY	13,238	1,969,708	0.006721	12,355	83
68.00	06800	SPEECH PATHOLOGY	7,756	1,154,447	0.006718	10,041	67
69.00	06900	ELECTROCARDIOLOGY	26,566	3,402,625	0.007808	76,015	594
70.00	07000	ELECTROENCEPHALOGRAPHY	23,511	641,428	0.036654	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	136,359	56,302,306	0.002422	1,241,490	3,007
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	101,325	11,885,914	0.008525	17,346	148
73.00	07300	DRUGS CHARGED TO PATIENTS	490,622	70,860,229	0.006924	2,192,650	15,182
74.00	07400	RENAL DIALYSIS	2,647	142,991	0.018512	0	0
76.00	03950	DIABETES CENTER	5,402	33,575	0.160894	0	0
76.97	07697	CARDIAC REHABILITATION	38,152	546,615	0.069797	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	4,057	2,789	1.454643	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	35,096	1,070,403	0.032788	0	0
88.01	08801	RURAL HEALTH CLINIC II	113,225	507,545	0.223084	0	0
88.02	08802	RURAL HEALTH CLINIC III	88,481	767,206	0.115329	0	0
88.03	08803	RURAL HEALTH CLINIC IV	95,661	966,363	0.098991	0	0
88.04	08804	RURAL HEALTH CLINIC V	329,142	1,711,974	0.192259	0	0
88.05	08805	RURAL HEALTH CLINIC VI	14,675	243,183	0.060346	0	0
88.06	08806	RURAL HEALTH CLINIC VII	30,267	506,562	0.059750	0	0
88.07	08807	RURAL HEALTH CLINIC VIII	14,455	531,767	0.027183	0	0
88.08	08808	RURAL HEALTH CLINIC IX	403,096	4,935,792	0.081668	0	0
88.09	08809	RURAL HEALTH CLINIC X	20,088	511,280	0.039290	0	0
91.00	09100	EMERGENCY	649,443	25,367,766	0.025601	577,333	14,780
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	82,884	3,265,825	0.025379	73,432	1,864
200.00	Total (lines 50 through 199)		7,289,762	413,192,967		7,301,620	92,083

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 26-0025		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part III Date/Time Prepared: 4/28/2021 2:10 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	0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF		0	0	0	0	0	0	41.00
43.00	04300	NURSERY		0	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)		0	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	12,622	0.00		955	30.00
31.00	03100	INTENSIVE CARE UNIT			0	2,227	0.00		116	31.00
41.00	04100	SUBPROVIDER - IRF		0	0	2,810	0.00		0	41.00
43.00	04300	NURSERY			0	1,018	0.00		105	43.00
200.00		Total (lines 30 through 199)			0	18,677			1,176	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 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/28/2021 2:10 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	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 10/01/2019
To 09/30/2020Worksheet D
Part IV
Date/Time Prepared:
4/28/2021 2:10 pm

Cost Center Description			Title XIX		Hospital	Cost	
			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) (see instructions)
			4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	78,402,097	0.000000
51.00	05100	RECOVERY ROOM	0	0	0	6,036,395	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,645,116	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	20,929,561	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,384,089	0.000000
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	6,755,191	0.000000
56.00	05600	RADIOISOTOPE	0	0	0	2,387,016	0.000000
57.00	05700	CT SCAN	0	0	0	24,060,868	0.000000
58.00	05800	MRI	0	0	0	5,221,946	0.000000
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	11,505,061	0.000000
60.00	06000	LABORATORY	0	0	0	41,704,133	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,558,160	0.000000
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,575,055	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,170,059	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	2,529,927	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,969,708	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,154,447	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,402,625	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	641,428	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	56,302,306	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,885,914	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	70,860,229	0.000000
74.00	07400	RENAL DIALYSIS	0	0	0	142,991	0.000000
76.00	03950	DIABETES CENTER	0	0	0	33,575	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	546,615	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	2,789	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,070,403	0.000000
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	507,545	0.000000
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	767,206	0.000000
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	966,363	0.000000
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	1,711,974	0.000000
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	243,183	0.000000
88.06	08806	RURAL HEALTH CLINIC VII	0	0	0	506,562	0.000000
88.07	08807	RURAL HEALTH CLINIC VIII	0	0	0	531,767	0.000000
88.08	08808	RURAL HEALTH CLINIC IX	0	0	0	4,935,792	0.000000
88.09	08809	RURAL HEALTH CLINIC X	0	0	0	511,280	0.000000
91.00	09100	EMERGENCY	0	0	0	25,367,766	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,265,825	0.000000
200.00		Total (lines 50 through 199)	0	0	0	413,192,967	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part IV
Date/Time Prepared:
4/28/2021 2:10 pm

Cost Center Description			Title XIX			Hospital		Cost	
			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
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	94,065	0	0	0	50.00	
51.00	05100	RECOVERY ROOM	0.000000	61,479	0	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	13,105	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.000000	175,670	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	342,518	0	0	0	54.00	
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	2,290	0	0	0	55.00	
56.00	05600	RADIOISOTOPE	0.000000	38,001	0	0	0	56.00	
57.00	05700	CT SCAN	0.000000	575,908	0	0	0	57.00	
58.00	05800	MRI	0.000000	44,069	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	380,681	0	0	0	59.00	
60.00	06000	LABORATORY	0.000000	1,019,242	0	0	0	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	19,545	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	298,921	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	35,464	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	12,355	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	10,041	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	76,015	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	1,241,490	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	17,346	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,192,650	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	577,333	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	73,432	0	0	0	92.00	
200.00		Total (lines 50 through 199)		7,301,620	0	0	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part V
Date/Time Prepared:
4/28/2021 2:10 pm

			Title XIX		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Charges		Costs	
					Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.086505	0	22,325	0	0	50.00
51.00	05100	RECOVERY ROOM	0.466099	0	5,350	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.283750	0	6,259	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.026527	0	653,680	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.333256	0	596,164	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.473071	0	62,290	0	0	55.00
56.00	05600	RADIOISOTOPE	0.230230	0	87,022	0	0	56.00
57.00	05700	CT SCAN	0.045942	0	1,398,069	0	0	57.00
58.00	05800	MRI	0.139000	0	276,953	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.178952	0	304,739	0	0	59.00
60.00	06000	LABORATORY	0.159365	0	1,832,715	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.443854	0	18,030	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.703480	0	176,847	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.380184	0	78,089	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.811265	0	9,595	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.405828	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.351371	0	2,710	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.057569	0	206,621	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.519692	0	121,170	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.161288	0	1,460,263	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.567725	0	153,864	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.188459	0	3,500,279	0	0	73.00
74.00	07400	RENAL DIALYSIS	1.385122	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	5.588563	0	663	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.812883	0	10,875	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	57.371101	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
88.02	08802	RURAL HEALTH CLINIC III						88.02
88.03	08803	RURAL HEALTH CLINIC IV						88.03
88.04	08804	RURAL HEALTH CLINIC V						88.04
88.05	08805	RURAL HEALTH CLINIC VI						88.05
88.06	08806	RURAL HEALTH CLINIC VII						88.06
88.07	08807	RURAL HEALTH CLINIC VIII						88.07
88.08	08808	RURAL HEALTH CLINIC IX						88.08
88.09	08809	RURAL HEALTH CLINIC X						88.09
91.00	09100	EMERGENCY	0.305676	0	2,010,304	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.383701	0	134,620	0	0	92.00
200.00		Subtotal (see instructions)		0	13,129,496	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00
202.00		Only Charges						
202.00		Net Charges (line 200 - line 201)		0	13,129,496	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part V
Date/Time Prepared:
4/28/2021 2:10 pm

			Title XIX		Hospital	Cost
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,931	0		50.00
51.00	05100	RECOVERY ROOM	2,494	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,035	0		52.00
53.00	05300	ANESTHESIOLOGY	17,340	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	198,675	0		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	29,468	0		55.00
56.00	05600	RADIOISOTOPE	20,035	0		56.00
57.00	05700	CT SCAN	64,230	0		57.00
58.00	05800	MRI	38,496	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	54,534	0		59.00
60.00	06000	LABORATORY	292,071	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	8,003	0		62.00
64.00	06400	INTRAVENOUS THERAPY	124,408	0		64.00
65.00	06500	RESPIRATORY THERAPY	29,688	0		65.00
66.00	06600	PHYSICAL THERAPY	7,784	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	952	0		68.00
69.00	06900	ELECTROCARDIOLOGY	11,895	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	62,971	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	235,523	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	87,352	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	659,659	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	DIABETES CENTER	3,705	0		76.00
76.97	07697	CARDIAC REHABILITATION	8,840	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
88.04	08804	RURAL HEALTH CLINIC V				88.04
88.05	08805	RURAL HEALTH CLINIC VI				88.05
88.06	08806	RURAL HEALTH CLINIC VII				88.06
88.07	08807	RURAL HEALTH CLINIC VIII				88.07
88.08	08808	RURAL HEALTH CLINIC IX				88.08
88.09	08809	RURAL HEALTH CLINIC X				88.09
91.00	09100	EMERGENCY	614,502	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	51,654	0		92.00
200.00		Subtotal (see instructions)	2,634,245	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	2,634,245	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0025 Component CCN: 26-T025		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/28/2021 2:10 pm	
				Title XIX		Subprovider - IRF		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	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 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/28/2021 2:10 pm	
				Title XIX		Subprovider - IRF		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) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	78,402,097	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	6,036,395	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	1,645,116	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	20,929,561	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	14,384,089	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	6,755,191	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	2,387,016	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	24,060,868	0.000000	57.00
58.00	05800	MRI	0	0	0	0	5,221,946	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	11,505,061	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	0	41,704,133	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	1,558,160	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	3,575,055	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	5,170,059	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	2,529,927	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	1,969,708	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	1,154,447	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	3,402,625	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	641,428	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	56,302,306	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	11,885,914	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	70,860,229	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	142,991	0.000000	74.00
76.00	03950	DIABETES CENTER	0	0	0	0	33,575	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	546,615	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	2,789	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	1,070,403	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	507,545	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	767,206	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	966,363	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	1,711,974	0.000000	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	243,183	0.000000	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	0	0	0	506,562	0.000000	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	0	0	0	531,767	0.000000	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	0	0	0	4,935,792	0.000000	88.08
88.09	08809	RURAL HEALTH CLINIC X	0	0	0	0	511,280	0.000000	88.09
91.00	09100	EMERGENCY	0	0	0	0	25,367,766	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	3,265,825	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	413,192,967		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0025 Component CCN: 26-T025		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/28/2021 2:10 pm	
				Title XIX		Subprovider - IRF		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 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/28/2021 2:10 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)		12,622	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		12,622	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)		11,801	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) (see instructions)		6,129	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)		19,265,115	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)		19,265,115	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)		19,265,115	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)		1,526.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		9,354,754	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)		9,354,754	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020

Worksheet D-1

Date/Time Prepared:
4/28/2021 2:10 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
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,745,732	2,227	2,131.00	1,327	2,827,837
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					11,957,182
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					24,139,773
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					894,951
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					791,814
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,686,765
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					22,453,008
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
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
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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)					821
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,526.31
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,253,101

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020

Worksheet D-1

Date/Time Prepared:
4/28/2021 2:10 pm

Cost Center Description		Title XVIII		Hospital	PPS	
		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	1,274,248	19,265,115	0.066143	1,253,101	82,884
91.00	Nursing School cost	0	19,265,115	0.000000	1,253,101	0
92.00	Allied health cost	0	19,265,115	0.000000	1,253,101	0
93.00	All other Medical Education	0	19,265,115	0.000000	1,253,101	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0025 Component CCN: 26-T025	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/28/2021 2:10 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)		2,810	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,810	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)		2,810	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) (see instructions)		2,122	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)		4,364,462	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)		4,364,462	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)		4,364,462	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)		1,553.19	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,295,869	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)		3,295,869	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 26-0025 Component CCN: 26-T025	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/28/2021 2:10 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
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00 CORONARY CARE UNIT					
45.00 BURN INTENSIVE CARE UNIT					
46.00 SURGICAL INTENSIVE CARE UNIT					
47.00 OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description					
	1.00				
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,302,498
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,598,367
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					167,978
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					46,812
52.00 Total Program excludable cost (sum of lines 50 and 51)					214,790
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					4,383,577
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
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
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
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
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
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
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
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0025 Component CCN: 26-T025		Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/28/2021 2:10 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	222,433	4,364,462	0.050965	0	0 90.00
91.00	Nursing School cost	0	4,364,462	0.000000	0	0 91.00
92.00	Allied health cost	0	4,364,462	0.000000	0	0 92.00
93.00	All other Medical Education	0	4,364,462	0.000000	0	0 93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0025	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/28/2021 2:10 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)		12,622	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		12,622	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)		11,801	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) (see instructions)		955	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)		1,018	15.00	
16.00	Nursery days (title V or XIX only)		105	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)		19,265,115	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)		19,265,115	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)		19,265,115	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)		1,526.31	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,457,626	39.00	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00	
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,457,626	41.00	

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 26-0025	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/28/2021 2:10 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)	616,306	1,018	605.41	105	63,568	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	4,745,732	2,227	2,131.00	116	247,196	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,437,366	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,205,756	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)					821	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,526.31	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,253,101	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020

Worksheet D-1

Date/Time Prepared:
4/28/2021 2:10 pm

Cost Center Description		Title XIX		Hospital		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	1,274,248	19,265,115	0.066143	1,253,101	82,884	90.00
91.00	Nursing School cost	0	19,265,115	0.000000	1,253,101	0	91.00
92.00	Allied health cost	0	19,265,115	0.000000	1,253,101	0	92.00
93.00	All other Medical Education	0	19,265,115	0.000000	1,253,101	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 26-0025	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3 Date/Time Prepared: 4/28/2021 2:10 pm	
Cost Center Description			Title XVIII	Hospital	PPS	
			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		3,872,295		30.00
31.00	03100	INTENSIVE CARE UNIT		1,395,109		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	0.086505	10,603,613	917,266	50.00
51.00	05100	RECOVERY ROOM	0.466099	591,136	275,528	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.283750	2,072	2,660	52.00
53.00	05300	ANESTHESIOLOGY	0.026527	2,403,790	63,765	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.333256	2,564,931	854,779	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.473071	3,633	1,719	55.00
56.00	05600	RADIOISOTOPE	0.230230	178,091	41,002	56.00
57.00	05700	CT SCAN	0.045942	2,993,643	137,534	57.00
58.00	05800	MRI	0.139000	202,235	28,111	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.178952	2,206,455	394,850	59.00
60.00	06000	LABORATORY	0.160629	6,252,003	1,004,253	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.443854	440,376	195,463	62.00
64.00	06400	INTRAVENOUS THERAPY	0.703480	24,237	17,050	64.00
65.00	06500	RESPIRATORY THERAPY	0.380184	2,298,544	873,870	65.00
66.00	06600	PHYSICAL THERAPY	0.811265	538,743	437,063	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.405828	229,746	93,237	67.00
68.00	06800	SPEECH PATHOLOGY	0.351371	70,432	24,748	68.00
69.00	06900	ELECTROCARDIOLOGY	0.057569	550,670	31,702	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.519692	365	190	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.161288	13,895,201	2,241,129	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.567725	1,589,914	902,634	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.188459	11,836,400	2,230,676	73.00
74.00	07400	RENAL DIALYSIS	1.385122	93,256	129,171	74.00
76.00	03950	DIABETES CENTER	5.588563	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.812883	450	366	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	57.371101	0	0	76.98
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0.000000		0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0.000000		0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0.000000		0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0.000000		0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0.000000		0	88.08
88.09	08809	RURAL HEALTH CLINIC X	0.000000		0	88.09
91.00	09100	EMERGENCY	0.305676	3,020,090	923,169	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.383701	352,480	135,247	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		62,942,506	11,957,182	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)		62,942,506		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 26-0025 Component CCN: 26-T025	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3 Date/Time Prepared: 4/28/2021 2:10 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		1,909,800		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.086505	16,736	1,448	50.00
51.00	05100 RECOVERY ROOM	0.466099	1,535	715	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.283750	1	1	52.00
53.00	05300 ANESTHESIOLOGY	0.026527	1,140	30	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.333256	49,058	16,349	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.473071	14,199	6,717	55.00
56.00	05600 RADIOISOTOPE	0.230230	0	0	56.00
57.00	05700 CT SCAN	0.045942	44,596	2,049	57.00
58.00	05800 MRI	0.139000	17,404	2,419	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.178952	822	147	59.00
60.00	06000 LABORATORY	0.160629	285,047	45,787	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.443854	12,277	5,449	62.00
64.00	06400 INTRAVENOUS THERAPY	0.703480	18	13	64.00
65.00	06500 RESPIRATORY THERAPY	0.380184	226,795	86,224	65.00
66.00	06600 PHYSICAL THERAPY	0.811265	848,233	688,142	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.405828	802,885	325,833	67.00
68.00	06800 SPEECH PATHOLOGY	0.351371	82,117	28,854	68.00
69.00	06900 ELECTROCARDIOLOGY	0.057569	10,560	608	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.519692	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.161288	197,040	31,780	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.567725	708	402	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.188459	230,362	43,414	73.00
74.00	07400 RENAL DIALYSIS	1.385122	10,842	15,017	74.00
76.00	03950 DIABETES CENTER	5.588563	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.812883	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	57.371101	0	0	76.98
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08804 RURAL HEALTH CLINIC V	0.000000		0	88.04
88.05	08805 RURAL HEALTH CLINIC VI	0.000000		0	88.05
88.06	08806 RURAL HEALTH CLINIC VII	0.000000		0	88.06
88.07	08807 RURAL HEALTH CLINIC VIII	0.000000		0	88.07
88.08	08808 RURAL HEALTH CLINIC IX	0.000000		0	88.08
88.09	08809 RURAL HEALTH CLINIC X	0.000000		0	88.09
91.00	09100 EMERGENCY	0.305676	3,600	1,100	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.383701	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,855,975	1,302,498	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		2,855,975		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 26-0025	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3 Date/Time Prepared: 4/28/2021 2:10 pm	
			Title XIX	Hospital	Cost	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		1,231,310		30.00
31.00	03100	INTENSIVE CARE UNIT		112,633		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		23,104		43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.086505	94,065	8,137	50.00
51.00	05100	RECOVERY ROOM	0.466099	61,479	28,655	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.283750	13,105	16,824	52.00
53.00	05300	ANESTHESIOLOGY	0.026527	175,670	4,660	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.333256	342,518	114,146	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.473071	2,290	1,083	55.00
56.00	05600	RADIOISOTOPE	0.230230	38,001	8,749	56.00
57.00	05700	CT SCAN	0.045942	575,908	26,458	57.00
58.00	05800	MRI	0.139000	44,069	6,126	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.178952	380,681	68,124	59.00
60.00	06000	LABORATORY	0.159365	1,019,242	162,432	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.443854	19,545	8,675	62.00
64.00	06400	INTRAVENOUS THERAPY	0.703480	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.380184	298,921	113,645	65.00
66.00	06600	PHYSICAL THERAPY	0.811265	35,464	28,771	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.405828	12,355	5,014	67.00
68.00	06800	SPEECH PATHOLOGY	0.351371	10,041	3,528	68.00
69.00	06900	ELECTROCARDIOLOGY	0.057569	76,015	4,376	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.519692	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.161288	1,241,490	200,237	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.567725	17,346	9,848	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.188459	2,192,650	413,225	73.00
74.00	07400	RENAL DIALYSIS	1.385122	0	0	74.00
76.00	03950	DIABETES CENTER	5.588563	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.812883	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	57.371101	0	0	76.98
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1.123105	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.413443	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1.483429	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	3.304213	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	1.117012	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	1.143127	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0.888472	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0.651031	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	1.765497	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC X	1.440710	0	0	88.09
91.00	09100	EMERGENCY	0.305676	577,333	176,477	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.383701	73,432	28,176	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,301,620	1,437,366	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00		Net charges (line 200 minus line 201)		7,301,620	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020Worksheet E
Part A
Date/Time Prepared:
4/28/2021 2:10 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)			14,568,322	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)				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
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)			258,367	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			0	2.04
3.00	Managed Care Simulated Payments			255,499	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			83.76	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)			5.30	30.00
31.00	Percentage of Medicaid patient days (see instructions)			15.02	31.00
32.00	Sum of lines 30 and 31			20.32	32.00
33.00	Allowable disproportionate share percentage (see instructions)			5.98	33.00
34.00	Disproportionate share adjustment (see instructions)			217,797	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0025	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part A Date/Time Prepared: 4/28/2021 2:10 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	8,350,599,096	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000134462		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	1,122,838	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	1,122,838	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,122,838		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges, excluding 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 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		16,167,324		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		18,782,639		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			18,782,639	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			1,150,936	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			5,038	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 instructions)			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)			19,938,613	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			19,938,613	61.00
62.00	Deductibles billed to program beneficiaries			1,770,384	62.00
63.00	Coinsurance billed to program beneficiaries			38,786	63.00
64.00	Allowable bad debts (see instructions)			631,900	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			410,735	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			469,275	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			18,540,178	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)			27,104	70.93
70.94	HRR adjustment amount (see instructions)			-75,782	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0025	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part A Date/Time Prepared: 4/28/2021 2:10 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		18,491,500	71.00
71.01	Sequestration adjustment (see instructions)		214,501	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		18,571,614	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-294,615	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
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
Comparison 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 10/01/2019 To 09/30/2020	Worksheet E Part B Date/Time Prepared: 4/28/2021 2:10 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,471	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		16,345,229	2.00
3.00	OPPS payments		14,724,592	3.00
4.00	Outlier payment (see instructions)		230,411	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.882	5.00
6.00	Line 2 times line 5		14,416,492	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)		2,471	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		2,636	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		2,636	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		2,636	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		165	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)		2,471	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)		14,955,003	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		429	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,421,847	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)		12,535,198	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)		12,535,198	30.00
31.00	Primary payer payments		423	31.00
32.00	Subtotal (line 30 minus line 31)		12,534,775	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)		231,184	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		150,270	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		111,848	36.00
37.00	Subtotal (see instructions)		12,685,045	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-166	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		12,685,211	40.00
40.01	Sequestration adjustment (see instructions)		147,148	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		12,537,956	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		107	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
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 10/01/2019
To 09/30/2020Worksheet E-1
Part I
Date/Time Prepared:
4/28/2021 2:10 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		18,571,614		12,537,956	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)		18,571,614		12,537,956	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		107	6.01
6.02	SETTLEMENT TO PROGRAM		294,615		0	6.02
7.00	Total Medicare program liability (see instructions)		18,276,999		12,538,063	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

Period:

Worksheet E-1

Component CCN: 26-T025

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
4/28/2021 2:10 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				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		4,004,045		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)		4,004,045		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		2,426		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,006,471		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 10/01/2019 To 09/30/2020	Worksheet E-1 Part II Date/Time Prepared: 4/28/2021 2:10 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 10/01/2019 To 09/30/2020	Worksheet E-3 Part III Date/Time Prepared: 4/28/2021 2:10 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
	PART III - MEDICARE PART A SERVICES - IRF PPS			
1.00	Net Federal PPS Payment (see instructions)			3,625,573 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0301 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			34,443 3.00
4.00	Outlier Payments			440,798 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)			7.677596 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)			4,100,814 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)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			4,100,814 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			4,100,814 19.00
20.00	Deductibles			19,580 20.00
21.00	Subtotal (line 19 minus line 20)			4,081,234 21.00
22.00	Coinurance			27,742 22.00
23.00	Subtotal (line 21 minus line 22)			4,053,492 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)			4,053,492 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)			4,053,492 32.00
32.01	Sequestration adjustment (see instructions)			47,021 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			4,004,045 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)			2,426 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			440,798 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0025	Period: From 10/01/2019 To 09/30/2020	Worksheet E-3 Part VII Date/Time Prepared: 4/28/2021 2:10 pm
		Title XIX	Hospital	Cost
			Inpatient	Outpatient
			1.00	2.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	3,205,756		1.00
2.00	Medical and other services		2,634,245	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	3,205,756	2,634,245	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	3,205,756	2,634,245	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	1,367,047		8.00
9.00	Ancillary service charges	7,301,620	13,129,496	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	8,668,667	13,129,496	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	8,668,667	13,129,496	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	5,462,911	10,495,251	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	3,205,756	2,634,245	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	3,205,756	2,634,245	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	3,205,756	2,634,245	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	3,205,756	2,634,245	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	3,205,756	2,634,245	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	3,205,756	2,634,245	40.00
41.00	Interim payments	3,205,756	2,634,245	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0025 Component CCN: 26-T025	Period: From 10/01/2019 To 09/30/2020	Worksheet E-3 Part VII Date/Time Prepared: 4/28/2021 2:10 pm
		Title XIX	Subprovider - IRF	Cost
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020

Worksheet G

Date/Time Prepared:
4/28/2021 2:10 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	23,428,149	0	0	0	1.00
2.00 Temporary investments	1,659,175	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	23,439,551	0	0	0	4.00
5.00 Other receivable	1,623,121	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	4,833,104	0	0	0	7.00
8.00 Prepaid expenses	1,846,399	0	0	0	8.00
9.00 Other current assets	8,383,703	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)	65,213,202	0	0	0	11.00
FIXED ASSETS					
12.00 Land	3,712,256	0	0	0	12.00
13.00 Land improvements	10,075,739	0	0	0	13.00
14.00 Accumulated depreciation	-7,062,976	0	0	0	14.00
15.00 Buildings	86,740,371	0	0	0	15.00
16.00 Accumulated depreciation	-42,897,578	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	25,507,462	0	0	0	19.00
20.00 Accumulated depreciation	-6,105,530	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	79,148,968	0	0	0	23.00
24.00 Accumulated depreciation	-60,180,528	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	925,158	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	89,863,342	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	57,354,443	0	0	0	31.00
32.00 Deposits on leases	0	0	0	0	32.00
33.00 Due from owners/officers	0	0	0	0	33.00
34.00 Other assets	3,995,330	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	61,349,773	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	216,426,317	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	7,998,312	0	0	0	37.00
38.00 Salaries, wages, and fees payable	12,921,678	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	2,684,859	0	0	0	40.00
41.00 Deferred income	7,392,631	0	0	0	41.00
42.00 Accelerated payments	19,397,237	0	0	0	42.00
43.00 Due to other funds	1,822,747	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)	52,217,464	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	42,950,622	0	0	0	47.00
48.00 Unsecured loans	1,378,791	0	0	0	48.00
49.00 Other long term liabilities	2,187,109	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	46,516,522	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	98,733,986	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	117,692,331	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	117,692,331	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	216,426,317	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020

Worksheet G-1

Date/Time Prepared:
4/28/2021 2:10 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		121,465,224		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-3,542,128				2.00
3.00	Total (sum of line 1 and line 2)		117,923,096		0		3.00
4.00	FOUNDATION NET INCOME	308,806		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		308,806		0		10.00
11.00	Subtotal (line 3 plus line 10)		118,231,902		0		11.00
12.00	CHANGE IN NET ASSETS	539,571		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)		539,571		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		117,692,331		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			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	CHANGE IN NET ASSETS		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 10/01/2019
To 09/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
4/28/2021 2:10 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	8,914,072		8,914,072	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	2,503,372		2,503,372	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)	11,417,444		11,417,444	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	1,642,106		1,642,106	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)	1,642,106		1,642,106	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	13,059,550		13,059,550	17.00
18.00	Ancillary services	135,985,302	236,821,999	372,807,301	18.00
19.00	Outpatient services	6,887,998	21,745,593	28,633,591	19.00
20.00	RURAL HEALTH CLINIC	0	1,070,403	1,070,403	20.00
20.01	RURAL HEALTH CLINIC II	0	507,545	507,545	20.01
20.02	RURAL HEALTH CLINIC III	0	767,206	767,206	20.02
20.03	RURAL HEALTH CLINIC IV	0	966,363	966,363	20.03
20.04	RURAL HEALTH CLINIC V	0	1,711,974	1,711,974	20.04
20.05	RURAL HEALTH CLINIC VI	0	243,183	243,183	20.05
20.06	RURAL HEALTH CLINIC VII	0	506,562	506,562	20.06
20.07	RURAL HEALTH CLINIC VIII	0	531,767	531,767	20.07
20.08	RURAL HEALTH CLINIC IX	0	4,935,792	4,935,792	20.08
20.09	RURAL HEALTH CLINIC X	0	511,280	511,280	20.09
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,365,943	2,365,943	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	2,090,739	7,841,558	9,932,297	27.00
27.01	PHYSICIAN REVENUE - NRCC	1,559,636	38,146,420	39,706,056	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	159,583,225	318,673,588	478,256,813	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		183,179,823		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)		183,179,823		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 26-0025

Period:
From 10/01/2019
To 09/30/2020

Worksheet G-3

Date/Time Prepared:
4/28/2021 2:10 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	478,256,813	1.00
2.00	Less contractual allowances and discounts on patients' accounts	307,499,012	2.00
3.00	Net patient revenues (line 1 minus line 2)	170,757,801	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	183,179,823	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-12,422,022	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	984,431	6.00
7.00	Income from investments	2,015,222	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	704,955	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	25,139	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	474,167	22.00
23.00	Governmental appropriations	0	23.00
24.00	DAYCARE INCOME	743,148	24.00
24.01	MISCELLANEOUS INCOME	700,988	24.01
24.02	TRANSFER FROM FOUNDATION	967,750	24.02
24.50	COVID-19 PHE Funding	3,121,336	24.50
25.00	Total other income (sum of lines 6-24)	9,737,136	25.00
26.00	Total (line 5 plus line 25)	-2,684,886	26.00
27.00	LOSS ON SALE OF ASSETS	4,224	27.00
27.01	UNREALIZED LOSS ON INVESTMENTS	692,104	27.01
27.02	NET ASSETS RELEASED FROM RESTRICTION	160,914	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	857,242	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-3,542,128	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 26-0025

Period: From 10/01/2019 To 09/30/2020

Worksheet H

HHA CCN: 26-7282

Date/Time Prepared: 4/28/2021 2:10 pm

Home Health Agency I

PPS

	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	1,212	1,212	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	207,430	23,430	0	44,696	96,163	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	708,618	80,043	0	3,242	791,903	6.00
7.00	Physical Therapy	270,734	30,581	0	0	301,315	7.00
8.00	Occupational Therapy	27,878	3,149	0	0	31,027	8.00
9.00	Speech Pathology	127,883	14,445	0	6,443	148,771	9.00
10.00	Medical Social Services	36,598	4,134	0	0	40,732	10.00
11.00	Home Health Aide	18,961	2,142	0	0	21,103	11.00
12.00	Supplies (see instructions)	0	0	0	22,922	22,922	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,398,102	157,924	0	51,139	1,733,704	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	371,719	0	371,719		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	791,903	0	791,903		6.00
7.00	Physical Therapy	0	301,315	0	301,315		7.00
8.00	Occupational Therapy	0	31,027	0	31,027		8.00
9.00	Speech Pathology	0	148,771	0	148,771		9.00
10.00	Medical Social Services	0	40,732	0	40,732		10.00
11.00	Home Health Aide	0	21,103	0	21,103		11.00
12.00	Supplies (see instructions)	0	22,922	0	22,922		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	1,733,704	0	1,733,704		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

Period:

Worksheet H-1

HHA CCN: 26-7282

From 10/01/2019

Part I

To 09/30/2020

Date/Time Prepared:

					Home Health Agency I		4/28/2021 2:10 pm PPS	
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation		
			Bldgs & Fixtures	Movable Equipment			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	0	4.00
5.00	Administrative and General	371,719	3,000	0	1,212	0	375,931	5.00
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	791,903	0	0	0	0	791,903	6.00
7.00	Physical Therapy	301,315	0	0	0	0	301,315	7.00
8.00	Occupational Therapy	31,027	0	0	0	0	31,027	8.00
9.00	Speech Pathology	148,771	0	0	0	0	148,771	9.00
10.00	Medical Social Services	40,732	0	0	0	0	40,732	10.00
11.00	Home Health Aide	21,103	0	0	0	0	21,103	11.00
12.00	Supplies (see instructions)	22,922	0	0	0	0	22,922	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)	1,733,704	3,000	0	1,212	0	1,733,704	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	375,931						5.00
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	219,256	1,011,159					6.00
7.00	Physical Therapy	83,426	384,741					7.00
8.00	Occupational Therapy	8,591	39,618					8.00
9.00	Speech Pathology	41,191	189,962					9.00
10.00	Medical Social Services	11,278	52,010					10.00
11.00	Home Health Aide	5,843	26,946					11.00
12.00	Supplies (see instructions)	6,346	29,268					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)		1,733,704					24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 26-0025

Period:

Worksheet H-1

HHA CCN: 26-7282

From 10/01/2019
To 09/30/2020Part II
Date/Time Prepared:
4/28/2021 2:10 pmHome Health
Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00	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	-375,931	1,357,773 5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	791,903	6.00
7.00	Physical Therapy	0	0	0	0	301,315	7.00
8.00	Occupational Therapy	0	0	0	0	31,027	8.00
9.00	Speech Pathology	0	0	0	0	148,771	9.00
10.00	Medical Social Services	0	0	0	0	40,732	10.00
11.00	Home Health Aide	0	0	0	0	21,103	11.00
12.00	Supplies (see instructions)	0	0	0	0	22,922	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	3,000	0	3,000	0	-375,931	1,357,773 24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	3,000	0	1,212	0		375,931 25.00
26.00	Unit Cost Multiplier	1.000000	0.000000	0.404000	0.000000		0.276873 26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 26-0025

Period:

Worksheet H-2

HHA CCN: 26-7282

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
4/28/2021 2:10 pmHome Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			BLDG & FIXT	MVBLE EQUIP				
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	31,090	5,191	44,614	80,895	22,071	1.00
2.00	Skilled Nursing Care	1,011,159	0	0	152,411	1,163,570	317,469	2.00
3.00	Physical Therapy	384,741	0	0	58,229	442,970	120,859	3.00
4.00	Occupational Therapy	39,618	0	0	5,996	45,614	12,445	4.00
5.00	Speech Pathology	189,962	0	0	27,505	217,467	59,333	5.00
6.00	Medical Social Services	52,010	0	0	7,871	59,881	16,338	6.00
7.00	Home Health Aide	26,946	0	0	4,078	31,024	8,465	7.00
8.00	Supplies (see instructions)	29,268	0	0	0	29,268	7,985	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)	1,733,704	31,090	5,191	300,704	2,070,689	564,965	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	7,476	53,353	0	17,039	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)	7,476	53,353	0	17,039	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

Period:

Worksheet H-2

HHA CCN: 26-7282

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
4/28/2021 2:10 pmHome Health
Agency I

PPS

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	230,707	0	0	0	411,541	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	1,481,039	0	2.00
3.00	Physical Therapy	0	0	0	0	563,829	0	3.00
4.00	Occupational Therapy	0	0	0	0	58,059	0	4.00
5.00	Speech Pathology	0	0	0	0	276,800	0	5.00
6.00	Medical Social Services	0	0	0	0	76,219	0	6.00
7.00	Home Health Aide	0	0	0	0	39,489	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	37,253	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)	230,707	0	0	0	2,944,229	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	411,541						1.00
2.00	Skilled Nursing Care	1,481,039	240,656	1,721,695				2.00
3.00	Physical Therapy	563,829	91,618	655,447				3.00
4.00	Occupational Therapy	58,059	9,434	67,493				4.00
5.00	Speech Pathology	276,800	44,978	321,778				5.00
6.00	Medical Social Services	76,219	12,385	88,604				6.00
7.00	Home Health Aide	39,489	6,417	45,906				7.00
8.00	Supplies (see instructions)	37,253	6,053	43,306				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)	2,944,229	411,541	2,944,229				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.		0.162492					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

Period:

Worksheet H-2

HHA CCN: 26-7282

From 10/01/2019

Part II

To 09/30/2020

Date/Time Prepared: 4/28/2021 2:10 pm

Home Health
Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	3,000	5,102	207,430	0	80,895	3,000	1.00
2.00	Skilled Nursing Care	0	0	708,618	0	1,163,570	0	2.00
3.00	Physical Therapy	0	0	270,734	0	442,970	0	3.00
4.00	Occupational Therapy	0	0	27,878	0	45,614	0	4.00
5.00	Speech Pathology	0	0	127,883	0	217,467	0	5.00
6.00	Medical Social Services	0	0	36,598	0	59,881	0	6.00
7.00	Home Health Aide	0	0	18,961	0	31,024	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	29,268	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	5,102	1,398,102		2,070,689	3,000	20.00
21.00	Total cost to be allocated	31,090	5,191	300,704		564,965	7,476	21.00
22.00	Unit cost multiplier	10.363333	1.017444	0.215080		0.272839	2.492000	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	40,341	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	40,341	20.00
21.00	Total cost to be allocated	53,353	0	17,039	0	0	230,707	21.00
22.00	Unit cost multiplier	17.784333	0.000000	5.679667	0.000000	0.000000	5.718921	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 26-0025

Period:

Worksheet H-2

HHA CCN: 26-7282

From 10/01/2019
To 09/30/2020Part II
Date/Time Prepared:
4/28/2021 2:10 pmHome Health
Agency I

PPS

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

Period:

Worksheet H-3

HHA CCN: 26-7282

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
4/28/2021 2:10 pm

				Title XVIII		Home Health Agency I	PPS		
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)		
		0	1.00	2.00	3.00	4.00	5.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	2.00	1,721,695		1,721,695	6,071	283.59	1.00	
2.00	Physical Therapy	3.00	655,447	0	655,447	2,894	226.48	2.00	
3.00	Occupational Therapy	4.00	67,493	0	67,493	298	226.49	3.00	
4.00	Speech Pathology	5.00	321,778	0	321,778	1,367	235.39	4.00	
5.00	Medical Social Services	6.00	88,604		88,604	18	4,922.44	5.00	
6.00	Home Health Aide	7.00	45,906		45,906	675	68.01	6.00	
7.00	Total (sum of lines 1-6)		2,900,923	0	2,900,923	11,323		7.00	
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits				
					Part B				
						Not Subject to Deductibles & Coinsurance	Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00		
Limitation Cost Computation									
8.00	Skilled Nursing Care		99914	0	355			8.00	
8.01	Skilled Nursing Care		99926	0	2,681			8.01	
9.00	Physical Therapy		99914	0	250			9.00	
9.01	Physical Therapy		99926	0	1,602			9.01	
10.00	Occupational Therapy		99914	0	59			10.00	
10.01	Occupational Therapy		99926	0	951			10.01	
11.00	Speech Pathology		99914	0	0			11.00	
11.01	Speech Pathology		99926	0	200			11.01	
12.00	Medical Social Services		99914	0	0			12.00	
12.01	Medical Social Services		99926	0	7			12.01	
13.00	Home Health Aide		99914	0	39			13.00	
13.01	Home Health Aide		99926	0	427			13.01	
14.00	Total (sum of lines 8-13)			0	6,571			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	43,306	3,473	46,779	28,293	1.653377	15.00	
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00	
Cost Center Description		Program Visits			Cost of Services				
		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
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	3,036		0	860,979		1.00	
2.00	Physical Therapy	0	1,852		0	419,441		2.00	
3.00	Occupational Therapy	0	1,010		0	228,755		3.00	
4.00	Speech Pathology	0	200		0	47,078		4.00	
5.00	Medical Social Services	0	7		0	34,457		5.00	
6.00	Home Health Aide	0	466		0	31,693		6.00	
7.00	Total (sum of lines 1-6)	0	6,571		0	1,622,403		7.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 26-0025

Period:

Worksheet H-3

HHA CCN: 26-7282

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
4/28/2021 2:10 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description						Agency 1			
		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 A	Part B		Part A	Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
			6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	28,293	0	0	46,779	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	860,979							1.00
2.00	Physical Therapy	419,441							2.00
3.00	Occupational Therapy	228,755							3.00
4.00	Speech Pathology	47,078							4.00
5.00	Medical Social Services	34,457							5.00
6.00	Home Health Aide	31,693							6.00
7.00	Total (sum of lines 1-6)	1,622,403							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

Period:

Worksheet H-3

HHA CCN: 26-7282

From 10/01/2019
To 09/30/2020Part II
Date/Time Prepared:
4/28/2021 2:10 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	0.811265	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.405828	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.351371	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.161288	21,532	3,473	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.188459	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0025 HHA CCN: 26-7282	Period: From 10/01/2019 To 09/30/2020	Worksheet H-4 Part I-II Date/Time Prepared: 4/28/2021 2:10 pm	
		Title XVIII	Home Health Agency I	PPS	
		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	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	882,387	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes		0	19,061	13.00
14.00	Total PPS Reimbursement - PEP Episodes		0	1,452	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	183,472	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0	16.00
17.00	Total Other Payments		0	0	17.00
18.00	DME Payments		0	0	18.00
19.00	Oxygen Payments		0	0	19.00
20.00	Prosthetic and Orthotic Payments		0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	1,086,372	22.00
23.00	Excess reasonable cost (from line 8)		0	0	23.00
24.00	Subtotal (line 22 minus line 23)		0	1,086,372	24.00
25.00	Coinsurance billed to program patients (from your records)		0	0	25.00
26.00	Net cost (line 24 minus line 25)		0	1,086,372	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	1,086,372	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	1,086,372	31.00
31.01	Sequestration adjustment (see instructions)		0	21,530	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	0	31.02
32.00	Interim payments (see instructions)		0	1,064,842	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

Period:

Worksheet H-5

HHA CCN: 26-7282

From 10/01/2019

Date/Time Prepared:

To 09/30/2020

4/28/2021 2:10 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			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		1,064,842	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		1,064,842	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		1,064,842	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 10/01/2019 To 09/30/2020	Worksheet L Parts I-III Date/Time Prepared: 4/28/2021 2:10 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,143,026	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		7,910	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		38.77	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)		1,150,936	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

Period:

Worksheet M-1

Component CCN: 26-8512

From 10/01/2019

Date/Time Prepared:

To 09/30/2020

4/28/2021 2:10 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	249,788	0	249,788	-338	249,450
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	81,173	0	81,173	-71	81,102
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	162,669	0	162,669	0	162,669
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	493,630	0	493,630	-409	493,221
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	12,777	12,777	0	12,777
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	12,777	12,777	0	12,777
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	493,630	12,777	506,407	-409	505,998
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	14,698	14,698	0	14,698
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	409	409
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	14,698	14,698	409	15,107
FACILITY OVERHEAD						
29.00	Facility Costs	0	23,999	23,999	0	23,999
30.00	Administrative Costs	127,968	133,779	261,747	0	261,747
31.00	Total Facility Overhead (sum of lines 29 and 30)	127,968	157,778	285,746	0	285,746
32.00	Total facility costs (sum of lines 22, 28 and 31)	621,598	185,253	806,851	0	806,851

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8512

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 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	249,450	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	81,102	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	162,669	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	493,221	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	12,777	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	12,777	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	505,998	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	14,698	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	409	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	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	15,107	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	23,999	29.00
30.00	Administrative Costs	0	261,747	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	285,746	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	806,851	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-3984

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 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	0	0	0	0	0
2.00 Physician Assistant	0	0	0	0	0
3.00 Nurse Practitioner	142,554	0	142,554	-77	142,477
4.00 Visiting Nurse	0	0	0	0	0
5.00 Other Nurse	57,428	0	57,428	0	57,428
6.00 Clinical Psychologist	0	0	0	0	0
7.00 Clinical Social Worker	0	0	0	0	0
8.00 Laboratory Technician	0	0	0	0	0
9.00 Other Facility Health Care Staff Costs	0	0	0	0	0
10.00 Subtotal (sum of lines 1 through 9)	199,982	0	199,982	-77	199,905
11.00 Physician Services Under Agreement	0	0	0	0	0
12.00 Physician Supervision Under Agreement	0	0	0	0	0
13.00 Other Costs Under Agreement	0	0	0	0	0
14.00 Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00 Medical Supplies	0	9,108	9,108	0	9,108
16.00 Transportation (Health Care Staff)	0	0	0	0	0
17.00 Depreciation-Medical Equipment	0	0	0	0	0
18.00 Professional Liability Insurance	0	0	0	0	0
19.00 Other Health Care Costs	0	0	0	0	0
20.00 Allowable GME Costs	0	0	0	0	0
21.00 Subtotal (sum of lines 15 through 20)	0	9,108	9,108	0	9,108
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	199,982	9,108	209,090	-77	209,013
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00 Pharmacy	0	11,376	11,376	0	11,376
24.00 Dental	0	0	0	0	0
25.00 Optometry	0	0	0	0	0
25.01 Telehealth	0	0	0	77	77
25.02 Chronic Care Management	0	0	0	0	0
26.00 All other nonreimbursable costs	0	0	0	0	0
27.00 Nonallowable GME costs	0	0	0	0	0
28.00 Total Nonreimbursable Costs (sum of lines 23 through 27)	0	11,376	11,376	77	11,453
FACILITY OVERHEAD					
29.00 Facility Costs	0	70,541	70,541	0	70,541
30.00 Administrative Costs	63,529	102,478	166,007	30,348	196,355
31.00 Total Facility Overhead (sum of lines 29 and 30)	63,529	173,019	236,548	30,348	266,896
32.00 Total facility costs (sum of lines 22, 28 and 31)	263,511	193,503	457,014	30,348	487,362

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-3984

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 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	0	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	142,477	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	57,428	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	199,905	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	9,108	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	9,108	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	209,013	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	11,376	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	77	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	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	11,453	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	70,541	29.00
30.00	Administrative Costs	0	196,355	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	266,896	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	487,362	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8513

From 10/01/2019

Date/Time Prepared:

To 09/30/2020

4/28/2021 2:10 pm

				RHC III		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	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	97,339	0	97,339	19,201	116,540	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	119,877	0	119,877	-207	119,670	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	90,326	0	90,326	0	90,326	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)	307,542	0	307,542	18,994	326,536	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	10,059	10,059	0	10,059	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	10,059	10,059	0	10,059	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	307,542	10,059	317,601	18,994	336,595	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	21,670	21,670	0	21,670	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	3,988	3,988	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	21,670	21,670	3,988	25,658	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	6,703	6,703	0	6,703	29.00
30.00	Administrative Costs	130,994	118,158	249,152	0	249,152	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	130,994	124,861	255,855	0	255,855	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	438,536	156,590	595,126	22,982	618,108	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8513

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 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	116,540	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	119,670	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	90,326	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	326,536	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	10,059	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	10,059	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	336,595	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	21,670	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	3,988	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	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	25,658	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	6,703	29.00
30.00	Administrative Costs	0	249,152	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	255,855	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	618,108	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8723

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 pm

				RHC IV		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	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	771,449	771,449	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	409,030	409,030	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	361,337	361,337	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)	0	0	0	1,541,816	1,541,816	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	9,964	9,964	0	9,964	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	9,964	9,964	0	9,964	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	9,964	9,964	1,541,816	1,551,780	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	16,893	16,893	0	16,893	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	1,070	1,070	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	16,893	16,893	1,070	17,963	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	61,132	61,132	0	61,132	29.00
30.00	Administrative Costs	45,034	94,874	139,908	352,510	492,418	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	45,034	156,006	201,040	352,510	553,550	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	45,034	182,863	227,897	1,895,396	2,123,293	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8723

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 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	771,449	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	409,030	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	361,337	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	1,541,816	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	9,964	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	9,964	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,551,780	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	16,893	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	1,070	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	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	17,963	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	61,132	29.00
30.00	Administrative Costs	0	492,418	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	553,550	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,123,293	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8724

From 10/01/2019

Date/Time Prepared:

To 09/30/2020

4/28/2021 2:10 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	1,101,959	0	1,101,959	-839,416	262,543
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	584,965	0	584,965	-409,477	175,488
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	412,765	0	412,765	-361,337	51,428
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	2,099,689	0	2,099,689	-1,610,230	489,459
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	62,679	62,679	0	62,679
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	62,679	62,679	0	62,679
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,099,689	62,679	2,162,368	-1,610,230	552,138
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	67,872	67,872	0	67,872
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	1,502	1,502
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	67,872	67,872	1,502	69,374
FACILITY OVERHEAD						
29.00	Facility Costs	0	293,861	293,861	0	293,861
30.00	Administrative Costs	314,640	397,344	711,984	-315,486	396,498
31.00	Total Facility Overhead (sum of lines 29 and 30)	314,640	691,205	1,005,845	-315,486	690,359
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,414,329	821,756	3,236,085	-1,924,214	1,311,871

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8724

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 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	262,543	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	175,488	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	51,428	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	489,459	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	62,679	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	62,679	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	552,138	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	67,872	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	1,502	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	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	69,374	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	293,861	29.00
30.00	Administrative Costs	0	396,498	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	690,359	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,311,871	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8756

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 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	41,804	0	41,804	0	41,804
2.00 Physician Assistant	0	0	0	0	0
3.00 Nurse Practitioner	69,865	0	69,865	0	69,865
4.00 Visiting Nurse	0	0	0	0	0
5.00 Other Nurse	31,019	0	31,019	0	31,019
6.00 Clinical Psychologist	0	0	0	0	0
7.00 Clinical Social Worker	0	0	0	0	0
8.00 Laboratory Technician	0	0	0	0	0
9.00 Other Facility Health Care Staff Costs	0	0	0	0	0
10.00 Subtotal (sum of lines 1 through 9)	142,688	0	142,688	0	142,688
11.00 Physician Services Under Agreement	0	0	0	0	0
12.00 Physician Supervision Under Agreement	0	0	0	0	0
13.00 Other Costs Under Agreement	0	0	0	0	0
14.00 Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00 Medical Supplies	0	3,401	3,401	0	3,401
16.00 Transportation (Health Care Staff)	0	0	0	0	0
17.00 Depreciation-Medical Equipment	0	0	0	0	0
18.00 Professional Liability Insurance	0	0	0	0	0
19.00 Other Health Care Costs	0	0	0	0	0
20.00 Allowable GME Costs	0	0	0	0	0
21.00 Subtotal (sum of lines 15 through 20)	0	3,401	3,401	0	3,401
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	142,688	3,401	146,089	0	146,089
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00 Pharmacy	0	319	319	0	319
24.00 Dental	0	0	0	0	0
25.00 Optometry	0	0	0	0	0
25.01 Telehealth	0	0	0	0	0
25.02 Chronic Care Management	0	0	0	0	0
26.00 All other nonreimbursable costs	0	0	0	0	0
27.00 Nonallowable GME costs	0	0	0	0	0
28.00 Total Nonreimbursable Costs (sum of lines 23 through 27)	0	319	319	0	319
FACILITY OVERHEAD					
29.00 Facility Costs	0	13,691	13,691	0	13,691
30.00 Administrative Costs	236	27,326	27,562	0	27,562
31.00 Total Facility Overhead (sum of lines 29 and 30)	236	41,017	41,253	0	41,253
32.00 Total facility costs (sum of lines 22, 28 and 31)	142,924	44,737	187,661	0	187,661

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8756

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 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	41,804		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	69,865		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	31,019		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	142,688		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	3,401		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	3,401		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	146,089		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	319		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	319		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	13,691		29.00
30.00	Administrative Costs	0	27,562		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	41,253		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	187,661		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8757

From 10/01/2019

Date/Time Prepared:

To 09/30/2020

4/28/2021 2:10 pm

				RHC VII		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	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	47,343	0	47,343	0	47,343	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	95,537	0	95,537	0	95,537	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	82,166	0	82,166	0	82,166	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)	225,046	0	225,046	0	225,046	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	5,137	5,137	0	5,137	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	5,137	5,137	0	5,137	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	225,046	5,137	230,183	0	230,183	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	709	709	0	709	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	709	709	0	709	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	30,640	30,640	0	30,640	29.00
30.00	Administrative Costs	0	43,657	43,657	0	43,657	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	74,297	74,297	0	74,297	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	225,046	80,143	305,189	0	305,189	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8757

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC VII	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	47,343		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	95,537		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	82,166		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	225,046		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	5,137		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	5,137		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	230,183		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	709		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	709		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	30,640		29.00
30.00	Administrative Costs	0	43,657		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	74,297		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	305,189		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8758

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 pm

				RHC VIII		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	20,045	0	20,045	0	20,045	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	92,306	0	92,306	0	92,306	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	71,294	0	71,294	0	71,294	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)	183,645	0	183,645	0	183,645	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	350	350	0	350	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	350	350	0	350	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	183,645	350	183,995	0	183,995	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
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	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	2,123	2,123	0	2,123	29.00
30.00	Administrative Costs	0	22,968	22,968	0	22,968	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	25,091	25,091	0	25,091	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	183,645	25,441	209,086	0	209,086	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8758

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 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	20,045	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	92,306	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	71,294	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	183,645	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	350	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	350	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	183,995	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	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	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	2,123	29.00
30.00	Administrative Costs	0	22,968	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	25,091	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	209,086	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8754

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 pm

		RHC IX		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	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	2,869,659	0	2,869,659	42,733	2,912,392
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	286,939	0	286,939	-11,554	275,385
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	631,550	0	631,550	0	631,550
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	3,788,148	0	3,788,148	31,179	3,819,327
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	70,813	70,813	0	70,813
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	70,813	70,813	0	70,813
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,788,148	70,813	3,858,961	31,179	3,890,140
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	416,461	416,461	0	416,461
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	43,985	43,985
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	416,461	416,461	43,985	460,446
FACILITY OVERHEAD						
29.00	Facility Costs	0	1,817	1,817	0	1,817
30.00	Administrative Costs	273,383	584,881	858,264	0	858,264
31.00	Total Facility Overhead (sum of lines 29 and 30)	273,383	586,698	860,081	0	860,081
32.00	Total facility costs (sum of lines 22, 28 and 31)	4,061,531	1,073,972	5,135,503	75,164	5,210,667

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8754

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 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	2,912,392		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	275,385		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	631,550		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	3,819,327		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	70,813		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	70,813		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	3,890,140		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	416,461		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	43,985		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	460,446		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	1,817		29.00
30.00	Administrative Costs	-7,500	850,764		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-7,500	852,581		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-7,500	5,203,167		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8759

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 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	137,266	137,266
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	123,735	0	123,735	0	123,735
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	74,230	0	74,230	0	74,230
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	197,965	0	197,965	137,266	335,231
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	10,675	10,675	0	10,675
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	10,675	10,675	0	10,675
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	197,965	10,675	208,640	137,266	345,906
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	2,662	2,662	0	2,662
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	2,662	2,662	0	2,662
FACILITY OVERHEAD						
29.00	Facility Costs	0	8,890	8,890	0	8,890
30.00	Administrative Costs	69,964	53,170	123,134	0	123,134
31.00	Total Facility Overhead (sum of lines 29 and 30)	69,964	62,060	132,024	0	132,024
32.00	Total facility costs (sum of lines 22, 28 and 31)	267,929	75,397	343,326	137,266	480,592

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8759

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 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	137,266		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	123,735		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	74,230		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	335,231		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	10,675		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	10,675		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	345,906		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	2,662		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	2,662		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	8,890		29.00
30.00	Administrative Costs	0	123,134		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	132,024		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	480,592		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025

Period:

Worksheet M-2

Component CCN: 26-8512

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 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	0.94	2,539	4,200	3,948		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.74	2,364	2,100	1,554		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.68	4,903		5,502	5,502	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)	1.68	4,903			5,502	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)					505,998	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					15,107	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					521,105	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.971010	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					285,746	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					395,324	15.00
16.00	Total overhead (sum of lines 14 and 15)					681,070	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					681,070	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					661,326	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,167,324	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025

Period:

Worksheet M-2

Component CCN: 26-3984

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 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	0.00	0	4,200	0
2.00	Physician Assistant	0.00	0	2,100	0
3.00	Nurse Practitioner	1.01	2,762	2,100	2,121
4.00	Subtotal (sum of lines 1 through 3)	1.01	2,762	2,121	2,762
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	0.00	0		0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.01	2,762		2,762
9.00	Physician Services Under Agreements		0		0
					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)				209,013
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				11,453
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				220,466
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.948051
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				266,896
15.00	Parent provider overhead allocated to facility (see instructions)				230,024
16.00	Total overhead (sum of lines 14 and 15)				496,920
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				496,920
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				471,106
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				680,119

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025

Period:

Worksheet M-2

Component CCN: 26-8513

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 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	0.44	1,254	4,200	1,848		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.98	3,036	2,100	2,058		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.42	4,290		3,906	4,290	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)	1.42	4,290			4,290	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)					336,595	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					25,658	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					362,253	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.929171	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					255,855	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					519,988	15.00
16.00	Total overhead (sum of lines 14 and 15)					775,843	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					775,843	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					720,891	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,057,486	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025

Period:

Worksheet M-2

Component CCN: 26-8723

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 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	2.73	3,673	4,200	11,466		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	3.55	2,246	2,100	7,455		3.00
4.00	Subtotal (sum of lines 1 through 3)	6.28	5,919		18,921	18,921	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)	6.28	5,919			18,921	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)					1,551,780	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					17,963	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,569,743	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.988557	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					553,550	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,069,776	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,623,326	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,623,326	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,604,750	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,156,530	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025

Period:

Worksheet M-2

Component CCN: 26-8724

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 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	1.17	5,707	4,200	4,914		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.52	5,799	2,100	3,192		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.69	11,506		8,106	11,506	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)	2.69	11,506			11,506	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)					552,138	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					69,374	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					621,512	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.888379	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					690,359	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					600,425	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,290,784	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,290,784	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,146,705	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,698,843	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025

Period:

Worksheet M-2

Component CCN: 26-8756

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 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	0.17	640	4,200	714
2.00	Physician Assistant	0.00	0	2,100	0
3.00	Nurse Practitioner	0.73	483	2,100	1,533
4.00	Subtotal (sum of lines 1 through 3)	0.90	1,123	2,247	2,247
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	0.00	0		0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.90	1,123		2,247
9.00	Physician Services Under Agreements		0		0
					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)				146,089
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				319
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				146,408
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.997821
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				41,253
15.00	Parent provider overhead allocated to facility (see instructions)				90,328
16.00	Total overhead (sum of lines 14 and 15)				131,581
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				131,581
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				131,294
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				277,383

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025

Period:

Worksheet M-2

Component CCN: 26-8757

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 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	476	4,200	840
2.00	Physician Assistant	0.00	0	2,100	0
3.00	Nurse Practitioner	1.00	1,888	2,100	2,100
4.00	Subtotal (sum of lines 1 through 3)	1.20	2,364	2,940	2,940
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	0.00	0		0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.20	2,364		2,940
9.00	Physician Services Under Agreements		0		0
					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)				230,183
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				709
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				230,892
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.996929
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				74,297
15.00	Parent provider overhead allocated to facility (see instructions)				144,877
16.00	Total overhead (sum of lines 14 and 15)				219,174
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				219,174
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				218,501
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				448,684

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025

Period:

Worksheet M-2

Component CCN: 26-8758

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 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	0.08	328	4,200	336
2.00	Physician Assistant	0.00	0	2,100	0
3.00	Nurse Practitioner	0.94	2,217	2,100	1,974
4.00	Subtotal (sum of lines 1 through 3)	1.02	2,545	2,310	2,545
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	0.00	0		0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.02	2,545		2,545
9.00	Physician Services Under Agreements		0		0
					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)				183,995
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				183,995
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				25,091
15.00	Parent provider overhead allocated to facility (see instructions)				137,111
16.00	Total overhead (sum of lines 14 and 15)				162,202
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				162,202
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				162,202
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				346,197

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025

Period:

Worksheet M-2

Component CCN: 26-8754

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/28/2021 2:10 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	10.66	20,349	4,200	44,772		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	2.47	2,738	2,100	5,187		3.00
4.00	Subtotal (sum of lines 1 through 3)	13.13	23,087		49,959	49,959	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)	13.13	23,087			49,959	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)					3,890,140	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					460,446	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					4,350,586	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.894165	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					852,581	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					3,510,961	15.00
16.00	Total overhead (sum of lines 14 and 15)					4,363,542	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					4,363,542	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					3,901,727	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					7,791,867	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025

Period:

Worksheet M-2

Component CCN: 26-8759

From 10/01/2019

To 09/30/2020

Date/Time Prepared:
4/28/2021 2:10 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	1.00	3,035	2,100	2,100		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.00	3,035		2,100	3,035	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)	1.00	3,035			3,035	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)					345,906	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					2,662	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					348,568	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.992363	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					132,024	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					256,014	15.00
16.00	Total overhead (sum of lines 14 and 15)					388,038	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					388,038	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					385,075	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					730,981	20.00

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 26-0025	Period: From 10/01/2019 To 09/30/2020	Worksheet M-3		
		Component CCN: 26-8512		Date/Time Prepared: 4/28/2021 2:10 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)			1,167,324	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			38,623	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,128,701	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			5,502	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)			5,502	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			205.14	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)			0.00	86.31	8.00
9.00	Rate for Program covered visits (see instructions)			0.00	86.31	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	1,168	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	100,810	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	100,810	16.00
16.01	Total program charges (see instructions)(from contractor's records)				209,971	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				1,468	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				705	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)				59,530	16.04
16.05	Total program cost (see instructions)			0	60,235	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				25,692	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				36,535	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				60,235	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				19,171	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				79,406	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)				79,406	26.00
26.01	Sequestration adjustment (see instructions)				921	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				56,783	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)				21,702	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2				0	30.00

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 26-0025	Period: From 10/01/2019 To 09/30/2020	Worksheet M-3	
		Component CCN: 26-3984		Date/Time Prepared: 4/28/2021 2:10 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)			680,119	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			44,719	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			635,400	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,762	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)			2,762	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			230.05	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)		0.00	86.31	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	86.31	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	691	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	59,640	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	59,640	16.00
16.01	Total program charges (see instructions)(from contractor's records)			123,347	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.)			32,458	16.04
16.05	Total program cost (see instructions)		0	32,458	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			19,067	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			20,856	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			32,458	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			29,613	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			62,071	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)			62,071	26.00
26.01	Sequestration adjustment (see instructions)			720	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			30,169	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)			31,182	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 10/01/2019 To 09/30/2020	Worksheet M-3 Date/Time Prepared: 4/28/2021 2:10 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)			1,057,486	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			64,713	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			992,773	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,290	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			4,290	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			231.42	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)		0.00	86.31	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	86.31	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	1,101	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	95,027	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	95,027	16.00
16.01	Total program charges (see instructions)(from contractor's records)			184,801	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			2,318	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			1,192	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.)			57,537	16.04
16.05	Total program cost (see instructions)		0	58,729	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			21,914	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			32,114	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			58,729	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			29,273	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			88,002	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)			88,002	26.00
26.01	Sequestration adjustment (see instructions)			1,021	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			55,849	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)			31,132	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 26-0025	Period: From 10/01/2019 To 09/30/2020	Worksheet M-3	
		Component CCN: 26-8723		Date/Time Prepared: 4/28/2021 2:10 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)			3,156,530	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			38,589	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			3,117,941	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			18,921	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)			18,921	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			164.79	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)		0.00	86.31	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	86.31	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	1,364	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	117,727	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	117,727	16.00
16.01	Total program charges (see instructions)(from contractor's records)			211,574	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.)			71,583	16.04
16.05	Total program cost (see instructions)		0	71,583	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			28,248	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			36,665	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			71,583	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			26,878	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			98,461	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)			98,461	26.00
26.01	Sequestration adjustment (see instructions)			1,142	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			68,171	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)			29,148	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 26-0025	Period: From 10/01/2019 To 09/30/2020	Worksheet M-3	
		Component CCN: 26-8724		Date/Time Prepared: 4/28/2021 2:10 pm	
		Title XVIII	RHC V	Cost	
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,698,843	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			100,803	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,598,040	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			11,506	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)			11,506	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			138.89	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)		0.00	86.31	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	86.31	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	1,653	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	142,670	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	142,670	16.00
16.01	Total program charges (see instructions)(from contractor's records)			261,331	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.)			86,798	16.04
16.05	Total program cost (see instructions)		0	86,798	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			34,172	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			45,364	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			86,798	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			43,499	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			130,297	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)			130,297	26.00
26.01	Sequestration adjustment (see instructions)			1,511	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			82,857	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)			45,929	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 26-0025	Period: From 10/01/2019 To 09/30/2020	Worksheet M-3	
		Component CCN: 26-8756		Date/Time Prepared: 4/28/2021 2:10 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)			277,383	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			832	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			276,551	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,247	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)			2,247	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			123.08	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)		0.00	86.31	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	86.31	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	244	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	21,060	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	21,060	16.00
16.01	Total program charges (see instructions)(from contractor's records)			60,279	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			1,240	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			433	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.)			13,074	16.04
16.05	Total program cost (see instructions)		0	13,507	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			4,284	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			10,951	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			13,507	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			265	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			13,772	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)			13,772	26.00
26.01	Sequestration adjustment (see instructions)			160	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			12,789	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)			823	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 26-0025	Period: From 10/01/2019	Worksheet M-3	
		Component CCN: 26-8757	To 09/30/2020	Date/Time Prepared: 4/28/2021 2:10 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)			448,684	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			210	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			448,474	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,940	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)			2,940	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			152.54	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)		0.00	86.31	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	86.31	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	1,038	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	89,590	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	89,590	16.00
16.01	Total program charges (see instructions)(from contractor's records)			223,086	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			192	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			77	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.)			51,104	16.04
16.05	Total program cost (see instructions)		0	51,181	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			25,633	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			39,452	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			51,181	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			51,181	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)			51,181	26.00
26.01	Sequestration adjustment (see instructions)			594	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			47,785	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)			2,802	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 26-0025	Period: From 10/01/2019 To 09/30/2020	Worksheet M-3	
		Component CCN: 26-8758		Date/Time Prepared: 4/28/2021 2:10 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)			346,197	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			1,837	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			344,360	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,545	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)			2,545	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			135.31	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)		0.00	86.31	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	86.31	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	510	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	44,018	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	44,018	16.00
16.01	Total program charges (see instructions)(from contractor's records)			110,691	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			155	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			62	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			26,163	16.04
16.05	Total program cost (see instructions)		0	26,225	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			11,252	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			19,840	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			26,225	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			26,225	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)			26,225	26.00
26.01	Sequestration adjustment (see instructions)			304	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			24,729	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)			1,192	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 26-0025	Period: From 10/01/2019 To 09/30/2020	Worksheet M-3	
		Component CCN: 26-8754		Date/Time Prepared: 4/28/2021 2:10 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)			7,791,867	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			436,297	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			7,355,570	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			49,959	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)			49,959	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			147.23	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)		0.00	86.31	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	86.31	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	3,753	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	323,921	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	323,921	16.00
16.01	Total program charges (see instructions)(from contractor's records)			678,659	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			300	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			143	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.)			224,710	16.04
16.05	Total program cost (see instructions)		0	224,853	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			42,891	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			127,025	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			224,853	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			50,698	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			275,551	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)			275,551	26.00
26.01	Sequestration adjustment (see instructions)			3,196	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			217,344	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)			55,011	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 10/01/2019 To 09/30/2020	Worksheet M-3 Date/Time Prepared: 4/28/2021 2:10 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)			730,981	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			15,133	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			715,848	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,035	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)			3,035	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			235.86	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)		0.00	86.31	8.00
9.00	Rate for Program covered visits (see instructions)		0.00	86.31	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	239	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	20,628	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	20,628	16.00
16.01	Total program charges (see instructions)(from contractor's records)			34,170	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.)			10,334	16.04
16.05	Total program cost (see instructions)		0	10,334	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			7,711	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			5,292	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			10,334	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			5,818	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			16,152	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)			16,152	26.00
26.01	Sequestration adjustment (see instructions)			187	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			9,491	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)			6,474	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 10/01/2019 To 09/30/2020	Worksheet M-4 Date/Time Prepared: 4/28/2021 2:10 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)		493,221	493,221	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000437	0.003137	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		216	1,547	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		6,408	8,571	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		6,624	10,118	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		505,998	505,998	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		661,326	661,326	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.013091	0.019996	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		8,657	13,224	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		15,281	23,342	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		45	323	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		339.58	72.27	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		29	129	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		9,848	9,323	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			38,623	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)			19,171	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 26-0025 Component CCN: 26-3984	Period: From 10/01/2019 To 09/30/2020	Worksheet M-4 Date/Time Prepared: 4/28/2021 2:10 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)		199,905	199,905	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000621	0.003860	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		124	772	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		6,121	6,726	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		6,245	7,498	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		209,013	209,013	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		471,106	471,106	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.029879	0.035873	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		14,076	16,900	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		20,321	24,398	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		39	242	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		521.05	100.82	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		34	118	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		17,716	11,897	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)			44,719	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)			29,613	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 26-0025 Component CCN: 26-8513	Period: From 10/01/2019 To 09/30/2020	Worksheet M-4 Date/Time Prepared: 4/28/2021 2:10 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)		326,536	326,536	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000863	0.004620	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		282	1,509	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		10,456	8,351	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		10,738	9,860	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		336,595	336,595	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		720,891	720,891	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.031902	0.029293	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		22,998	21,117	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		33,736	30,977	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		70	375	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		481.94	82.61	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		34	156	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		16,386	12,887	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)			64,713	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)			29,273	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 26-0025 Component CCN: 26-8723	Period: From 10/01/2019 To 09/30/2020	Worksheet M-4 Date/Time Prepared: 4/28/2021 2:10 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)		1,541,816	1,541,816	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000218	0.001415	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		336	2,182	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		7,166	9,287	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		7,502	11,469	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,551,780	1,551,780	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,604,750	1,604,750	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.004834	0.007391	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		7,757	11,861	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		15,259	23,330	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		55	357	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		277.44	65.35	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		46	216	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		12,762	14,116	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			38,589	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)			26,878	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 26-0025 Component CCN: 26-8724	Period: From 10/01/2019 To 09/30/2020	Worksheet M-4 Date/Time Prepared: 4/28/2021 2:10 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)		489,459	489,459	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001240	0.004488	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		607	2,197	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		19,222	10,736	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		19,829	12,933	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		552,138	552,138	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,146,705	1,146,705	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.035913	0.023423	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		41,182	26,859	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		61,011	39,792	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		134	485	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		455.31	82.05	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		64	175	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		29,140	14,359	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)			100,803	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)			43,499	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 26-0025 Component CCN: 26-8756	Period: From 10/01/2019 To 09/30/2020	Worksheet M-4 Date/Time Prepared: 4/28/2021 2:10 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)		142,688	142,688	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000083	0.000289	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		12	41	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		204	181	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		216	222	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		146,089	146,089	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		131,294	131,294	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.001479	0.001520	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		194	200	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		410	422	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		2	7	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		205.00	60.29	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		1	1	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		205	60	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)			832	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)			265	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 26-0025 Component CCN: 26-8757	Period: From 10/01/2019 To 09/30/2020	Worksheet M-4 Date/Time Prepared: 4/28/2021 2:10 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)		225,046	225,046	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000000	0.000169	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		0	38	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		0	70	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		0	108	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		230,183	230,183	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		218,501	218,501	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.000000	0.000469	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		0	102	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		0	210	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		0	7	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		0.00	30.00	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		0	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		0	0	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)			210	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)			0	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 26-0025 Component CCN: 26-8758	Period: From 10/01/2019 To 09/30/2020	Worksheet M-4 Date/Time Prepared: 4/28/2021 2:10 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)		183,645	183,645	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000079	0.000344	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		15	63	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		612	286	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		627	349	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		183,995	183,995	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		162,202	162,202	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.003408	0.001897	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		553	308	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		1,180	657	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		3	13	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		393.33	50.54	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		0	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		0	0	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)			1,837	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)			0	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 26-0025 Component CCN: 26-8754	Period: From 10/01/2019 To 09/30/2020	Worksheet M-4 Date/Time Prepared: 4/28/2021 2:10 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)		3,819,327	3,819,327	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.002063	0.005489	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		7,879	20,964	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		154,519	34,462	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		162,398	55,426	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		3,890,140	3,890,140	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		3,901,727	3,901,727	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.041746	0.014248	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		162,881	55,592	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		325,279	111,018	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		878	2,336	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		370.48	47.52	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		89	373	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		32,973	17,725	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)			436,297	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)			50,698	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 26-0025 Component CCN: 26-8759	Period: From 10/01/2019 To 09/30/2020	Worksheet M-4 Date/Time Prepared: 4/28/2021 2:10 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)		335,231	335,231	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000240	0.011699	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		80	3,922	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		377	2,782	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		457	6,704	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		345,906	345,906	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		385,075	385,075	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.001321	0.019381	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		509	7,463	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		966	14,167	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		3	146	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		322.00	97.03	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		3	50	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		966	4,852	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			15,133	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)			5,818	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 10/01/2019 To 09/30/2020	Worksheet M-5 Date/Time Prepared: 4/28/2021 2:10 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		56,783	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)		56,783	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		21,702	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		78,485	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 10/01/2019 To 09/30/2020	Worksheet M-5 Date/Time Prepared: 4/28/2021 2:10 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			30,169	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)			30,169	4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01				0	5.01
5.02				0	5.02
5.03				0	5.03
Provider to Program					
5.50				0	5.50
5.51				0	5.51
5.52				0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER			31,182	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			61,351	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 10/01/2019 To 09/30/2020	Worksheet M-5 Date/Time Prepared: 4/28/2021 2:10 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		55,849	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)		55,849	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		31,132	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		86,981	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 10/01/2019 To 09/30/2020	Worksheet M-5 Date/Time Prepared: 4/28/2021 2:10 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		68,171	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)		68,171		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		29,148		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		97,319		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 10/01/2019 To 09/30/2020	Worksheet M-5 Date/Time Prepared: 4/28/2021 2:10 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		82,857	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		82,857	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		45,929	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		128,786	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 10/01/2019 To 09/30/2020	Worksheet M-5 Date/Time Prepared: 4/28/2021 2:10 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		12,789	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)		12,789	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		823	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		13,612	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 10/01/2019 To 09/30/2020	Worksheet M-5 Date/Time Prepared: 4/28/2021 2:10 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		47,785	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		47,785	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		2,802	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		50,587	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 10/01/2019 To 09/30/2020	Worksheet M-5 Date/Time Prepared: 4/28/2021 2:10 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		24,729	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)		24,729	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		1,192	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		25,921	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 10/01/2019 To 09/30/2020	Worksheet M-5 Date/Time Prepared: 4/28/2021 2:10 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		217,344	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)		217,344	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		55,011	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		272,355	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 10/01/2019 To 09/30/2020	Worksheet M-5 Date/Time Prepared: 4/28/2021 2:10 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		9,491	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)		9,491	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		6,474	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		15,965	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00