

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 10/01/2020 To 09/30/2021	Worksheet S Parts I-III Date/Time Prepared: 2/27/2022 2:59 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 2/27/2022	Time: 2:59 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 BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

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 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 10/01/2020 and ending 09/30/2021 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.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1	Rob Gasaway	☒	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Rob Gasaway		2
3	Signatory Title	CHIEF FINANCIAL OFFICER		3
4	Date	(Dated when report is electronica		4

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-190,058	4,358	0	-983	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	18,660	0		0	3.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		20,151		0	10.00
10.01 RURAL HEALTH CLINIC II	0		23,017		0	10.01
10.02 RURAL HEALTH CLINIC III	0		40,167		0	10.02
10.03 RURAL HEALTH CLINIC IV	0		45,373		0	10.03
10.04 RURAL HEALTH CLINIC V	0		30,038		0	10.04
10.05 RURAL HEALTH CLINIC VI	0		415		0	10.05
10.06 RURAL HEALTH CLINIC VII	0		2,926		0	10.06
10.07 RURAL HEALTH CLINIC VIII	0		525		0	10.07
10.08 RURAL HEALTH CLINIC IX	0		41,357		0	10.08
10.09 RURAL HEALTH CLINIC X	0		4,715		0	10.09
200.00 Total	0	-171,398	213,042	0	-983	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 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/27/2022 2:59 pm	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: HIGHWAY 36, 6000 HOSPITAL DRIVE			PO Box:				1.00		
2.00	City: HANNIBAL			State: MO		Zip Code: 63401		County: MARION		
		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		07/03/2017	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)						10/01/2020	09/30/2021		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 10/01/2020
To 09/30/2021Worksheet S-2
Part I
Date/Time Prepared:
2/27/2022 2:59 pm

		1.00	2.00	3.00				
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? 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	22.04			
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.	1,281	0	168	0	1,351	14	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	49	0	0		25.00
						Urban/Rural S	Date of Geogr	
						1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					1		35.00
						Beginning:	Ending:	
						1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					10/01/2020	09/30/2021	36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
						Y/N	Y/N	
						1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	Y	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N

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		V 1.00	XVIII 2.00	XIX 3.00		
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00
		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

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			1.00		
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)			0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)			0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings					
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)			N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))
			1.00	2.00	3.00
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.					
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.000000
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
			1.00	2.00	3.00
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	0.000000
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))
			1.00	2.00	3.00
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.000000
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
			1.00	2.00	3.00

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To 09/30/2021Worksheet S-2
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
						1.00 2.00 3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y		75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N	N 0	76.00
						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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-0025	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 2/27/2022 2:59 pm	
		V 1.00	XIX 2.00		
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 1.00	Occupational 2.00	Speech 3.00	Respiratory 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	110.00
		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			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 1.00	Losses 2.00	Insurance 3.00	
118.01	List amounts of malpractice premiums and paid losses:	502,630	100,000		118.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-0025	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 2/27/2022 2:59 pm
		1.00	2.00	
118.00	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		118.00
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
		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:		141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:		143.00
		Zip Code:		
		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
		1.00	2.00	3.00
		Title XIX		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
156.00	Subprovider - IPF	N	N	N
157.00	Subprovider - IRF	N	N	N
158.00	SUBPROVIDER			
159.00	SNF	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N
161.00	CMHC		N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 26-0025		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/27/2022 2:59 pm	
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00	
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								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 10/01/2020 To 09/30/2021	Worksheet S-2 Part II Date/Time Prepared: 2/27/2022 2:59 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	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? 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 programs 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	01/14/2022	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

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		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

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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.	SIGNING 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 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
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Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	78	28,470	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		78	28,470	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		86	31,390	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	13	4,745		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.02 RURAL HEALTH CLINIC III	88.02				0	26.02
26.03 RURAL HEALTH CLINIC IV	88.03				0	26.03
26.04 RURAL HEALTH CLINIC V	88.04				0	26.04
26.05 RURAL HEALTH CLINIC VI	88.05				0	26.05
26.06 RURAL HEALTH CLINIC VII	88.06				0	26.06
26.07 RURAL HEALTH CLINIC VIII	88.07				0	26.07
26.08 RURAL HEALTH CLINIC IX	88.08				0	26.08
26.09 RURAL HEALTH CLINIC X	88.09				0	26.09
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		99				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 26-0025

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To 09/30/2021Worksheet S-3
Part I
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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)	6,950	910	16,454			1.00
2.00	HMO and other (see instructions)	3,030	1,351				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	6,950	910	16,454			7.00
8.00	INTENSIVE CARE UNIT	1,950	0	2,186			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		539	1,143			13.00
14.00	Total (see instructions)	8,900	1,449	19,783	0.00	998.40	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	2,121	49	2,948	0.00	17.90	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	7,243	0	12,987	0.00	19.07	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	1,124	149	4,350	0.00	8.07	26.00
26.01	RURAL HEALTH CLINIC II	738	76	2,377	0.00	4.32	26.01
26.02	RURAL HEALTH CLINIC III	910	141	3,437	0.00	6.66	26.02
26.03	RURAL HEALTH CLINIC IV	1,517	225	4,808	0.00	4.73	26.03
26.04	RURAL HEALTH CLINIC V	1,723	362	11,752	0.00	20.32	26.04
26.05	RURAL HEALTH CLINIC VI	326	178	1,515	0.00	2.99	26.05
26.06	RURAL HEALTH CLINIC VII	1,027	69	2,399	0.00	2.93	26.06
26.07	RURAL HEALTH CLINIC VIII	341	184	2,105	0.00	3.15	26.07
26.08	RURAL HEALTH CLINIC IX	3,779	951	19,855	0.00	34.46	26.08
26.09	RURAL HEALTH CLINIC X	158	76	2,414	0.00	5.02	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	1,128.02	27.00
28.00	Observation Bed Days		0	1,406			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	14	177			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 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/27/2022 2:59 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	1,848	334	4,355	1.00
2.00 HMO and other (see instructions)			553	339		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	1,848	334	4,355	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	208	3	270	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 10/01/2020
To 09/30/2021Worksheet S-3
Part II
Date/Time Prepared:
2/27/2022 2:59 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	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	92,202,003	0	92,202,003	2,341,623.59	39.38
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		409,133	0	409,133	2,176.85	187.95
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		12,222,090	0	12,222,090	103,022.99	118.63
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		3,078,589	0	3,078,589	139,074.72	22.14
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)		25,597,163	-289,580	25,307,583	461,246.89	54.87
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		3,889,754	0	3,889,754	36,960.08	105.24
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		310,697	0	310,697	1,281.36	242.47
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)		18,866,184	0	18,866,184		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		5,713,650	0	5,713,650		
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		46,576	0	46,576		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		2,069,399	0	2,069,399		
24.00	Wage-related costs (RHC/FQHC)		1,397,716	0	1,397,716		
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 10/01/2020
To 09/30/2021Worksheet S-3
Part II
Date/Time Prepared:
2/27/2022 2:59 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	572,329	351,302	923,631	36,408.88	25.37	26.00
27.00	Administrative & General	5.00	15,726,480	-316,491	15,409,989	461,408.73	33.40	27.00
28.00	Administrative & General under contract (see inst.)		530,625	0	530,625	4,083.23	129.95	28.00
29.00	Maintenance & Repairs	6.00	586,114	0	586,114	32,410.50	18.08	29.00
30.00	Operation of Plant	7.00	995,621	0	995,621	45,253.14	22.00	30.00
31.00	Laundry & Linen Service	8.00	28,265	0	28,265	2,240.58	12.62	31.00
32.00	Housekeeping	9.00	869,427	0	869,427	53,765.23	16.17	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,235,184	0	1,235,184	67,489.75	18.30	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	1,245,429	0	1,245,429	31,882.49	39.06	38.00
39.00	Central Services and Supply	14.00	211,941	0	211,941	10,868.11	19.50	39.00
40.00	Pharmacy	15.00	1,871,645	-1,871,645	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	1,130,240	0	1,130,240	51,809.86	21.82	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 10/01/2020
To 09/30/2021Worksheet S-3
Part III
Date/Time Prepared:
2/27/2022 2:59 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)	77,431,949	0	77,431,949	2,103,609.11	36.81	1.00
2.00	Excluded area salaries (see instructions)	25,597,163	-289,580	25,307,583	461,246.89	54.87	2.00
3.00	Subtotal salaries (line 1 minus line 2)	51,834,786	289,580	52,124,366	1,642,362.22	31.74	3.00
4.00	Subtotal other wages & related costs (see inst.)	4,200,451	0	4,200,451	38,241.44	109.84	4.00
5.00	Subtotal wage-related costs (see inst.)	18,912,760	0	18,912,760	0.00	36.28	5.00
6.00	Total (sum of lines 3 thru 5)	74,947,997	289,580	75,237,577	1,680,603.66	44.77	6.00
7.00	Total overhead cost (see instructions)	25,003,300	-1,836,834	23,166,466	797,620.50	29.04	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 26-0025	Period: From 10/01/2020 To 09/30/2021	Worksheet S-3 Part IV Date/Time Prepared: 2/27/2022 2:59 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			3,304,411 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			19,047 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)			16,544,416 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			41,631 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			63,785 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)			205,332 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			20,269 14.00
15.00	'Workers' Compensation Insurance			1,759,906 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			5,663,956 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			6,034 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))			354,680 21.00
22.00	Day Care Cost and Allowances			86,673 22.00
23.00	Tuition Reimbursement			23,385 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			28,093,525 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 10/01/2020
To 09/30/2021Worksheet S-3
Part V
Date/Time Prepared:
2/27/2022 2:59 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	3,961,530	28,093,525	1.00
2.00	Hospital	3,889,754	24,580,031	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	71,776	390,476	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	437,252	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	201,800	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	94,707	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	144,774	14.02
14.03	Hospital-Based Health Clinic RHC 3	0	61,210	14.03
14.04	Hospital-Based Health Clinic RHC 4	0	596,059	14.04
14.05	Hospital-Based Health Clinic RHC 5	0	61,185	14.05
14.06	Hospital-Based Health Clinic RHC 6	0	64,634	14.06
14.07	Hospital-Based Health Clinic RHC 7	0	56,965	14.07
14.08	Hospital-Based Health Clinic RHC 8	0	1,292,529	14.08
14.09	Hospital-Based Health Clinic RHC 9	0	111,903	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	Period: From 10/01/2020 To 09/30/2021	Worksheet S-4	
				Component CCN: 26-7282		Date/Time Prepared: 2/27/2022 2:59 pm	
					Home Health Agency I	PPS	
				1.00			
				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	1,047	10	426	1,483	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	415.00	30.00	271.00	716.00	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		0.85	0.00	0.85	3.00
4.00	Director(s) and Assistant Director(s)			0.71	0.00	0.71	4.00
5.00	Other Administrative Personnel			2.34	0.00	2.34	5.00
6.00	Direct Nursing Service			6.54	1.00	7.54	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			3.22	0.00	3.22	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			1.52	0.00	1.52	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.10	0.00	0.10	12.00
13.00	Speech Pathology Supervisor			0.01	0.00	0.01	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.71	0.00	0.71	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	2,647	568	80	40	3,335	21.00
22.00	Skilled Nursing Visit Charges	584,100	126,030	17,600	9,020	736,750	22.00
23.00	Physical Therapy Visits	1,554	507	22	15	2,098	23.00
24.00	Physical Therapy Visit Charges	349,650	114,075	4,950	3,375	472,050	24.00
25.00	Occupational Therapy Visits	471	472	9	6	958	25.00
26.00	Occupational Therapy Visit Charges	105,975	106,200	2,025	1,350	215,550	26.00
27.00	Speech Pathology Visits	48	65	0	8	121	27.00
28.00	Speech Pathology Visit Charges	10,800	14,625	0	1,800	27,225	28.00
29.00	Medical Social Service Visits	2	1	0	0	3	29.00
30.00	Medical Social Service Visit Charges	450	225	0	0	675	30.00
31.00	Home Health Aide Visits	468	256	2	2	728	31.00
32.00	Home Health Aide Visit Charges	56,160	30,720	240	240	87,360	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	5,190	1,869	113	71	7,243	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)	1,107,135	391,875	24,815	15,785	1,539,610	35.00
36.00	Total Number of Episodes (standard/non outlier)	500		51	8	559	36.00
37.00	Total Number of Outlier Episodes		72		1	73	37.00
38.00	Total Non-Routine Medical Supply Charges	7,941	2,440	160	403	10,944	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 10/01/2020 To 09/30/2021 Worksheet S-8 Date/Time Prepared: 2/27/2022 2:59 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	

Health Financial Systems		HANNIBAL REGIONAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 26-0025	Period: From 10/01/2020	Worksheet S-8
			Component CCN: 26-8512	To 09/30/2021	Date/Time Prepared: 2/27/2022 2:59 pm
			RHC I		Cost
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
Facility hours of operations (1)					
11.00	CLINIC	08:00	17:00		11.00

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 10/01/2020 To 09/30/2021 Worksheet S-8 Date/Time Prepared: 2/27/2022 2:59 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	
		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	LEWIS		2.00	
		Tuesday	Wednesday	Thursday	
		to	from to	from to	
		6.00	7.00 8.00	9.00 10.00	
Facility hours of operations (1)					
11.00	CLINIC	17:00	08:00	17:00	08:00 17:00 11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 26-0025

Period:

Worksheet S-8

Component CCN: 26-3984

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 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 10/01/2020 To 09/30/2021 Worksheet S-8 Date/Time Prepared: 2/27/2022 2:59 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	
11.00	Facility hours of operations (1)				
CLINIC		08:00		17:00	
		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	
		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)			15.00	
		County			
		4.00			
2.00	City, State, ZIP Code, County	MONROE		2.00	
		Tuesday		Wednesday	
		to		from to	
		6.00		7.00 8.00	
				Thursday	
				from to	
				9.00 10.00	
11.00	Facility hours of operations (1)				
CLINIC		17:00		08:00	
		17:00		08:00	
		17:00		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	Period: From 10/01/2020	Worksheet S-8
			Component CCN: 26-8513	To 09/30/2021	Date/Time Prepared: 2/27/2022 2:59 pm
			RHC III		Cost
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
Facility hours of operations (1)					
11.00	CLINIC	08:00	17:00		11.00

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 10/01/2020 To 09/30/2021 Worksheet S-8 Date/Time Prepared: 2/27/2022 2:59 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 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 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 10/01/2020 To 09/30/2021 Worksheet S-8 Date/Time Prepared: 2/27/2022 2:59 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	17:00
		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		19:00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 26-0025

Period:

Worksheet S-8

Component CCN: 26-8724

From 10/01/2020

To 09/30/2021

Date/Time Prepared:
2/27/2022 2:59 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 10/01/2020 To 09/30/2021
			Worksheet S-8		Date/Time Prepared: 2/27/2022 2:59 pm
			RHC VI		Cost
			1.00		
Clinic Address and Identification					
1.00	Street		29934 JULY ROAD		1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County		LA PLATA MO 63549		2.00
					1.00
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0 3.00
			Grant Award		Date
			1.00		2.00
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)				4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00
7.00	Appalachian Regional Commission				7.00
8.00	Look-Alikes				8.00
9.00	OTHER (SPECIFY)				9.00
			1.00		2.00
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N 0		10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		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
		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		MACON		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: 26-8756

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 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 10/01/2020 To 09/30/2021
			Worksheet S-8		Date/Time Prepared: 2/27/2022 2:59 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
		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
		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		SCHUYLER		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 Component CCN: 26-8757		Period: From 10/01/2020 To 09/30/2021		Worksheet S-8 Date/Time Prepared: 2/27/2022 2:59 pm	
						RHC VII		Cost	
				Friday		Saturday			
				from	to	from	to		
				11.00	12.00	13.00	14.00		
Facility hours of operations (1)									
11.00	CLINIC	08:00	17:00						11.00

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 10/01/2020 To 09/30/2021
			Worksheet S-8		Date/Time Prepared: 2/27/2022 2:59 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
			from	to	from
			1.00	2.00	3.00
			Tuesday		from
			1.00		2.00
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	XVIII
			1.00	2.00	3.00
			XIX		Total Visits
			1.00		2.00
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		ADAIR		2.00
			Tuesday		Wednesday
			to	from	to
			6.00	7.00	8.00
			Thursday		from
			6.00		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: 26-8758

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 pm

RHC VIII

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: 26-8754		Period: From 10/01/2020 To 09/30/2021
			Worksheet S-8		Date/Time Prepared: 2/27/2022 2:59 pm
			RHC IX		Cost
			1.00		
1.00	Clinic Address and Identification		6500 HOSPITAL DRIVE		
	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
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
			1.00	2.00	3.00
			Tuesday		from
			1.00		2.00
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		14.00		
			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)		15.00		
			County		4.00
2.00	City, State, ZIP Code, County		RALLS		
			Tuesday		Wednesday
			to	from	to
			6.00	7.00	8.00
			Thursday		from
			6.00		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: 26-8754

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 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	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 26-0025 Component CCN: 26-8759		Period: From 10/01/2020 To 09/30/2021		Worksheet S-8 Date/Time Prepared: 2/27/2022 2:59 pm	
				RHC X		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			3650 STARDUST DRIVE			1.00		
			City	State	ZIP Code				
			1.00	2.00	3.00				
2.00	City, State, ZIP Code, County			HANNIBAL		MO 63401		2.00	
						1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0		3.00	
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)							4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)							5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)							6.00	
7.00	Appalachian Regional Commission							7.00	
8.00	Look-Alikes							8.00	
9.00	OTHER (SPECIFY)							9.00	
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0		10.00	
				Sunday		Monday		Tuesday	
				from	to	from	to	from	
				1.00	2.00	3.00	4.00	5.00	
Facility hours of operations (1)									
11.00	CLINIC			11:00	18:00	08:00	20:00	08:00	11.00
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?							12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0		13.00	
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number							14.00	
				Y/N	V	XVIII	XIX	Total Visits	
				1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							15.00	
				County					
				4.00					
2.00	City, State, ZIP Code, County			MARION				2.00	
				Tuesday	Wednesday	Thursday			
				to	from	to	from	to	
				6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)									
11.00	CLINIC			20:00	08:00	20:00	08:00	20:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 26-0025

Period:

Worksheet S-8

Component CCN: 26-8759

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 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 10/01/2020
To 09/30/2021

Worksheet S-10

Date/Time Prepared:
2/27/2022 2:59 pm

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.285171	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		12,242,933	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		56,724,728	6.00
7.00	Medicaid cost (line 1 times line 6)		16,176,247	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)		3,933,314	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)		3,933,314	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)	5,343,322	2,482,094	7,825,416
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,523,760	2,482,094	4,005,854
22.00	Payments received from patients for amounts previously written off as charity care	104,687	28,887	133,574
23.00	Cost of charity care (line 21 minus line 22)	1,419,073	2,453,207	3,872,280
			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)		16,212,972	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		587,317	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		903,565	27.01
28.00	Non-Medicare bad debt expense (see instructions)		15,309,407	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		4,682,047	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		8,554,327	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		12,487,641	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021

Worksheet A

Date/Time Prepared:
2/27/2022 2:59 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	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		5,286,005	5,286,005	2,043,597	7,329,602	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		5,587,043	5,587,043	-314,779	5,272,264	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	572,329	19,509,527	20,081,856	437,975	20,519,831	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,726,480	12,906,707	28,633,187	-926,004	27,707,183	5.00
6.00	00600	MAINTENANCE & REPAIRS	586,114	88,407	674,521	0	674,521	6.00
7.00	00700	OPERATION OF PLANT	995,621	3,757,296	4,752,917	-329,785	4,423,132	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,265	438,966	467,231	0	467,231	8.00
9.00	00900	HOUSEKEEPING	869,427	203,405	1,072,832	329,785	1,402,617	9.00
10.00	01000	DIETARY	1,235,184	1,246,320	2,481,504	0	2,481,504	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,245,429	386,439	1,631,868	0	1,631,868	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	211,941	147,658	359,599	0	359,599	14.00
15.00	01500	PHARMACY	1,871,645	714,809	2,586,454	-1,871,645	714,809	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,130,240	1,323,326	2,453,566	0	2,453,566	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,669,386	5,259,329	15,928,715	-9,150	15,919,565	30.00
31.00	03100	INTENSIVE CARE UNIT	2,164,283	929,921	3,094,204	0	3,094,204	31.00
41.00	04100	SUBPROVIDER - IRF	1,281,530	1,303,588	2,585,118	0	2,585,118	41.00
43.00	04300	NURSERY	260,630	114,952	375,582	0	375,582	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,726,799	2,750,328	4,477,127	82,871	4,559,998	50.00
51.00	05100	RECOVERY ROOM	1,400,705	235,051	1,635,756	0	1,635,756	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,141,458	211,837	1,353,295	0	1,353,295	52.00
53.00	05300	ANESTHESIOLOGY	2,402,414	945,837	3,348,251	0	3,348,251	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,664,006	866,754	2,530,760	107,534	2,638,294	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	744,151	684,867	1,429,018	0	1,429,018	55.00
56.00	05600	RADIOISOTOPE	124,169	158,526	282,695	0	282,695	56.00
57.00	05700	CT SCAN	312,285	318,270	630,555	90,805	721,360	57.00
58.00	05800	MRI	121,956	234,308	356,264	113,790	470,054	58.00
59.00	05900	CARDIAC CATHETERIZATION	732,342	1,162,291	1,894,633	0	1,894,633	59.00
60.00	06000	LABORATORY	2,657,316	3,455,429	6,112,745	0	6,112,745	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	87,490	542,375	629,865	0	629,865	62.00
64.00	06400	INTRAVENOUS THERAPY	310,002	59,204	369,206	0	369,206	64.00
65.00	06500	RESPIRATORY THERAPY	985,818	521,600	1,507,418	0	1,507,418	65.00
66.00	06600	PHYSICAL THERAPY	581,643	926,629	1,508,272	0	1,508,272	66.00
67.00	06700	OCCUPATIONAL THERAPY	70,359	609,911	680,270	0	680,270	67.00
68.00	06800	SPEECH PATHOLOGY	232,898	41,029	273,927	0	273,927	68.00
69.00	06900	ELECTROCARDIOLOGY	64,348	38,871	103,219	0	103,219	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	156,668	36,198	192,866	0	192,866	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,252,939	4,252,939	-1,479,700	2,773,239	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,243,521	7,243,521	1,479,700	8,723,221	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,736,751	10,736,751	1,871,645	12,608,396	73.00
74.00	07400	RENAL DIALYSIS	0	267,292	267,292	0	267,292	74.00
76.00	03950	DIABETES CENTER	86,238	12,558	98,796	0	98,796	76.00
76.97	07697	CARDIAC REHABILITATION	186,705	38,131	224,836	0	224,836	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	89,965	10,859	100,824	0	100,824	76.98
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	662,300	199,094	861,394	23,416	884,810	88.00
88.01	08801	RURAL HEALTH CLINIC II	310,824	205,144	515,968	34,843	550,811	88.01
88.02	08802	RURAL HEALTH CLINIC III	475,143	182,521	657,664	23,416	681,080	88.02
88.03	08803	RURAL HEALTH CLINIC IV	200,890	242,840	443,730	832,772	1,276,502	88.03
88.04	08804	RURAL HEALTH CLINIC V	1,956,244	819,709	2,775,953	-754,938	2,021,015	88.04
88.05	08805	RURAL HEALTH CLINIC VI	200,806	52,612	253,418	0	253,418	88.05
88.06	08806	RURAL HEALTH CLINIC VII	212,127	95,559	307,686	0	307,686	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	186,958	34,766	221,724	923	222,647	88.07
88.08	08808	RURAL HEALTH CLINIC IX	4,242,036	1,122,390	5,364,426	114,914	5,479,340	88.08
88.09	08809	RURAL HEALTH CLINIC X	367,263	96,089	463,352	0	463,352	88.09
91.00	09100	EMERGENCY	4,343,540	3,489,873	7,833,413	0	7,833,413	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,435,046	664,004	2,099,050	0	2,099,050	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		1,953,386	1,953,386	-1,953,386	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	69,321,416	104,723,051	174,044,467	-51,401	173,993,066	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	21,716,197	7,410,279	29,126,476	-77,133	29,049,343	192.00
194.00	07950	FOUNDATION	123,703	118,779	242,482	0	242,482	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	1,000,447	246,830	1,247,277	-437,975	809,302	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 10/01/2020
To 09/30/2021

Worksheet A

Date/Time Prepared:
2/27/2022 2:59 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	566,509	566,509	194.03
194.04	07954	RESEARCH & INNOVATION	40,240	5,584	45,824	0	45,824	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	92,202,003	112,504,523	204,706,526	0	204,706,526	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021

Worksheet A

Date/Time Prepared:
2/27/2022 2:59 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-2,117,240	5,212,362	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-13,269	5,258,995	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,332,018	19,187,813	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,762,114	33,469,297	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	674,521	6.00
7.00	00700	OPERATION OF PLANT	-64,110	4,359,022	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	467,231	8.00
9.00	00900	HOUSEKEEPING	0	1,402,617	9.00
10.00	01000	DIETARY	-823,622	1,657,882	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,631,868	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	359,599	14.00
15.00	01500	PHARMACY	0	714,809	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-16,725	2,436,841	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-3,038,977	12,880,588	30.00
31.00	03100	INTENSIVE CARE UNIT	-365	3,093,839	31.00
41.00	04100	SUBPROVIDER - IRF	-231,704	2,353,414	41.00
43.00	04300	NURSERY	0	375,582	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-642,216	3,917,782	50.00
51.00	05100	RECOVERY ROOM	-1,392	1,634,364	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,353,295	52.00
53.00	05300	ANESTHESIOLOGY	-2,950,353	397,898	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-789	2,637,505	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	1,429,018	55.00
56.00	05600	RADIOISOTOPE	0	282,695	56.00
57.00	05700	CT SCAN	0	721,360	57.00
58.00	05800	MRI	0	470,054	58.00
59.00	05900	CARDIAC CATHETERIZATION	-595,755	1,298,878	59.00
60.00	06000	LABORATORY	-894,670	5,218,075	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	629,865	62.00
64.00	06400	INTRAVENOUS THERAPY	0	369,206	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,507,418	65.00
66.00	06600	PHYSICAL THERAPY	0	1,508,272	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	680,270	67.00
68.00	06800	SPEECH PATHOLOGY	0	273,927	68.00
69.00	06900	ELECTROCARDIOLOGY	-5,105	98,114	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	192,866	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,773,239	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,723,221	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-117,484	12,490,912	73.00
74.00	07400	RENAL DIALYSIS	0	267,292	74.00
76.00	03950	DIABETES CENTER	0	98,796	76.00
76.97	07697	CARDIAC REHABILITATION	-3,658	221,178	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	100,824	76.98
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	884,810	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	550,811	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	681,080	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	1,276,502	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	2,021,015	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	253,418	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	307,686	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	222,647	88.07
88.08	08808	RURAL HEALTH CLINIC IX	-6,750	5,472,590	88.08
88.09	08809	RURAL HEALTH CLINIC X	0	463,352	88.09
91.00	09100	EMERGENCY	-4,264,188	3,569,225	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	2,099,050	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-11,358,276	162,634,790	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	29,049,343	192.00
194.00	07950	FOUNDATION	0	242,482	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	809,302	194.01
194.02	07952	HWY 61 BUILDING	0	0	194.02
194.03	07953	MARKETING	0	566,509	194.03
194.04	07954	RESEARCH & INNOVATION	0	45,824	194.04

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021

Worksheet A

Date/Time Prepared:
2/27/2022 2:59 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
200.00	TOTAL (SUM OF LINES 118 through 199)	-11,358,276	193,348,250	200.00

RECLASSIFICATIONS

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-6

Date/Time Prepared:
2/27/2022 2:59 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - MARKETING				
1.00	MARKETING	194.03	138,855	427,654	1.00
	TOTALS		138,855	427,654	
	B - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,953,386	1.00
	TOTALS		0	1,953,386	
	C - CAPITAL LEASE EXP				
1.00	OPERATING ROOM	50.00	0	82,871	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	107,534	2.00
3.00	CT SCAN	57.00	0	90,805	3.00
4.00	MRI	58.00	0	113,790	4.00
5.00	RURAL HEALTH CLINIC II	88.01	0	11,427	5.00
	0		0	406,427	
	D - PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	181,859	1.00
	0		0	181,859	
	E - IMPLANTS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,479,700	1.00
	0		0	1,479,700	
	F - CHILDREN'S CENTER				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	351,302	86,673	1.00
	0		351,302	86,673	
	G - OUTSIDE CLEANING SERVICE				
1.00	HOUSEKEEPING	9.00	0	329,785	1.00
	0		0	329,785	
	H - PHARMACY SALARIES				
1.00	DRUGS CHARGED TO PATIENTS	73.00	1,871,645	0	1.00
	0		1,871,645	0	
	I - MEDICAL DIRECTORSHIPS				
1.00	ADMINISTRATIVE & GENERAL	5.00	177,413	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		177,413	0	
	J - RHC SALARIES				
1.00	RURAL HEALTH CLINIC	88.00	23,416	0	1.00
2.00	RURAL HEALTH CLINIC II	88.01	23,416	0	2.00
3.00	RURAL HEALTH CLINIC III	88.02	23,416	0	3.00
4.00	RURAL HEALTH CLINIC IV	88.03	38,917	0	4.00
5.00	RURAL HEALTH CLINIC V	88.04	38,917	0	5.00
6.00	RURAL HEALTH CLINIC VIII	88.07	923	0	6.00
7.00	RURAL HEALTH CLINIC IX	88.08	136,289	0	7.00
8.00	PHYSICIANS' PRIVATE OFFICES	192.00	69,755	0	8.00
	0		355,049	0	
	K - BOWLING GREEN & LOUISIANA CLINICS				
1.00	RURAL HEALTH CLINIC IV	88.03	722,801	71,054	1.00
	0		722,801	71,054	
500.00	Grand Total: Increases		3,617,065	4,936,538	500.00

RECLASSIFICATIONS

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-6

Date/Time Prepared:
2/27/2022 2:59 pm

	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	138,855	427,654	0		1.00
	TOTALS		138,855	427,654			
	B - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1,953,386	11		1.00
	TOTALS		0	1,953,386			
	C - CAPITAL LEASE EXP						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	406,427	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
	0		0	406,427			
	D - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	181,859	5		1.00
	0		0	181,859			
	E - IMPLANTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,479,700	0		1.00
	0		0	1,479,700			
	F - CHILDREN'S CENTER						
1.00	CHILD DEVELOPMENT CENTER	194.01	351,302	86,673	0		1.00
	0		351,302	86,673			
	G - OUTSIDE CLEANING SERVICE						
1.00	OPERATION OF PLANT	7.00	0	329,785	0		1.00
	0		0	329,785			
	H - PHARMACY SALARIES						
1.00	PHARMACY	15.00	1,871,645	0	0		1.00
	0		1,871,645	0			
	I - MEDICAL DIRECTORSHIPS						
1.00	ADULTS & PEDIATRICS	30.00	9,150	0	0		1.00
2.00	RURAL HEALTH CLINIC IX	88.08	21,375	0	0		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	146,888	0	0		3.00
	0		177,413	0			
	J - RHC SALARIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	355,049	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
	0		355,049	0			
	K - BOWLING GREEN & LOUISIANA CLINICS						
1.00	RURAL HEALTH CLINIC V	88.04	722,801	71,054	0		1.00
	0		722,801	71,054			
500.00	Grand Total: Decreases		3,617,065	4,936,538			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part I
Date/Time Prepared:
2/27/2022 2:59 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	168,130	0	168,130	0	1.00	
2.00	Land Improvements	10,075,739	85,087	0	85,087	0	2.00	
3.00	Buildings and Fixtures	86,740,371	440,209	0	440,209	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	25,507,462	33,174	0	33,174	0	5.00	
6.00	Movable Equipment	79,148,968	2,799,184	0	2,799,184	465,521	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	205,184,796	3,525,784	0	3,525,784	465,521	8.00	
9.00	Reconciling Items	-925,158	-2,203,679	0	-2,203,679	-1,153,060	9.00	
10.00	Total (line 8 minus line 9)	206,109,954	5,729,463	0	5,729,463	1,618,581	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,880,386	0				1.00	
2.00	Land Improvements	10,160,826	0				2.00	
3.00	Buildings and Fixtures	87,180,580	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	25,540,636	0				5.00	
6.00	Movable Equipment	81,482,631	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	208,245,059	0				8.00	
9.00	Reconciling Items	-1,975,777	0				9.00	
10.00	Total (line 8 minus line 9)	210,220,836	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part II
Date/Time Prepared:
2/27/2022 2:59 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	5,286,005	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,587,043	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	10,873,048	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	5,286,005				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,587,043				2.00
3.00	Total (sum of lines 1-2)	0	10,873,048				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part III
Date/Time Prepared:
2/27/2022 2:59 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	101,221,792	0	101,221,792	0.496050	90,211	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	107,023,267	4,189,282	102,833,985	0.503950	91,648	2.00
3.00	Total (sum of lines 1-2)	208,245,059	4,189,282	204,055,777	1.000000	181,859	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	90,211	5,122,151	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	91,648	5,167,347	0	2.00
3.00	Total (sum of lines 1-2)	0	0	181,859	10,289,498	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	90,211	0	0	5,212,362	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	91,648	0	0	5,258,995	2.00
3.00	Total (sum of lines 1-2)	0	181,859	0	0	10,471,357	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8

Date/Time Prepared:
2/27/2022 2:59 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	-1,953,386	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	-39,273	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-12,565,619			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	-823,622	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	-16,725	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	-918,273	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8

Date/Time Prepared:
2/27/2022 2:59 pm

Cost Center Description			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.	
			Cost Center	Line #			
	Basis/Code (2)	Amount					
	1.00	2.00	3.00	4.00	5.00		
33.01 MISC INCOME - A&P	B	-2,427	ADULTS & PEDIATRICS	30.00		0	33.01
33.02 MISC INCOME - REHAB	B	-23,940	SUBPROVIDER - IRF	41.00		0	33.02
33.03 MISC INCOME - RECOVERY ROOM	B	-1,392	RECOVERY ROOM	51.00		0	33.03
33.04 MISC INCOME - EKG	B	-5,105	ELECTROCARDIOLOGY	69.00		0	33.04
33.05 MISC INCOME - DRUGS	B	-117,484	DRUGS CHARGED TO PATIENTS	73.00		0	33.05
33.06 MISC INCOME - LABORATORY	B	-53,694	LABORATORY	60.00		0	33.06
33.07 MISC INCOME - ER	B	-1,682	EMERGENCY	91.00		0	33.07
33.08 MISC INCOME - PLANT	B	-24,837	OPERATION OF PLANT	7.00		0	33.08
33.09 MISC INCOME - RHC IX	B	-6,750	RURAL HEALTH CLINIC IX	88.00		0	33.09
33.10 MISC INCOME - SURGERY	B	-29,833	OPERATING ROOM	50.00		0	33.10
33.11 MISC INCOME - CARDIAC REHAB	B	-3,658	CARDIAC REHABILITATION	76.97		0	33.11
33.12 MISC INCOME - RADIOLOGY	B	-139	RADIOLOGY-DIAGNOSTIC	54.00		0	33.12
33.13 RENTAL INCOME	B	-163,854	CAP REL COSTS-BLDG & FIXT	1.00		9	33.13
34.00 ADVERTISING	A	-736,063	ADMINISTRATIVE & GENERAL	5.00		0	34.00
35.00 LOBBYING EXPENSE	A	-20,543	ADMINISTRATIVE & GENERAL	5.00		0	35.00
36.00 ALCOHOLIC BEVERAGE EXPENSE	A	-879	ADMINISTRATIVE & GENERAL	5.00		0	36.00
37.00 CONTRIBUTIONS	A	-22,603	ADMINISTRATIVE & GENERAL	5.00		0	37.00
38.00 RECRUITMENT FEES	A	-649,517	ADMINISTRATIVE & GENERAL	5.00		0	38.00
38.01 RECRUITMENT FEES	A	-101,803	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	38.01
39.00 PATIENT TELEPHONE EXPENSE OPERATING	A	-42,922	ADMINISTRATIVE & GENERAL	5.00		0	39.00
39.01 PATIENT TELEPHONE EXPENSE CAPITAL	A	-13,269	CAP REL COSTS-MVBLE EQUIP	2.00		9	39.01
40.00 MEDICAID/FRA	A	8,422,812	ADMINISTRATIVE & GENERAL	5.00		0	40.00
41.00 DAYCARE REVENUE	B	-303,201	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	41.00
42.00 EMPLOYED PHYSICIAN BENEFITS	A	-927,014	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	42.00
43.00 PHYSICIAN PENSION EXPENSE	A	-3	ADMINISTRATIVE & GENERAL	5.00		0	43.00
43.01 PHYSICIAN PENSION EXPENSE	A	-45,531	ADULTS & PEDIATRICS	30.00		0	43.01
43.02 PHYSICIAN PENSION EXPENSE	A	-6,433	SUBPROVIDER - IRF	41.00		0	43.02
43.03 PHYSICIAN PENSION EXPENSE	A	-855	OPERATING ROOM	50.00		0	43.03
43.04 PHYSICIAN PENSION EXPENSE	A	-97,612	ANESTHESIOLOGY	53.00		0	43.04
43.05 PHYSICIAN PENSION EXPENSE	A	-23,184	LABORATORY	60.00		0	43.05
43.06 PHYSICIAN PENSION EXPENSE	A	-37,963	EMERGENCY	91.00		0	43.06
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-11,358,276					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 10/01/2020
To 09/30/2021

Worksheet A-8-2

Date/Time Prepared:
2/27/2022 2:59 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	468,481	22,481	446,000	211,500	1,953	1.00
2.00	30.00	ADULTS & PEDIATRICS	2,991,019	2,991,019	0	211,500	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	365	365	0	211,500	0	3.00
4.00	41.00	SUBPROVIDER - IRF	201,331	201,331	0	211,500	0	4.00
5.00	50.00	OPERATING ROOM	611,528	611,528	0	246,400	0	5.00
6.00	53.00	ANESTHESIOLOGY	2,894,851	2,852,741	42,110	239,400	406	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	650	650	0	271,900	0	7.00
8.00	59.00	CARDIAC CATHETERIZATION	595,755	595,755	0	211,500	0	8.00
9.00	60.00	LABORATORY	890,621	771,761	118,860	260,300	566	9.00
10.00	91.00	EMERGENCY	4,279,131	4,166,271	112,860	211,500	533	10.00
200.00			12,933,732	12,213,902	719,830		3,458	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	198,586	9,929	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	29,278	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	46,729	2,336	45,949	668	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	7.00
8.00	59.00	CARDIAC CATHETERIZATION	0	0	5,966	0	0	8.00
9.00	60.00	LABORATORY	70,832	3,542	14,965	1,997	0	9.00
10.00	91.00	EMERGENCY	54,197	2,710	14,829	391	0	10.00
200.00			370,344	18,517	110,987	3,056	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	198,586	247,414	269,895		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,991,019		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	365		3.00
4.00	41.00	SUBPROVIDER - IRF	0	0	0	201,331		4.00
5.00	50.00	OPERATING ROOM	0	0	0	611,528		5.00
6.00	53.00	ANESTHESIOLOGY	0	47,397	0	2,852,741		6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	650		7.00
8.00	59.00	CARDIAC CATHETERIZATION	0	0	0	595,755		8.00
9.00	60.00	LABORATORY	0	72,829	46,031	817,792		9.00
10.00	91.00	EMERGENCY	0	54,588	58,272	4,224,543		10.00
200.00			0	373,400	351,717	12,565,619		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/27/2022 2:59 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	5,212,362	5,212,362			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	5,258,995		5,258,995		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	19,187,813	61,231	3,555	19,252,599	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	33,469,297	806,621	1,491,900	3,425,036	5.00
6.00	00600	MAINTENANCE & REPAIRS	674,521	0	0	130,848	6.00
7.00	00700	OPERATION OF PLANT	4,359,022	413,992	126,124	222,268	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	467,231	10,012	0	6,310	8.00
9.00	00900	HOUSEKEEPING	1,402,617	10,462	5,942	194,096	9.00
10.00	01000	DIETARY	1,657,882	60,770	23,295	275,750	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,631,868	5,074	464,979	278,037	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	359,599	15,344	11,356	47,315	14.00
15.00	01500	PHARMACY	714,809	18,888	168,165	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,436,841	51,376	111,471	252,322	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,880,588	485,133	228,834	2,059,246	30.00
31.00	03100	INTENSIVE CARE UNIT	3,093,839	202,727	135,079	483,168	31.00
41.00	04100	SUBPROVIDER - IRF	2,353,414	84,371	9,044	241,150	41.00
43.00	04300	NURSERY	375,582	4,680	9,224	58,185	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,917,782	152,093	866,826	377,767	50.00
51.00	05100	RECOVERY ROOM	1,634,364	122,597	3,558	312,702	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,353,295	95,902	25,976	254,826	52.00
53.00	05300	ANESTHESIOLOGY	397,898	4,219	54,075	21,314	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,637,505	119,616	548,145	371,483	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1,429,018	216,440	246,519	166,129	55.00
56.00	05600	RADIOISOTOPE	282,695	13,961	86,874	27,720	56.00
57.00	05700	CT SCAN	721,360	6,435	0	69,716	57.00
58.00	05800	MRI	470,054	9,495	159,457	27,226	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,298,878	41,004	41,462	163,492	59.00
60.00	06000	LABORATORY	5,218,075	67,474	134,791	410,666	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	629,865	1,519	600	19,532	62.00
64.00	06400	INTRAVENOUS THERAPY	369,206	20,980	10,616	69,207	64.00
65.00	06500	RESPIRATORY THERAPY	1,507,418	27,617	15,187	220,080	65.00
66.00	06600	PHYSICAL THERAPY	1,508,272	37,764	0	129,849	66.00
67.00	06700	OCCUPATIONAL THERAPY	680,270	1,912	0	15,707	67.00
68.00	06800	SPEECH PATHOLOGY	273,927	720	0	51,994	68.00
69.00	06900	ELECTROCARDIOLOGY	98,114	5,568	22,217	14,365	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	192,866	1,744	18,264	34,976	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,773,239	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,723,221	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,490,912	0	0	417,837	73.00
74.00	07400	RENAL DIALYSIS	267,292	0	0	0	74.00
76.00	03950	DIABETES CENTER	98,796	2,340	0	19,252	76.00
76.97	07697	CARDIAC REHABILITATION	221,178	24,209	0	41,681	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	100,824	0	0	20,084	76.98
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	884,810	0	6,536	153,083	88.00
88.01	08801	RURAL HEALTH CLINIC II	550,811	0	14,295	74,618	88.01
88.02	08802	RURAL HEALTH CLINIC III	681,080	64,538	0	111,301	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,276,502	0	3,171	214,898	88.03
88.04	08804	RURAL HEALTH CLINIC V	2,021,015	0	44,309	284,049	88.04
88.05	08805	RURAL HEALTH CLINIC VI	253,418	0	0	44,829	88.05
88.06	08806	RURAL HEALTH CLINIC VII	307,686	0	0	47,357	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	222,647	8,561	0	41,944	88.07
88.08	08808	RURAL HEALTH CLINIC IX	5,472,590	247,477	0	972,672	88.08
88.09	08809	RURAL HEALTH CLINIC X	463,352	0	458	81,990	88.09
91.00	09100	EMERGENCY	3,569,225	330,318	47,250	930,789	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	2,099,050	33,748	6,453	320,368	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	162,634,790	3,888,932	5,146,007	14,209,234	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	11,924	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	29,049,343	1,039,404	111,878	4,830,848	192.00
194.00	07950	FOUNDATION	242,482	5,962	73	27,616	194.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/27/2022 2:59 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	809,302	113,147	1,037	144,919	1,068,405	194.01
194.02	07952	HWY 61 BUILDING	0	113,620	0	0	113,620	194.02
194.03	07953	MARKETING	566,509	39,373	0	30,999	636,881	194.03
194.04	07954	RESEARCH & INNOVATION	45,824	0	0	8,983	54,807	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	193,348,250	5,212,362	5,258,995	19,252,599	193,348,250	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/27/2022 2:59 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	39,192,854					5.00
6.00	00600	MAINTENANCE & REPAIRS	204,759	1,010,128				6.00
7.00	00700	OPERATION OF PLANT	1,302,082	96,256	6,519,744			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	122,940	2,328	16,607	625,428		8.00
9.00	00900	HOUSEKEEPING	410,124	2,432	17,354	0	2,043,027	9.00
10.00	01000	DIETARY	512,985	14,129	100,802	0	31,753	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	605,088	1,180	8,416	0	2,651	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	110,243	3,568	25,452	0	8,017	14.00
15.00	01500	PHARMACY	229,292	4,392	31,330	0	9,869	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	725,104	11,945	85,220	0	26,845	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,979,869	112,797	804,714	218,328	253,486	30.00
31.00	03100	INTENSIVE CARE UNIT	995,314	47,135	336,273	79,958	105,926	31.00
41.00	04100	SUBPROVIDER - IRF	683,400	19,617	139,950	33,162	44,084	41.00
43.00	04300	NURSERY	113,817	1,088	7,763	0	2,445	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,351,166	35,363	252,284	65,618	79,470	50.00
51.00	05100	RECOVERY ROOM	527,102	28,505	203,357	25,630	64,058	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	439,840	22,298	159,077	0	50,109	52.00
53.00	05300	ANESTHESIOLOGY	121,403	981	6,998	0	2,204	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	934,788	27,811	198,412	43,724	62,500	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	523,259	50,324	359,019	6,084	113,091	55.00
56.00	05600	RADIOISOTOPE	104,557	3,246	23,157	0	7,295	56.00
57.00	05700	CT SCAN	202,762	1,496	10,674	0	3,362	57.00
58.00	05800	MRI	169,385	2,208	15,749	0	4,961	58.00
59.00	05900	CARDIAC CATHETERIZATION	392,764	9,534	68,016	9,148	21,425	59.00
60.00	06000	LABORATORY	1,482,492	15,688	111,923	2	35,256	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	165,643	353	2,519	0	794	62.00
64.00	06400	INTRAVENOUS THERAPY	119,496	4,878	34,801	0	10,962	64.00
65.00	06500	RESPIRATORY THERAPY	450,087	6,421	45,810	0	14,430	65.00
66.00	06600	PHYSICAL THERAPY	426,082	8,780	62,642	1,202	19,732	66.00
67.00	06700	OCCUPATIONAL THERAPY	177,433	445	3,172	0	999	67.00
68.00	06800	SPEECH PATHOLOGY	83,046	167	1,194	0	376	68.00
69.00	06900	ELECTROCARDIOLOGY	35,661	1,295	9,237	0	2,910	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	63,014	405	2,892	87	911	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	705,077	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,217,818	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,281,959	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	67,957	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	30,608	544	3,881	0	1,223	76.00
76.97	07697	CARDIAC REHABILITATION	72,985	5,629	40,156	0	12,649	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	30,740	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	265,539	0	0	348	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	162,645	0	0	158	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	217,866	15,006	107,053	353	33,722	88.02
88.03	08803	RURAL HEALTH CLINIC IV	379,984	0	0	1,273	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	597,312	0	0	546	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	75,827	0	0	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	90,267	0	0	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	69,447	1,990	14,200	0	4,473	88.07
88.08	08808	RURAL HEALTH CLINIC IX	1,701,582	57,540	410,502	0	129,309	88.08
88.09	08809	RURAL HEALTH CLINIC X	138,766	0	0	7	0	88.09
91.00	09100	EMERGENCY	1,240,091	76,801	547,915	139,800	172,594	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	625,341	7,847	55,980	0	17,634	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,736,808	702,422	4,324,501	625,428	1,351,525	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	3,032	2,773	19,780	0	6,231	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,906,431	241,668	1,724,114	0	543,096	192.00
194.00	07950	FOUNDATION	70,205	1,386	9,890	0	3,115	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	271,634	26,307	187,683	0	59,120	194.01
194.02	07952	HWY 61 BUILDING	28,887	26,417	188,466	0	59,367	194.02
194.03	07953	MARKETING	161,923	9,155	65,310	0	20,573	194.03
194.04	07954	RESEARCH & INNOVATION	13,934	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/27/2022 2:59 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	39,192,854	1,010,128	6,519,744	625,428	2,043,027	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/27/2022 2:59 pm

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	2,677,366					10.00
11.00	01100	CAFETERIA	1,899,039	1,899,039				11.00
13.00	01300	NURSING ADMINISTRATION	0	46,435	3,043,728			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	15,842	0	596,736		14.00
15.00	01500	PHARMACY	0	71,212	0	0	1,247,957	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	40,983	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	600,365	438,539	1,456,878	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	78,176	84,116	282,236	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	99,786	55,461	194,318	0	0	41.00
43.00	04300	NURSERY	0	9,238	33,218	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	80,602	276,433	0	0	50.00
51.00	05100	RECOVERY ROOM	0	57,824	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	46,404	166,547	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	33,864	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	68,395	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	19,507	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	4,544	0	0	0	56.00
57.00	05700	CT SCAN	0	12,692	0	0	0	57.00
58.00	05800	MRI	0	4,544	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	31,805	0	0	0	59.00
60.00	06000	LABORATORY	0	116,526	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	3,847	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	11,995	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	44,284	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	38,832	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	10,783	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	8,905	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,635	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,694	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	143,948	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	452,788	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,247,957	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	0	3,938	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	7,542	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	3,180	11,470	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	104,380	0	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC X	0	15,236	0	0	0	88.09
91.00	09100	EMERGENCY	0	137,396	415,230	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	207,398	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,677,366	1,640,180	3,043,728	596,736	1,247,957	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	256,103	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
194.04	07954	RESEARCH & INNOVATION	0	2,756	0	0	0	194.04

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/27/2022 2:59 pm

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2,677,366	1,899,039	3,043,728	596,736	1,247,957	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/27/2022 2:59 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,742,107				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,924,589	25,443,366	-2,410,978	23,032,388	30.00
31.00	03100	INTENSIVE CARE UNIT	220,112	6,144,059	-219,422	5,924,637	31.00
41.00	04100	SUBPROVIDER - IRF	343,408	4,301,165	0	4,301,165	41.00
43.00	04300	NURSERY	46,995	662,235	0	662,235	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	7,455,404	0	7,455,404	50.00
51.00	05100	RECOVERY ROOM	0	2,979,697	1,200,905	4,180,602	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	56,833	2,671,107	0	2,671,107	52.00
53.00	05300	ANESTHESIOLOGY	0	642,956	0	642,956	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,012,379	0	5,012,379	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	3,129,390	0	3,129,390	55.00
56.00	05600	RADIOISOTOPE	0	554,049	0	554,049	56.00
57.00	05700	CT SCAN	0	1,028,497	0	1,028,497	57.00
58.00	05800	MRI	0	863,079	0	863,079	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,077,528	0	2,077,528	59.00
60.00	06000	LABORATORY	0	7,592,893	0	7,592,893	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	824,672	0	824,672	62.00
64.00	06400	INTRAVENOUS THERAPY	0	652,141	1,429,495	2,081,636	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,331,334	0	2,331,334	65.00
66.00	06600	PHYSICAL THERAPY	0	2,233,155	0	2,233,155	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	890,721	0	890,721	67.00
68.00	06800	SPEECH PATHOLOGY	0	420,329	0	420,329	68.00
69.00	06900	ELECTROCARDIOLOGY	0	193,002	0	193,002	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	322,853	0	322,853	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,622,264	0	3,622,264	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,393,827	0	11,393,827	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	17,438,665	0	17,438,665	73.00
74.00	07400	RENAL DIALYSIS	0	335,249	0	335,249	74.00
76.00	03950	DIABETES CENTER	0	160,582	0	160,582	76.00
76.97	07697	CARDIAC REHABILITATION	0	426,029	0	426,029	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	166,298	0	166,298	76.98
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,310,316	0	1,310,316	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	802,527	0	802,527	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,230,919	0	1,230,919	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	1,875,828	0	1,875,828	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	2,947,231	0	2,947,231	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	374,074	0	374,074	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	445,310	0	445,310	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	363,262	0	363,262	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	9,096,052	0	9,096,052	88.08
88.09	08809	RURAL HEALTH CLINIC X	0	699,809	0	699,809	88.09
91.00	09100	EMERGENCY	1,150,170	8,757,579	0	8,757,579	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	3,373,819	0	3,373,819	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,742,107	143,245,651	0	143,245,651	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	43,740	0	43,740	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	46,702,885	0	46,702,885	192.00
194.00	07950	FOUNDATION	0	360,729	0	360,729	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	1,613,149	0	1,613,149	194.01
194.02	07952	HWY 61 BUILDING	0	416,757	0	416,757	194.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/27/2022 2:59 pm

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	893,842	0	893,842		194.03
194.04	07954	RESEARCH & INNOVATION	0	71,497	0	71,497		194.04
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)	3,742,107	193,348,250	0	193,348,250		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/27/2022 2:59 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	61,231	3,555	64,786	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,815	806,621	1,491,900	2,306,336	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	440	6.00
7.00	00700	OPERATION OF PLANT	352,044	413,992	126,124	892,160	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,012	0	10,012	8.00
9.00	00900	HOUSEKEEPING	-2,965	10,462	5,942	13,439	9.00
10.00	01000	DIETARY	0	60,770	23,295	84,065	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	16,832	5,074	464,979	486,885	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	15,344	11,356	26,700	14.00
15.00	01500	PHARMACY	187	18,888	168,165	187,240	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	51,376	111,471	162,847	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	77,317	485,133	228,834	791,284	30.00
31.00	03100	INTENSIVE CARE UNIT	5,386	202,727	135,079	343,192	31.00
41.00	04100	SUBPROVIDER - IRF	968	84,371	9,044	94,383	41.00
43.00	04300	NURSERY	0	4,680	9,224	13,904	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	470,252	152,093	866,826	1,489,171	50.00
51.00	05100	RECOVERY ROOM	0	122,597	3,558	126,155	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	95,902	25,976	121,878	52.00
53.00	05300	ANESTHESIOLOGY	473	4,219	54,075	58,767	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	107,697	119,616	548,145	775,458	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	216,440	246,519	462,959	55.00
56.00	05600	RADIOISOTOPE	0	13,961	86,874	100,835	56.00
57.00	05700	CT SCAN	105,105	6,435	0	111,540	57.00
58.00	05800	MRI	113,790	9,495	159,457	282,742	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,198	41,004	41,462	83,664	59.00
60.00	06000	LABORATORY	313	67,474	134,791	202,578	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,519	600	2,119	62.00
64.00	06400	INTRAVENOUS THERAPY	2,842	20,980	10,616	34,438	64.00
65.00	06500	RESPIRATORY THERAPY	120,870	27,617	15,187	163,674	65.00
66.00	06600	PHYSICAL THERAPY	96	37,764	0	37,860	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,912	0	1,912	67.00
68.00	06800	SPEECH PATHOLOGY	1,024	720	0	1,744	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,568	22,217	27,785	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,789	1,744	18,264	21,797	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	2,340	0	2,340	76.00
76.97	07697	CARDIAC REHABILITATION	131	24,209	0	24,340	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	14,566	0	6,536	21,102	88.00
88.01	08801	RURAL HEALTH CLINIC II	66,186	0	14,295	80,481	88.01
88.02	08802	RURAL HEALTH CLINIC III	182	64,538	0	64,720	88.02
88.03	08803	RURAL HEALTH CLINIC IV	47,608	0	3,171	50,779	88.03
88.04	08804	RURAL HEALTH CLINIC V	255,432	0	44,309	299,741	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	8,561	0	8,561	88.07
88.08	08808	RURAL HEALTH CLINIC IX	702	247,477	0	248,179	88.08
88.09	08809	RURAL HEALTH CLINIC X	11,489	0	458	11,947	88.09
91.00	09100	EMERGENCY	113	330,318	47,250	377,681	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	3,123	33,748	6,453	43,324	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,817,365	3,888,932	5,146,007	10,852,304	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	11,924	0	11,924	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	117,820	1,039,404	111,878	1,269,102	192.00
194.00	07950	FOUNDATION	0	5,962	73	6,035	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	113,147	1,037	114,184	194.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/27/2022 2:59 pm

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	113,620	0	113,620	0	194.02
194.03	07953	MARKETING	0	39,373	0	39,373	104	194.03
194.04	07954	RESEARCH & INNOVATION	0	0	0	0	30	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,935,185	5,212,362	5,258,995	12,406,542	64,786	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/27/2022 2:59 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,317,858					5.00
6.00	00600	MAINTENANCE & REPAIRS	12,110	12,550				6.00
7.00	00700	OPERATION OF PLANT	77,005	1,196	971,109			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,271	29	2,474	19,807		8.00
9.00	00900	HOUSEKEEPING	24,255	30	2,585	0	40,962	9.00
10.00	01000	DIETARY	30,338	176	15,014	0	637	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	35,785	15	1,254	0	53	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,520	44	3,791	0	161	14.00
15.00	01500	PHARMACY	13,560	55	4,667	0	198	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	42,883	148	12,693	0	538	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	235,371	1,401	119,861	6,915	5,082	30.00
31.00	03100	INTENSIVE CARE UNIT	58,863	586	50,087	2,532	2,124	31.00
41.00	04100	SUBPROVIDER - IRF	40,416	244	20,845	1,050	884	41.00
43.00	04300	NURSERY	6,731	14	1,156	0	49	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	79,908	439	37,577	2,078	1,593	50.00
51.00	05100	RECOVERY ROOM	31,173	354	30,290	812	1,284	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26,012	277	23,694	0	1,005	52.00
53.00	05300	ANESTHESIOLOGY	7,180	12	1,042	0	44	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	55,284	346	29,553	1,385	1,253	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	30,946	625	53,476	193	2,267	55.00
56.00	05600	RADIOISOTOPE	6,184	40	3,449	0	146	56.00
57.00	05700	CT SCAN	11,991	19	1,590	0	67	57.00
58.00	05800	MRI	10,017	27	2,346	0	99	58.00
59.00	05900	CARDIAC CATHETERIZATION	23,228	118	10,131	290	430	59.00
60.00	06000	LABORATORY	87,675	195	16,671	0	707	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	9,796	4	375	0	16	62.00
64.00	06400	INTRAVENOUS THERAPY	7,067	61	5,184	0	220	64.00
65.00	06500	RESPIRATORY THERAPY	26,618	80	6,823	0	289	65.00
66.00	06600	PHYSICAL THERAPY	25,199	109	9,330	38	396	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,493	6	472	0	20	67.00
68.00	06800	SPEECH PATHOLOGY	4,911	2	178	0	8	68.00
69.00	06900	ELECTROCARDIOLOGY	2,109	16	1,376	0	58	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,727	5	431	3	18	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	41,698	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	131,162	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	194,096	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	4,019	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	1,810	7	578	0	25	76.00
76.97	07697	CARDIAC REHABILITATION	4,316	70	5,981	0	254	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,818	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	15,704	0	0	11	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	9,619	0	0	5	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	12,885	186	15,945	11	676	88.02
88.03	08803	RURAL HEALTH CLINIC IV	22,472	0	0	40	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	35,325	0	0	17	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	4,484	0	0	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	5,338	0	0	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	4,107	25	2,115	0	90	88.07
88.08	08808	RURAL HEALTH CLINIC IX	100,632	715	61,144	0	2,593	88.08
88.09	08809	RURAL HEALTH CLINIC X	8,207	0	0	0	0	88.09
91.00	09100	EMERGENCY	73,339	954	81,611	4,427	3,460	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	36,983	97	8,338	0	354	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,758,640	8,727	644,127	19,807	27,098	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	179	34	2,946	0	125	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	526,714	3,003	256,808	0	10,890	192.00
194.00	07950	FOUNDATION	4,152	17	1,473	0	62	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	16,065	327	27,955	0	1,185	194.01
194.02	07952	HWY 61 BUILDING	1,708	328	28,072	0	1,190	194.02
194.03	07953	MARKETING	9,576	114	9,728	0	412	194.03
194.04	07954	RESEARCH & INNOVATION	824	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/27/2022 2:59 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,317,858	12,550	971,109	19,807	40,962	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/27/2022 2:59 pm

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	131,158					10.00
11.00	01100	CAFETERIA	93,029	93,029				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,275	527,202			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	776	0	38,151		14.00
15.00	01500	PHARMACY	0	3,488	0	0	209,208	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,008	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	29,411	21,483	252,344	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,830	4,121	48,886	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	4,888	2,717	33,658	0	0	41.00
43.00	04300	NURSERY	0	453	5,754	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	3,948	47,881	0	0	50.00
51.00	05100	RECOVERY ROOM	0	2,833	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,273	28,847	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,659	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,350	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	956	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	223	0	0	0	56.00
57.00	05700	CT SCAN	0	622	0	0	0	57.00
58.00	05800	MRI	0	223	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,558	0	0	0	59.00
60.00	06000	LABORATORY	0	5,708	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	188	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	588	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,169	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,902	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	528	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	436	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	178	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	377	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	9,202	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	28,949	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	209,208	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	0	193	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	369	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	156	1,987	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	5,113	0	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC X	0	746	0	0	0	88.09
91.00	09100	EMERGENCY	0	6,731	71,922	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	35,923	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	131,158	80,348	527,202	38,151	209,208	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	12,546	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
194.04	07954	RESEARCH & INNOVATION	0	135	0	0	0	194.04

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/27/2022 2:59 pm

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	131,158	93,029	527,202	38,151	209,208	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/27/2022 2:59 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	221,966				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	114,159	1,584,238	0	1,584,238	30.00
31.00	03100	INTENSIVE CARE UNIT	13,056	528,902	0	528,902	31.00
41.00	04100	SUBPROVIDER - IRF	20,369	220,265	0	220,265	41.00
43.00	04300	NURSERY	2,788	31,045	0	31,045	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,663,866	0	1,663,866	50.00
51.00	05100	RECOVERY ROOM	0	193,953	0	193,953	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,371	208,214	0	208,214	52.00
53.00	05300	ANESTHESIOLOGY	0	68,776	0	68,776	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	867,879	0	867,879	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	551,981	0	551,981	55.00
56.00	05600	RADIOISOTOPE	0	110,970	0	110,970	56.00
57.00	05700	CT SCAN	0	126,064	0	126,064	57.00
58.00	05800	MRI	0	295,546	0	295,546	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	119,969	0	119,969	59.00
60.00	06000	LABORATORY	0	314,915	0	314,915	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	12,564	0	12,564	62.00
64.00	06400	INTRAVENOUS THERAPY	0	47,791	0	47,791	64.00
65.00	06500	RESPIRATORY THERAPY	0	200,393	0	200,393	65.00
66.00	06600	PHYSICAL THERAPY	0	75,271	0	75,271	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	13,484	0	13,484	67.00
68.00	06800	SPEECH PATHOLOGY	0	7,454	0	7,454	68.00
69.00	06900	ELECTROCARDIOLOGY	0	31,570	0	31,570	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	26,476	0	26,476	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	50,900	0	50,900	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	160,111	0	160,111	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	404,710	0	404,710	73.00
74.00	07400	RENAL DIALYSIS	0	4,019	0	4,019	74.00
76.00	03950	DIABETES CENTER	0	5,018	0	5,018	76.00
76.97	07697	CARDIAC REHABILITATION	0	35,470	0	35,470	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	4,029	0	4,029	76.98
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	37,332	0	37,332	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	90,356	0	90,356	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	94,797	0	94,797	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	74,014	0	74,014	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	336,039	0	336,039	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	15,435	0	15,435	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	29,497	0	29,497	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	15,039	0	15,039	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	421,648	0	421,648	88.08
88.09	08809	RURAL HEALTH CLINIC X	0	21,176	0	21,176	88.09
91.00	09100	EMERGENCY	68,223	691,479	0	691,479	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	126,097	0	126,097	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	221,966	9,918,752	0	9,918,752	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	15,208	0	15,208	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,095,332	0	2,095,332	192.00
194.00	07950	FOUNDATION	0	11,832	0	11,832	194.00
194.01	07951	CHILD DEVELOPMENT CENTER	0	160,204	0	160,204	194.01
194.02	07952	HWY 61 BUILDING	0	144,918	0	144,918	194.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/27/2022 2:59 pm

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	59,307	0	59,307		194.03
194.04	07954	RESEARCH & INNOVATION	0	989	0	989		194.04
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)	221,966	12,406,542	0	12,406,542		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/27/2022 2:59 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	463,343					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		5,167,347				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,443	3,493	86,239,339			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	71,703	1,465,901	15,341,982	-39,192,854	154,155,396	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	586,114	0	805,369	6.00
7.00	00700	OPERATION OF PLANT	36,801	123,926	995,621	0	5,121,406	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	890	0	28,265	0	483,553	8.00
9.00	00900	HOUSEKEEPING	930	5,838	869,427	0	1,613,117	9.00
10.00	01000	DIETARY	5,402	22,889	1,235,184	0	2,017,697	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	451	456,876	1,245,429	0	2,379,958	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,364	11,158	211,941	0	433,614	14.00
15.00	01500	PHARMACY	1,679	165,234	0	0	901,862	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,567	109,528	1,130,240	0	2,852,010	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	43,125	224,846	9,224,112	0	15,653,801	30.00
31.00	03100	INTENSIVE CARE UNIT	18,021	132,725	2,164,283	0	3,914,813	31.00
41.00	04100	SUBPROVIDER - IRF	7,500	8,886	1,080,199	0	2,687,979	41.00
43.00	04300	NURSERY	416	9,063	260,630	0	447,671	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,520	851,720	1,692,156	0	5,314,468	50.00
51.00	05100	RECOVERY ROOM	10,898	3,496	1,400,705	0	2,073,221	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,525	25,523	1,141,458	0	1,729,999	52.00
53.00	05300	ANESTHESIOLOGY	375	53,133	95,475	0	477,506	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,633	538,593	1,664,006	0	3,676,749	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	19,240	242,223	744,151	0	2,058,106	55.00
56.00	05600	RADIOISOTOPE	1,241	85,360	124,169	0	411,250	56.00
57.00	05700	CT SCAN	572	0	312,285	0	797,511	57.00
58.00	05800	MRI	844	156,678	121,956	0	666,232	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,645	40,739	732,342	0	1,544,836	59.00
60.00	06000	LABORATORY	5,998	132,442	1,839,524	0	5,831,006	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	135	590	87,490	0	651,516	62.00
64.00	06400	INTRAVENOUS THERAPY	1,865	10,431	310,002	0	470,009	64.00
65.00	06500	RESPIRATORY THERAPY	2,455	14,922	985,818	0	1,770,302	65.00
66.00	06600	PHYSICAL THERAPY	3,357	0	581,643	0	1,675,885	66.00
67.00	06700	OCCUPATIONAL THERAPY	170	0	70,359	0	697,889	67.00
68.00	06800	SPEECH PATHOLOGY	64	0	232,898	0	326,641	68.00
69.00	06900	ELECTROCARDIOLOGY	495	21,830	64,348	0	140,264	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	155	17,946	156,668	0	247,850	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	2,773,239	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	8,723,221	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,871,645	0	12,908,749	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	267,292	74.00
76.00	03950	DIABETES CENTER	208	0	86,238	0	120,388	76.00
76.97	07697	CARDIAC REHABILITATION	2,152	0	186,705	0	287,068	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	89,965	0	120,908	76.98
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	6,422	685,716	0	1,044,429	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	14,046	334,240	0	639,724	88.01
88.02	08802	RURAL HEALTH CLINIC III	5,737	0	498,559	0	856,919	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	3,116	962,608	0	1,494,571	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	43,537	1,272,360	0	2,349,373	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	200,806	0	298,247	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	0	212,127	0	355,043	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	761	0	187,881	0	273,152	88.07
88.08	08808	RURAL HEALTH CLINIC IX	21,999	0	4,356,950	0	6,692,739	88.08
88.09	08809	RURAL HEALTH CLINIC X	0	450	367,263	0	545,800	88.09
91.00	09100	EMERGENCY	29,363	46,427	4,169,343	0	4,877,582	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	3,000	6,341	1,435,046	0	2,459,619	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	345,699	5,056,328	63,648,332	-39,192,854	116,962,153	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,060	0	0	0	11,924	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	92,396	109,928	21,639,064	0	35,031,473	192.00
194.00	07950	FOUNDATION	530	72	123,703	0	276,133	194.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/27/2022 2:59 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	10,058	1,019	649,145	0	1,068,405	194.01
194.02	07952	HWY 61 BUILDING	10,100	0	0	0	113,620	194.02
194.03	07953	MARKETING	3,500	0	138,855	0	636,881	194.03
194.04	07954	RESEARCH & INNOVATION	0	0	40,240	0	54,807	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,212,362	5,258,995	19,252,599		39,192,854	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.249467	1.017736	0.223246		0.254243	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			64,786		2,317,858	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000751		0.015036	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 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/27/2022 2:59 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	386,197				6.00
7.00	00700	OPERATION OF PLANT	36,801	349,396			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	890	890	614,931		8.00
9.00	00900	HOUSEKEEPING	930	930	0	347,576	9.00
10.00	01000	DIETARY	5,402	5,402	0	5,402	367,584
11.00	01100	CAFETERIA	0	0	0	0	260,725
13.00	01300	NURSING ADMINISTRATION	451	451	0	451	0
14.00	01400	CENTRAL SERVICES & SUPPLY	1,364	1,364	0	1,364	0
15.00	01500	PHARMACY	1,679	1,679	0	1,679	0
16.00	01600	MEDICAL RECORDS & LIBRARY	4,567	4,567	0	4,567	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	43,125	43,125	214,663	43,125	82,426
31.00	03100	INTENSIVE CARE UNIT	18,021	18,021	78,616	18,021	10,733
41.00	04100	SUBPROVIDER - IRF	7,500	7,500	32,605	7,500	13,700
43.00	04300	NURSERY	416	416	0	416	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	13,520	13,520	64,517	13,520	0
51.00	05100	RECOVERY ROOM	10,898	10,898	25,200	10,898	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,525	8,525	0	8,525	0
53.00	05300	ANESTHESIOLOGY	375	375	0	375	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,633	10,633	42,990	10,633	0
55.00	05500	RADIOLOGY - THERAPEUTIC	19,240	19,240	5,982	19,240	0
56.00	05600	RADIOISOTOPE	1,241	1,241	0	1,241	0
57.00	05700	CT SCAN	572	572	0	572	0
58.00	05800	MRI	844	844	0	844	0
59.00	05900	CARDIAC CATHETERIZATION	3,645	3,645	8,994	3,645	0
60.00	06000	LABORATORY	5,998	5,998	2	5,998	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	135	135	0	135	0
64.00	06400	INTRAVENOUS THERAPY	1,865	1,865	0	1,865	0
65.00	06500	RESPIRATORY THERAPY	2,455	2,455	0	2,455	0
66.00	06600	PHYSICAL THERAPY	3,357	3,357	1,182	3,357	0
67.00	06700	OCCUPATIONAL THERAPY	170	170	0	170	0
68.00	06800	SPEECH PATHOLOGY	64	64	0	64	0
69.00	06900	ELECTROCARDIOLOGY	495	495	0	495	0
70.00	07000	ELECTROENCEPHALOGRAPHY	155	155	86	155	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.00	03950	DIABETES CENTER	208	208	0	208	0
76.97	07697	CARDIAC REHABILITATION	2,152	2,152	0	2,152	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	342	0	0
88.01	08801	RURAL HEALTH CLINIC II	0	0	155	0	0
88.02	08802	RURAL HEALTH CLINIC III	5,737	5,737	347	5,737	0
88.03	08803	RURAL HEALTH CLINIC IV	0	0	1,252	0	0
88.04	08804	RURAL HEALTH CLINIC V	0	0	537	0	0
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	0	0
88.06	08806	RURAL HEALTH CLINIC VII	0	0	0	0	0
88.07	08807	RURAL HEALTH CLINIC VIII	761	761	0	761	0
88.08	08808	RURAL HEALTH CLINIC IX	21,999	21,999	0	21,999	0
88.09	08809	RURAL HEALTH CLINIC X	0	0	7	0	0
91.00	09100	EMERGENCY	29,363	29,363	137,454	29,363	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	3,000	3,000	0	3,000	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	268,553	231,752	614,931	229,932	367,584
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,060	1,060	0	1,060	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	92,396	92,396	0	92,396	0
194.00	07950	FOUNDATION	530	530	0	530	0
194.01	07951	CHILD DEVELOPMENT CENTER	10,058	10,058	0	10,058	0
194.02	07952	HWY 61 BUILDING	10,100	10,100	0	10,100	0
194.03	07953	MARKETING	3,500	3,500	0	3,500	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/27/2022 2:59 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
194.04	07954	RESEARCH & INNOVATION	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,010,128	6,519,744	625,428	2,043,027	2,677,366	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.615577	18.660042	1.017070	5.877929	7.283685	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	12,550	971,109	19,807	40,962	131,158	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.032496	2.779394	0.032210	0.117850	0.356811	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 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/27/2022 2:59 pm

Cost Center Description			CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	62,695					11.00
13.00	01300	NURSING ADMINISTRATION	1,533	582,203				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	523	0	11,496,460			14.00
15.00	01500	PHARMACY	2,351	0	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,353	0	0	0	35,753	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,478	278,671	0	0	18,388	30.00
31.00	03100	INTENSIVE CARE UNIT	2,777	53,986	0	0	2,103	31.00
41.00	04100	SUBPROVIDER - IRF	1,831	37,169	0	0	3,281	41.00
43.00	04300	NURSERY	305	6,354	0	0	449	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,661	52,876	0	0	0	50.00
51.00	05100	RECOVERY ROOM	1,909	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,532	31,857	0	0	543	52.00
53.00	05300	ANESTHESIOLOGY	1,118	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,258	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	644	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	150	0	0	0	0	56.00
57.00	05700	CT SCAN	419	0	0	0	0	57.00
58.00	05800	MRI	150	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,050	0	0	0	0	59.00
60.00	06000	LABORATORY	3,847	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	127	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	396	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,462	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,282	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	356	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	294	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	120	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	254	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	2,773,239	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	8,723,221	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	130	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	249	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	105	2,194	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	3,446	0	0	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC X	503	0	0	0	0	88.09
91.00	09100	EMERGENCY	4,536	79,425	0	0	10,989	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	39,671	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)	54,149	582,203	11,496,460	100	35,753	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,455	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 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/27/2022 2:59 pm

Cost Center Description			CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
194.03	07953	MARKETING	0	0	0	0	0	194.03
194.04	07954	RESEARCH & INNOVATION	91	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,899,039	3,043,728	596,736	1,247,957	3,742,107	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	30.290119	5.227950	0.051906	12,479.570000	104.665539	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	93,029	527,202	38,151	209,208	221,966	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.483834	0.905530	0.003318	2,092.080000	6.208318	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 10/01/2020
To 09/30/2021

Worksheet B-2

Date/Time Prepared:
2/27/2022 2:59 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 1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM		1	94.00	0 2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1	74.00	0 3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM		1	94.00	0 4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS		1	74.00	0 5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM		1	94.00	0 6.00
7.00		ICU OBSERVATION		1	30.00	219,422 7.00
8.00		ICU OBSERVATION		1	31.00	-219,422 8.00
9.00		IV THERAPY IN A&PS		1	64.00	1,429,495 9.00
10.00		RECOVERY ROOM IN A&PS		1	51.00	1,200,905 10.00
11.00		A&P IV THERAPY & RECOVERY		1	30.00	-2,630,400 11.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/27/2022 2:59 pm

			Title XVIII		Hospital		PPS
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
					Total Costs	RCE Disallowance	Total Costs
			1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	23,032,388		23,032,388	0	23,032,388
31.00	03100	INTENSIVE CARE UNIT	5,924,637		5,924,637	0	5,924,637
41.00	04100	SUBPROVIDER - IRF	4,301,165		4,301,165	0	4,301,165
43.00	04300	NURSERY	662,235		662,235	0	662,235
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,455,404		7,455,404	0	7,455,404
51.00	05100	RECOVERY ROOM	4,180,602		4,180,602	0	4,180,602
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,671,107		2,671,107	0	2,671,107
53.00	05300	ANESTHESIOLOGY	642,956		642,956	0	642,956
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,012,379		5,012,379	0	5,012,379
55.00	05500	RADIOLOGY - THERAPEUTIC	3,129,390		3,129,390	0	3,129,390
56.00	05600	RADIOISOTOPE	554,049		554,049	0	554,049
57.00	05700	CT SCAN	1,028,497		1,028,497	0	1,028,497
58.00	05800	MRI	863,079		863,079	0	863,079
59.00	05900	CARDIAC CATHETERIZATION	2,077,528		2,077,528	0	2,077,528
60.00	06000	LABORATORY	7,592,893		7,592,893	46,031	7,638,924
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	824,672		824,672	0	824,672
64.00	06400	INTRAVENOUS THERAPY	2,081,636		2,081,636	0	2,081,636
65.00	06500	RESPIRATORY THERAPY	2,331,334	0	2,331,334	0	2,331,334
66.00	06600	PHYSICAL THERAPY	2,233,155	0	2,233,155	0	2,233,155
67.00	06700	OCCUPATIONAL THERAPY	890,721	0	890,721	0	890,721
68.00	06800	SPEECH PATHOLOGY	420,329	0	420,329	0	420,329
69.00	06900	ELECTROCARDIOLOGY	193,002		193,002	0	193,002
70.00	07000	ELECTROENCEPHALOGRAPHY	322,853		322,853	0	322,853
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,622,264		3,622,264	0	3,622,264
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,393,827		11,393,827	0	11,393,827
73.00	07300	DRUGS CHARGED TO PATIENTS	17,438,665		17,438,665	0	17,438,665
74.00	07400	RENAL DIALYSIS	335,249		335,249	0	335,249
76.00	03950	DIABETES CENTER	160,582		160,582	0	160,582
76.97	07697	CARDIAC REHABILITATION	426,029		426,029	0	426,029
76.98	07698	HYPERBARIC OXYGEN THERAPY	166,298		166,298	0	166,298
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,310,316		1,310,316	0	1,310,316
88.01	08801	RURAL HEALTH CLINIC II	802,527		802,527	0	802,527
88.02	08802	RURAL HEALTH CLINIC III	1,230,919		1,230,919	0	1,230,919
88.03	08803	RURAL HEALTH CLINIC IV	1,875,828		1,875,828	0	1,875,828
88.04	08804	RURAL HEALTH CLINIC V	2,947,231		2,947,231	0	2,947,231
88.05	08805	RURAL HEALTH CLINIC VI	374,074		374,074	0	374,074
88.06	08806	RURAL HEALTH CLINIC VII	445,310		445,310	0	445,310
88.07	08807	RURAL HEALTH CLINIC VIII	363,262		363,262	0	363,262
88.08	08808	RURAL HEALTH CLINIC IX	9,096,052		9,096,052	0	9,096,052
88.09	08809	RURAL HEALTH CLINIC X	699,809		699,809	0	699,809
91.00	09100	EMERGENCY	8,757,579		8,757,579	58,272	8,815,851
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,813,192		1,813,192		1,813,192
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	3,373,819		3,373,819		3,373,819
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
200.00		Subtotal (see instructions)	145,058,843	0	145,058,843	104,303	145,163,146
201.00		Less Observation Beds	1,813,192		1,813,192		1,813,192
202.00		Total (see instructions)	143,245,651	0	143,245,651	104,303	143,349,954

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/27/2022 2:59 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	12,811,134		12,811,134		30.00
31.00	03100	INTENSIVE CARE UNIT	2,237,855		2,237,855		31.00
41.00	04100	SUBPROVIDER - IRF	2,710,991		2,710,991		41.00
43.00	04300	NURSERY	406,326		406,326		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	21,561,812	63,638,073	85,199,885	0.087505	0.000000
51.00	05100	RECOVERY ROOM	1,316,158	6,263,926	7,580,084	0.551524	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,751,190	326,279	2,077,469	1.285751	0.000000
53.00	05300	ANESTHESIOLOGY	6,878,064	16,036,912	22,914,976	0.028058	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,427,918	12,942,034	19,369,952	0.258771	0.000000
55.00	05500	RADIOLOGY - THERAPEUTIC	29,092	6,200,068	6,229,160	0.502378	0.000000
56.00	05600	RADIOISOTOPE	287,801	1,555,024	1,842,825	0.300652	0.000000
57.00	05700	CT SCAN	8,797,939	25,524,157	34,322,096	0.029966	0.000000
58.00	05800	MRI	867,359	6,952,126	7,819,485	0.110375	0.000000
59.00	05900	CARDIAC CATHETERIZATION	5,755,347	7,224,451	12,979,798	0.160059	0.000000
60.00	06000	LABORATORY	20,501,493	37,640,211	58,141,704	0.130593	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,269,997	1,137,541	2,407,538	0.342537	0.000000
64.00	06400	INTRAVENOUS THERAPY	26,759	2,545,915	2,572,674	0.809133	0.000000
65.00	06500	RESPIRATORY THERAPY	1,492,274	738,740	2,231,014	1.044966	0.000000
66.00	06600	PHYSICAL THERAPY	2,332,058	674,360	3,006,418	0.742796	0.000000
67.00	06700	OCCUPATIONAL THERAPY	1,649,509	482,256	2,131,765	0.417833	0.000000
68.00	06800	SPEECH PATHOLOGY	312,693	923,757	1,236,450	0.339948	0.000000
69.00	06900	ELECTROCARDIOLOGY	1,377,439	2,941,186	4,318,625	0.044691	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	9,490	788,275	797,765	0.404697	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,782,505	21,141,146	40,923,651	0.088513	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,028,131	17,724,381	32,752,512	0.347876	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	38,804,786	47,843,698	86,648,484	0.201258	0.000000
74.00	07400	RENAL DIALYSIS	298,647	0	298,647	1.122559	0.000000
76.00	03950	DIABETES CENTER	0	48,716	48,716	3.296289	0.000000
76.97	07697	CARDIAC REHABILITATION	2,700	590,060	592,760	0.718721	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	760	760	218.813158	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,031,032	1,031,032		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	602,136	602,136		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	797,576	797,576		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	1,079,175	1,079,175		88.03
88.04	08804	RURAL HEALTH CLINIC V	0	2,118,569	2,118,569		88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	316,534	316,534		88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	423,505	423,505		88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	423,240	423,240		88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	4,760,094	4,760,094		88.08
88.09	08809	RURAL HEALTH CLINIC X	0	403,375	403,375		88.09
91.00	09100	EMERGENCY	7,694,479	19,700,571	27,395,050	0.319677	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	566,720	3,178,830	3,745,550	0.484092	0.000000
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	2,607,972	2,607,972		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	182,988,666	319,326,661	502,315,327		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	182,988,666	319,326,661	502,315,327		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/27/2022 2:59 pm

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			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	0.087505			50.00
51.00	05100	RECOVERY ROOM	0.551524			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.285751			52.00
53.00	05300	ANESTHESIOLOGY	0.028058			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.258771			54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.502378			55.00
56.00	05600	RADIOISOTOPE	0.300652			56.00
57.00	05700	CT SCAN	0.029966			57.00
58.00	05800	MRI	0.110375			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.160059			59.00
60.00	06000	LABORATORY	0.131385			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.342537			62.00
64.00	06400	INTRAVENOUS THERAPY	0.809133			64.00
65.00	06500	RESPIRATORY THERAPY	1.044966			65.00
66.00	06600	PHYSICAL THERAPY	0.742796			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.417833			67.00
68.00	06800	SPEECH PATHOLOGY	0.339948			68.00
69.00	06900	ELECTROCARDIOLOGY	0.044691			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.404697			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.088513			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.347876			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.201258			73.00
74.00	07400	RENAL DIALYSIS	1.122559			74.00
76.00	03950	DIABETES CENTER	3.296289			76.00
76.97	07697	CARDIAC REHABILITATION	0.718721			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	218.813158			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	0.321805			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.484092			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 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/27/2022 2:59 pm

			Title XIX		Hospital		Cost
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
					Total Costs	RCE Disallowance	Total Costs
			1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	23,032,388		23,032,388	0	23,032,388
31.00	03100	INTENSIVE CARE UNIT	5,924,637		5,924,637	0	5,924,637
41.00	04100	SUBPROVIDER - IRF	4,301,165		4,301,165	0	4,301,165
43.00	04300	NURSERY	662,235		662,235	0	662,235
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,455,404		7,455,404	0	7,455,404
51.00	05100	RECOVERY ROOM	4,180,602		4,180,602	0	4,180,602
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,671,107		2,671,107	0	2,671,107
53.00	05300	ANESTHESIOLOGY	642,956		642,956	0	642,956
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,012,379		5,012,379	0	5,012,379
55.00	05500	RADIOLOGY - THERAPEUTIC	3,129,390		3,129,390	0	3,129,390
56.00	05600	RADIOISOTOPE	554,049		554,049	0	554,049
57.00	05700	CT SCAN	1,028,497		1,028,497	0	1,028,497
58.00	05800	MRI	863,079		863,079	0	863,079
59.00	05900	CARDIAC CATHETERIZATION	2,077,528		2,077,528	0	2,077,528
60.00	06000	LABORATORY	7,592,893		7,592,893	46,031	7,638,924
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	824,672		824,672	0	824,672
64.00	06400	INTRAVENOUS THERAPY	2,081,636		2,081,636	0	2,081,636
65.00	06500	RESPIRATORY THERAPY	2,331,334	0	2,331,334	0	2,331,334
66.00	06600	PHYSICAL THERAPY	2,233,155	0	2,233,155	0	2,233,155
67.00	06700	OCCUPATIONAL THERAPY	890,721	0	890,721	0	890,721
68.00	06800	SPEECH PATHOLOGY	420,329	0	420,329	0	420,329
69.00	06900	ELECTROCARDIOLOGY	193,002		193,002	0	193,002
70.00	07000	ELECTROENCEPHALOGRAPHY	322,853		322,853	0	322,853
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,622,264		3,622,264	0	3,622,264
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,393,827		11,393,827	0	11,393,827
73.00	07300	DRUGS CHARGED TO PATIENTS	17,438,665		17,438,665	0	17,438,665
74.00	07400	RENAL DIALYSIS	335,249		335,249	0	335,249
76.00	03950	DIABETES CENTER	160,582		160,582	0	160,582
76.97	07697	CARDIAC REHABILITATION	426,029		426,029	0	426,029
76.98	07698	HYPERBARIC OXYGEN THERAPY	166,298		166,298	0	166,298
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,310,316		1,310,316	0	1,310,316
88.01	08801	RURAL HEALTH CLINIC II	802,527		802,527	0	802,527
88.02	08802	RURAL HEALTH CLINIC III	1,230,919		1,230,919	0	1,230,919
88.03	08803	RURAL HEALTH CLINIC IV	1,875,828		1,875,828	0	1,875,828
88.04	08804	RURAL HEALTH CLINIC V	2,947,231		2,947,231	0	2,947,231
88.05	08805	RURAL HEALTH CLINIC VI	374,074		374,074	0	374,074
88.06	08806	RURAL HEALTH CLINIC VII	445,310		445,310	0	445,310
88.07	08807	RURAL HEALTH CLINIC VIII	363,262		363,262	0	363,262
88.08	08808	RURAL HEALTH CLINIC IX	9,096,052		9,096,052	0	9,096,052
88.09	08809	RURAL HEALTH CLINIC X	699,809		699,809	0	699,809
91.00	09100	EMERGENCY	8,757,579		8,757,579	58,272	8,815,851
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,813,192		1,813,192		1,813,192
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	3,373,819		3,373,819		3,373,819
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
200.00		Subtotal (see instructions)	145,058,843	0	145,058,843	104,303	145,163,146
201.00		Less Observation Beds	1,813,192		1,813,192		1,813,192
202.00		Total (see instructions)	143,245,651	0	143,245,651	104,303	143,349,954

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/27/2022 2:59 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	12,811,134		12,811,134			30.00	
31.00	03100	INTENSIVE CARE UNIT	2,237,855		2,237,855			31.00	
41.00	04100	SUBPROVIDER - IRF	2,710,991		2,710,991			41.00	
43.00	04300	NURSERY	406,326		406,326			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	21,561,812	63,638,073	85,199,885	0.087505	0.000000	50.00	
51.00	05100	RECOVERY ROOM	1,316,158	6,263,926	7,580,084	0.551524	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,751,190	326,279	2,077,469	1.285751	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	6,878,064	16,036,912	22,914,976	0.028058	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,427,918	12,942,034	19,369,952	0.258771	0.000000	54.00	
55.00	05500	RADIOLOGY - THERAPEUTIC	29,092	6,200,068	6,229,160	0.502378	0.000000	55.00	
56.00	05600	RADIOISOTOPE	287,801	1,555,024	1,842,825	0.300652	0.000000	56.00	
57.00	05700	CT SCAN	8,797,939	25,524,157	34,322,096	0.029966	0.000000	57.00	
58.00	05800	MRI	867,359	6,952,126	7,819,485	0.110375	0.000000	58.00	
59.00	05900	CARDIAC CATHETERIZATION	5,755,347	7,224,451	12,979,798	0.160059	0.000000	59.00	
60.00	06000	LABORATORY	20,501,493	37,640,211	58,141,704	0.130593	0.000000	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,269,997	1,137,541	2,407,538	0.342537	0.000000	62.00	
64.00	06400	INTRAVENOUS THERAPY	26,759	2,545,915	2,572,674	0.809133	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY	1,492,274	738,740	2,231,014	1.044966	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	2,332,058	674,360	3,006,418	0.742796	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	1,649,509	482,256	2,131,765	0.417833	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	312,693	923,757	1,236,450	0.339948	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	1,377,439	2,941,186	4,318,625	0.044691	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	9,490	788,275	797,765	0.404697	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,782,505	21,141,146	40,923,651	0.088513	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,028,131	17,724,381	32,752,512	0.347876	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	38,804,786	47,843,698	86,648,484	0.201258	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	298,647	0	298,647	1.122559	0.000000	74.00	
76.00	03950	DIABETES CENTER	0	48,716	48,716	3.296289	0.000000	76.00	
76.97	07697	CARDIAC REHABILITATION	2,700	590,060	592,760	0.718721	0.000000	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	760	760	218.813158	0.000000	76.98	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,031,032	1,031,032	1.270878	0.000000	88.00	
88.01	08801	RURAL HEALTH CLINIC II	0	602,136	602,136	1.332800	0.000000	88.01	
88.02	08802	RURAL HEALTH CLINIC III	0	797,576	797,576	1.543325	0.000000	88.02	
88.03	08803	RURAL HEALTH CLINIC IV	0	1,079,175	1,079,175	1.738206	0.000000	88.03	
88.04	08804	RURAL HEALTH CLINIC V	0	2,118,569	2,118,569	1.391142	0.000000	88.04	
88.05	08805	RURAL HEALTH CLINIC VI	0	316,534	316,534	1.181781	0.000000	88.05	
88.06	08806	RURAL HEALTH CLINIC VII	0	423,505	423,505	1.051487	0.000000	88.06	
88.07	08807	RURAL HEALTH CLINIC VIII	0	423,240	423,240	0.858288	0.000000	88.07	
88.08	08808	RURAL HEALTH CLINIC IX	0	4,760,094	4,760,094	1.910898	0.000000	88.08	
88.09	08809	RURAL HEALTH CLINIC X	0	403,375	403,375	1.734884	0.000000	88.09	
91.00	09100	EMERGENCY	7,694,479	19,700,571	27,395,050	0.319677	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	566,720	3,178,830	3,745,550	0.484092	0.000000	92.00	
	OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	2,607,972	2,607,972			101.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	182,988,666	319,326,661	502,315,327			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	182,988,666	319,326,661	502,315,327			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/27/2022 2:59 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 10/01/2020
To 09/30/2021Worksheet D
Part I
Date/Time Prepared:
2/27/2022 2:59 pm

Title XVIII			Hospital		PPS			
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	1,584,238	0	1,584,238	17,860	88.70	30.00	
31.00	INTENSIVE CARE UNIT	528,902		528,902	2,186	241.95	31.00	
41.00	SUBPROVIDER - IRF	220,265	0	220,265	2,948	74.72	41.00	
43.00	NURSERY	31,045		31,045	1,143	27.16	43.00	
200.00	Total (lines 30 through 199)	2,364,450		2,364,450	24,137		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	6,950	616,465					30.00
31.00	INTENSIVE CARE UNIT	1,950	471,803					31.00
41.00	SUBPROVIDER - IRF	2,121	158,481					41.00
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30 through 199)	11,021	1,246,749					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part II
Date/Time Prepared:
2/27/2022 2:59 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	1,663,866	85,199,885	0.019529	10,589,203	206,797	50.00
51.00	05100	RECOVERY ROOM	193,953	7,580,084	0.025587	604,416	15,465	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	208,214	2,077,469	0.100225	7,502	752	52.00
53.00	05300	ANESTHESIOLOGY	68,776	22,914,976	0.003001	2,458,999	7,379	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	867,879	19,369,952	0.044805	3,226,240	144,552	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	551,981	6,229,160	0.088612	13,638	1,208	55.00
56.00	05600	RADIOISOTOPE	110,970	1,842,825	0.060217	122,891	7,400	56.00
57.00	05700	CT SCAN	126,064	34,322,096	0.003673	4,503,694	16,542	57.00
58.00	05800	MRI	295,546	7,819,485	0.037796	440,198	16,638	58.00
59.00	05900	CARDIAC CATHETERIZATION	119,969	12,979,798	0.009243	2,350,915	21,730	59.00
60.00	06000	LABORATORY	314,915	58,141,704	0.005416	9,489,641	51,396	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	12,564	2,407,538	0.005219	517,846	2,703	62.00
64.00	06400	INTRAVENOUS THERAPY	47,791	2,572,674	0.018576	21,044	391	64.00
65.00	06500	RESPIRATORY THERAPY	200,393	2,231,014	0.089821	719,291	64,607	65.00
66.00	06600	PHYSICAL THERAPY	75,271	3,006,418	0.025037	619,712	15,516	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,484	2,131,765	0.006325	267,263	1,690	67.00
68.00	06800	SPEECH PATHOLOGY	7,454	1,236,450	0.006029	89,289	538	68.00
69.00	06900	ELECTROCARDIOLOGY	31,570	4,318,625	0.007310	699,276	5,112	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	26,476	797,765	0.033188	6,205	206	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	50,900	40,923,651	0.001244	13,209,342	16,432	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	160,111	32,752,512	0.004889	1,716,487	8,392	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	404,710	86,648,484	0.004671	16,026,445	74,860	73.00
74.00	07400	RENAL DIALYSIS	4,019	298,647	0.013457	125,799	1,693	74.00
76.00	03950	DIABETES CENTER	5,018	48,716	0.103005	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	35,470	592,760	0.059839	675	40	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	4,029	760	5.301316	0	0	76.98
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	37,332	1,031,032	0.036208	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	90,356	602,136	0.150059	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	94,797	797,576	0.118856	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	74,014	1,079,175	0.068584	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	336,039	2,118,569	0.158616	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	15,435	316,534	0.048763	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	29,497	423,505	0.069650	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	15,039	423,240	0.035533	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	421,648	4,760,094	0.088580	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC X	21,176	403,375	0.052497	0	0	88.09
91.00	09100	EMERGENCY	691,479	27,395,050	0.025241	3,615,080	91,248	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	124,717	3,745,550	0.033297	275,200	9,163	92.00
200.00		Total (lines 50 through 199)	7,552,922	481,541,049		71,716,291	782,450	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part III
Date/Time Prepared:
2/27/2022 2:59 pm

Cost Center Description				Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	PPS
				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	17,860	0.00	6,950	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	2,186	0.00	1,950	31.00	
41.00	04100	SUBPROVIDER - IRF	0	0	2,948	0.00	2,121	41.00	
43.00	04300	NURSERY	0	0	1,143	0.00	0	43.00	
200.00		Total (lines 30 through 199)	0	0	24,137		11,021	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						
31.00	03100	INTENSIVE CARE UNIT	0						
41.00	04100	SUBPROVIDER - IRF	0						
43.00	04300	NURSERY	0						
200.00		Total (lines 30 through 199)	0						

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/27/2022 2:59 pm

Cost Center Description			Title XVIII		Hospital		PPS
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	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 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/27/2022 2:59 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	85,199,885	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	7,580,084	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,077,469	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	22,914,976	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	19,369,952	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	6,229,160	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	1,842,825	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	34,322,096	0.000000	57.00
58.00	05800	MRI	0	0	0	7,819,485	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	12,979,798	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	58,141,704	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	2,407,538	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,572,674	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,231,014	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,006,418	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,131,765	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,236,450	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,318,625	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	797,765	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	40,923,651	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	32,752,512	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	86,648,484	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	298,647	0.000000	74.00
76.00	03950	DIABETES CENTER	0	0	0	48,716	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	592,760	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	760	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,031,032	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	602,136	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	797,576	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	1,079,175	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	2,118,569	0.000000	88.04
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	316,534	0.000000	88.05
88.06	08806	RURAL HEALTH CLINIC VII	0	0	0	423,505	0.000000	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0	0	0	423,240	0.000000	88.07
88.08	08808	RURAL HEALTH CLINIC IX	0	0	0	4,760,094	0.000000	88.08
88.09	08809	RURAL HEALTH CLINIC X	0	0	0	403,375	0.000000	88.09
91.00	09100	EMERGENCY	0	0	0	27,395,050	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,745,550	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	481,541,049		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/27/2022 2:59 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	10,589,203	0	21,473,319	0
51.00	05100	RECOVERY ROOM	0.000000	604,416	0	1,713,913	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	7,502	0	0	0
53.00	05300	ANESTHESIOLOGY	0.000000	2,458,999	0	4,023,302	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	3,226,240	0	3,876,239	0
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	13,638	0	3,283,569	0
56.00	05600	RADIOISOTOPE	0.000000	122,891	0	696,947	0
57.00	05700	CT SCAN	0.000000	4,503,694	0	7,859,985	0
58.00	05800	MRI	0.000000	440,198	0	2,210,795	0
59.00	05900	CARDIAC CATHETERIZATION	0.000000	2,350,915	0	3,351,739	0
60.00	06000	LABORATORY	0.000000	9,489,641	0	5,446,819	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	517,846	0	320,094	0
64.00	06400	INTRAVENOUS THERAPY	0.000000	21,044	0	1,220,674	0
65.00	06500	RESPIRATORY THERAPY	0.000000	719,291	0	339,328	0
66.00	06600	PHYSICAL THERAPY	0.000000	619,712	0	54,394	0
67.00	06700	OCCUPATIONAL THERAPY	0.000000	267,263	0	35,655	0
68.00	06800	SPEECH PATHOLOGY	0.000000	89,289	0	1,140	0
69.00	06900	ELECTROCARDIOLOGY	0.000000	699,276	0	1,014,932	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	6,205	0	165,860	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	13,209,342	0	11,774,857	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,716,487	0	4,167,819	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	16,026,445	0	16,646,122	0
74.00	07400	RENAL DIALYSIS	0.000000	125,799	0	0	0
76.00	03950	DIABETES CENTER	0.000000	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0.000000	675	0	264,900	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	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	3,615,080	0	4,542,384	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	275,200	0	1,164,550	0
200.00		Total (lines 50 through 199)		71,716,291	0	95,649,336	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part V
Date/Time Prepared:
2/27/2022 2:59 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	0.087505	21,473,319	0	0	1,879,023	50.00	
51.00	05100	RECOVERY ROOM	0.551524	1,713,913	0	0	945,264	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.285751	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.028058	4,023,302	0	0	112,886	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.258771	3,876,239	0	0	1,003,058	54.00	
55.00	05500	RADIOLOGY - THERAPEUTIC	0.502378	3,283,569	0	0	1,649,593	55.00	
56.00	05600	RADIOISOTOPE	0.300652	696,947	0	0	209,539	56.00	
57.00	05700	CT SCAN	0.029966	7,859,985	0	0	235,532	57.00	
58.00	05800	MRI	0.110375	2,210,795	0	0	244,016	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.160059	3,351,739	0	0	536,476	59.00	
60.00	06000	LABORATORY	0.130593	5,446,819	0	0	711,316	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.342537	320,094	0	0	109,644	62.00	
64.00	06400	INTRAVENOUS THERAPY	0.809133	1,220,674	0	0	987,688	64.00	
65.00	06500	RESPIRATORY THERAPY	1.044966	339,328	0	0	354,586	65.00	
66.00	06600	PHYSICAL THERAPY	0.742796	54,394	0	0	40,404	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.417833	35,655	0	0	14,898	67.00	
68.00	06800	SPEECH PATHOLOGY	0.339948	1,140	0	0	388	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.044691	1,014,932	0	0	45,358	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.404697	165,860	0	0	67,123	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.088513	11,774,857	0	0	1,042,228	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.347876	4,167,819	0	0	1,449,884	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.201258	16,646,122	0	4,000	3,350,165	73.00	
74.00	07400	RENAL DIALYSIS	1.122559	0	0	0	0	74.00	
76.00	03950	DIABETES CENTER	3.296289	0	0	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	0.718721	264,900	0	0	190,389	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	218.813158	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	0.319677	4,542,384	0	0	1,452,096	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.484092	1,164,550	0	0	563,749	92.00	
200.00		Subtotal (see instructions)		95,649,336	0	4,000	17,195,303	200.00	
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00	
		Only Charges							
202.00		Net Charges (line 200 - line 201)		95,649,336	0	4,000	17,195,303	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part V
Date/Time Prepared:
2/27/2022 2:59 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	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	805		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	DIABETES CENTER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				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)	0	805		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	805		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 26-0025

Period:

Worksheet D

Component CCN: 26-T025

From 10/01/2020
To 09/30/2021Part II
Date/Time Prepared:
2/27/2022 2:59 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	1,663,866	85,199,885	0.019529	669	13
51.00	05100	RECOVERY ROOM	193,953	7,580,084	0.025587	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	208,214	2,077,469	0.100225	0	0
53.00	05300	ANESTHESIOLOGY	68,776	22,914,976	0.003001	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	867,879	19,369,952	0.044805	65,744	2,946
55.00	05500	RADIOLOGY - THERAPEUTIC	551,981	6,229,160	0.088612	0	0
56.00	05600	RADIOISOTOPE	110,970	1,842,825	0.060217	0	0
57.00	05700	CT SCAN	126,064	34,322,096	0.003673	59,806	220
58.00	05800	MRI	295,546	7,819,485	0.037796	15,911	601
59.00	05900	CARDIAC CATHETERIZATION	119,969	12,979,798	0.009243	1,191	11
60.00	06000	LABORATORY	314,915	58,141,704	0.005416	268,384	1,454
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	12,564	2,407,538	0.005219	8,257	43
64.00	06400	INTRAVENOUS THERAPY	47,791	2,572,674	0.018576	0	0
65.00	06500	RESPIRATORY THERAPY	200,393	2,231,014	0.089821	27,331	2,455
66.00	06600	PHYSICAL THERAPY	75,271	3,006,418	0.025037	842,506	21,094
67.00	06700	OCCUPATIONAL THERAPY	13,484	2,131,765	0.006325	802,301	5,075
68.00	06800	SPEECH PATHOLOGY	7,454	1,236,450	0.006029	105,259	635
69.00	06900	ELECTROCARDIOLOGY	31,570	4,318,625	0.007310	11,100	81
70.00	07000	ELECTROENCEPHALOGRAPHY	26,476	797,765	0.033188	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	50,900	40,923,651	0.001244	162,979	203
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	160,111	32,752,512	0.004889	354	2
73.00	07300	DRUGS CHARGED TO PATIENTS	404,710	86,648,484	0.004671	400,265	1,870
74.00	07400	RENAL DIALYSIS	4,019	298,647	0.013457	18,411	248
76.00	03950	DIABETES CENTER	5,018	48,716	0.103005	0	0
76.97	07697	CARDIAC REHABILITATION	35,470	592,760	0.059839	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	4,029	760	5.301316	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	37,332	1,031,032	0.036208	0	0
88.01	08801	RURAL HEALTH CLINIC II	90,356	602,136	0.150059	0	0
88.02	08802	RURAL HEALTH CLINIC III	94,797	797,576	0.118856	0	0
88.03	08803	RURAL HEALTH CLINIC IV	74,014	1,079,175	0.068584	0	0
88.04	08804	RURAL HEALTH CLINIC V	336,039	2,118,569	0.158616	0	0
88.05	08805	RURAL HEALTH CLINIC VI	15,435	316,534	0.048763	0	0
88.06	08806	RURAL HEALTH CLINIC VII	29,497	423,505	0.069650	0	0
88.07	08807	RURAL HEALTH CLINIC VIII	15,039	423,240	0.035533	0	0
88.08	08808	RURAL HEALTH CLINIC IX	421,648	4,760,094	0.088580	0	0
88.09	08809	RURAL HEALTH CLINIC X	21,176	403,375	0.052497	0	0
91.00	09100	EMERGENCY	691,479	27,395,050	0.025241	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,745,550	0.000000	0	0
200.00	Total (lines 50 through 199)		7,428,205	481,541,049		2,790,468	36,951

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0025 Component CCN: 26-T025		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/27/2022 2:59 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	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 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/27/2022 2:59 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	85,199,885	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	7,580,084	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	2,077,469	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	22,914,976	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	19,369,952	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC		0	0	0	6,229,160	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	1,842,825	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	34,322,096	0.000000	57.00
58.00	05800	MRI		0	0	0	7,819,485	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	12,979,798	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	58,141,704	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	2,407,538	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	2,572,674	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	2,231,014	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	3,006,418	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	2,131,765	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	1,236,450	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	4,318,625	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	797,765	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	40,923,651	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	32,752,512	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	86,648,484	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	298,647	0.000000	74.00
76.00	03950	DIABETES CENTER		0	0	0	48,716	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	592,760	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	760	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	1,031,032	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II		0	0	0	602,136	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III		0	0	0	797,576	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV		0	0	0	1,079,175	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V		0	0	0	2,118,569	0.000000	88.04
88.05	08805	RURAL HEALTH CLINIC VI		0	0	0	316,534	0.000000	88.05
88.06	08806	RURAL HEALTH CLINIC VII		0	0	0	423,505	0.000000	88.06
88.07	08807	RURAL HEALTH CLINIC VIII		0	0	0	423,240	0.000000	88.07
88.08	08808	RURAL HEALTH CLINIC IX		0	0	0	4,760,094	0.000000	88.08
88.09	08809	RURAL HEALTH CLINIC X		0	0	0	403,375	0.000000	88.09
91.00	09100	EMERGENCY		0	0	0	27,395,050	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	3,745,550	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	481,541,049		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-0025 Component CCN: 26-T025		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/27/2022 2:59 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	669	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	65,744	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	59,806	0	0	0	57.00
58.00	05800	MRI		0.000000	15,911	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	1,191	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	268,384	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0.000000	8,257	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	27,331	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	842,506	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	802,301	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	105,259	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	11,100	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	162,979	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	354	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	400,265	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	18,411	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)			2,790,468	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part I
Date/Time Prepared:
2/27/2022 2:59 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	1,584,238	0	1,584,238	17,860	88.70	30.00	
31.00	INTENSIVE CARE UNIT	528,902		528,902	2,186	241.95	31.00	
41.00	SUBPROVIDER - IRF	220,265	0	220,265	2,948	74.72	41.00	
43.00	NURSERY	31,045		31,045	1,143	27.16	43.00	
200.00	Total (lines 30 through 199)	2,364,450		2,364,450	24,137		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	910	80,717					30.00
31.00	INTENSIVE CARE UNIT	0	0					31.00
41.00	SUBPROVIDER - IRF	49	3,661					41.00
43.00	NURSERY	539	14,639					43.00
200.00	Total (lines 30 through 199)	1,498	99,017					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part II
Date/Time Prepared:
2/27/2022 2:59 pm

Cost Center Description			Title XIX		Hospital	Cost		
			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	1,663,866	85,199,885	0.019529	1,415	28	50.00
51.00	05100	RECOVERY ROOM	193,953	7,580,084	0.025587	57,789	1,479	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	208,214	2,077,469	0.100225	41,679	4,177	52.00
53.00	05300	ANESTHESIOLOGY	68,776	22,914,976	0.003001	205,828	618	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	867,879	19,369,952	0.044805	386,292	17,308	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	551,981	6,229,160	0.088612	0	0	55.00
56.00	05600	RADIOISOTOPE	110,970	1,842,825	0.060217	32,489	1,956	56.00
57.00	05700	CT SCAN	126,064	34,322,096	0.003673	680,888	2,501	57.00
58.00	05800	MRI	295,546	7,819,485	0.037796	81,774	3,091	58.00
59.00	05900	CARDIAC CATHETERIZATION	119,969	12,979,798	0.009243	326,251	3,016	59.00
60.00	06000	LABORATORY	314,915	58,141,704	0.005416	1,301,370	7,048	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	12,564	2,407,538	0.005219	31,740	166	62.00
64.00	06400	INTRAVENOUS THERAPY	47,791	2,572,674	0.018576	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	200,393	2,231,014	0.089821	71,042	6,381	65.00
66.00	06600	PHYSICAL THERAPY	75,271	3,006,418	0.025037	44,212	1,107	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,484	2,131,765	0.006325	18,385	116	67.00
68.00	06800	SPEECH PATHOLOGY	7,454	1,236,450	0.006029	9,618	58	68.00
69.00	06900	ELECTROCARDIOLOGY	31,570	4,318,625	0.007310	97,260	711	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	26,476	797,765	0.033188	1,095	36	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	50,900	40,923,651	0.001244	1,339,068	1,666	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	160,111	32,752,512	0.004889	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	404,710	86,648,484	0.004671	2,294,169	10,716	73.00
74.00	07400	RENAL DIALYSIS	4,019	298,647	0.013457	10,404	140	74.00
76.00	03950	DIABETES CENTER	5,018	48,716	0.103005	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	35,470	592,760	0.059839	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	4,029	760	5.301316	0	0	76.98
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	37,332	1,031,032	0.036208	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	90,356	602,136	0.150059	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	94,797	797,576	0.118856	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	74,014	1,079,175	0.068584	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	336,039	2,118,569	0.158616	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	15,435	316,534	0.048763	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	29,497	423,505	0.069650	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	15,039	423,240	0.035533	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	421,648	4,760,094	0.088580	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC X	21,176	403,375	0.052497	0	0	88.09
91.00	09100	EMERGENCY	691,479	27,395,050	0.025241	624,530	15,764	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	124,717	3,745,550	0.033297	54,880	1,827	92.00
200.00		Total (lines 50 through 199)	7,552,922	481,541,049		7,712,178	79,910	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 26-0025		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part III Date/Time Prepared: 2/27/2022 2:59 pm	
					Title XIX		Hospital		Cost	
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00		
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00		
43.00	04300	NURSERY	0	0	0	0	0	43.00		
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	17,860	0.00	910	30.00		
31.00	03100	INTENSIVE CARE UNIT		0	2,186	0.00	0	31.00		
41.00	04100	SUBPROVIDER - IRF	0	0	2,948	0.00	49	41.00		
43.00	04300	NURSERY		0	1,143	0.00	539	43.00		
200.00		Total (lines 30 through 199)		0	24,137		1,498	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 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/27/2022 2:59 pm

Cost Center Description		Title XIX			Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	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 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/27/2022 2:59 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	85,199,885	0.000000
51.00	05100	RECOVERY ROOM	0	0	0	7,580,084	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,077,469	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	22,914,976	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	19,369,952	0.000000
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	6,229,160	0.000000
56.00	05600	RADIOISOTOPE	0	0	0	1,842,825	0.000000
57.00	05700	CT SCAN	0	0	0	34,322,096	0.000000
58.00	05800	MRI	0	0	0	7,819,485	0.000000
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	12,979,798	0.000000
60.00	06000	LABORATORY	0	0	0	58,141,704	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	2,407,538	0.000000
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,572,674	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,231,014	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	3,006,418	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,131,765	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,236,450	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,318,625	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	797,765	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	40,923,651	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	32,752,512	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	86,648,484	0.000000
74.00	07400	RENAL DIALYSIS	0	0	0	298,647	0.000000
76.00	03950	DIABETES CENTER	0	0	0	48,716	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	592,760	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	760	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,031,032	0.000000
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	602,136	0.000000
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	797,576	0.000000
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	1,079,175	0.000000
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	2,118,569	0.000000
88.05	08805	RURAL HEALTH CLINIC VI	0	0	0	316,534	0.000000
88.06	08806	RURAL HEALTH CLINIC VII	0	0	0	423,505	0.000000
88.07	08807	RURAL HEALTH CLINIC VIII	0	0	0	423,240	0.000000
88.08	08808	RURAL HEALTH CLINIC IX	0	0	0	4,760,094	0.000000
88.09	08809	RURAL HEALTH CLINIC X	0	0	0	403,375	0.000000
91.00	09100	EMERGENCY	0	0	0	27,395,050	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,745,550	0.000000
200.00		Total (lines 50 through 199)	0	0	0	481,541,049	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/27/2022 2:59 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	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	1,415	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	57,789	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	41,679	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	205,828	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	386,292	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	32,489	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	680,888	0	0	0	57.00
58.00	05800	MRI	0.000000	81,774	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	326,251	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	1,301,370	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	31,740	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	71,042	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	44,212	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	18,385	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	9,618	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	97,260	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	1,095	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,339,068	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	2,294,169	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	10,404	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	624,530	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	54,880	0	0	0	92.00
200.00		Total (lines 50 through 199)		7,712,178	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part V
Date/Time Prepared:
2/27/2022 2:59 pm

			Title XIX		Hospital		Cost	
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	0.087505	0	2,647,473	0	0	50.00
51.00	05100	RECOVERY ROOM	0.551524	0	268,242	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.285751	0	11,587	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.028058	0	658,491	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.258771	0	790,000	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.502378	0	81,614	0	0	55.00
56.00	05600	RADIOISOTOPE	0.300652	0	379,289	0	0	56.00
57.00	05700	CT SCAN	0.029966	0	2,206,186	0	0	57.00
58.00	05800	MRI	0.110375	0	352,561	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.160059	0	367,001	0	0	59.00
60.00	06000	LABORATORY	0.130593	0	2,496,011	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.342537	0	32,520	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.809133	0	186,903	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1.044966	0	54,429	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.742796	0	2,349	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.417833	0	260	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.339948	0	3,000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.044691	0	218,785	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.404697	0	114,479	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.088513	0	1,702,479	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.347876	0	123,948	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.201258	0	3,277,326	0	0	73.00
74.00	07400	RENAL DIALYSIS	1.122559	0	0	0	0	74.00
76.00	03950	DIABETES CENTER	3.296289	0	1,386	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.718721	0	9,375	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	218.813158	0	400	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	0.319677	0	1,911,076	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.484092	0	166,261	0	0	92.00
200.00		Subtotal (see instructions)		0	18,063,431	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00
		Only Charges						
202.00		Net Charges (line 200 - line 201)		0	18,063,431	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part V
Date/Time Prepared:
2/27/2022 2:59 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	231,667	0		50.00
51.00	05100	RECOVERY ROOM	147,942	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,898	0		52.00
53.00	05300	ANESTHESIOLOGY	18,476	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	204,429	0		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	41,001	0		55.00
56.00	05600	RADIOISOTOPE	114,034	0		56.00
57.00	05700	CT SCAN	66,111	0		57.00
58.00	05800	MRI	38,914	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	58,742	0		59.00
60.00	06000	LABORATORY	325,962	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	11,139	0		62.00
64.00	06400	INTRAVENOUS THERAPY	151,229	0		64.00
65.00	06500	RESPIRATORY THERAPY	56,876	0		65.00
66.00	06600	PHYSICAL THERAPY	1,745	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	109	0		67.00
68.00	06800	SPEECH PATHOLOGY	1,020	0		68.00
69.00	06900	ELECTROCARDIOLOGY	9,778	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	46,329	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	150,692	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	43,119	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	659,588	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	DIABETES CENTER	4,569	0		76.00
76.97	07697	CARDIAC REHABILITATION	6,738	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	87,525	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	610,927	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	80,486	0		92.00
200.00		Subtotal (see instructions)	3,184,045	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,184,045	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0025	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/27/2022 2:59 pm	
		Title XVIII	Hospital	PPS	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		17,860	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		17,860	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)		16,454	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)		6,950	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)		23,032,388	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)		23,032,388	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)		23,032,388	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)		1,289.61	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		8,962,790	39.00	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00	
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		8,962,790	41.00	

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 26-0025	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/27/2022 2:59 pm	
			Title XVIII	Hospital	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	5,924,637	2,186	2,710.26	1,950	5,285,007	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)					12,036,078	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					26,283,875	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,088,268	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					782,450	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,870,718	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					24,413,157	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					1,406	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,289.61	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,813,192	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021

Worksheet D-1

Date/Time Prepared:
2/27/2022 2:59 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	1,584,238	23,032,388	0.068783	1,813,192	124,717
91.00	Nursing Program cost	0	23,032,388	0.000000	1,813,192	0
92.00	Allied health cost	0	23,032,388	0.000000	1,813,192	0
93.00	All other Medical Education	0	23,032,388	0.000000	1,813,192	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0025 Component CCN: 26-T025	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/27/2022 2:59 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)		2,948	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,948	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)		2,948	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)		2,121	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)		4,301,165	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)		4,301,165	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)		4,301,165	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)		1,459.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,094,560	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)		3,094,560	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0025 Component CCN: 26-T025		Period: From 10/01/2020 To 09/30/2021		Worksheet D-1 Date/Time Prepared: 2/27/2022 2:59 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)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description						1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,200,551		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,295,111		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)					158,481		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					36,951		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					195,432		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					4,099,679		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0025 Component CCN: 26-T025		Period: From 10/01/2020 To 09/30/2021		Worksheet D-1 Date/Time Prepared: 2/27/2022 2:59 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	220,265	4,301,165	0.051211	0	0	90.00
91.00	Nursing Program cost	0	4,301,165	0.000000	0	0	91.00
92.00	Allied health cost	0	4,301,165	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,301,165	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0025	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/27/2022 2:59 pm	
		Title XIX	Hospital	Cost	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			17,860	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			17,860	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)			16,454	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)			910	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)			1,143	15.00
16.00	Nursery days (title V or XIX only)			539	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)			23,032,388	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)			23,032,388	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)			23,032,388	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)			1,289.61	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,173,545	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)			1,173,545	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021

Worksheet D-1

Date/Time Prepared:
2/27/2022 2:59 pm

		Title XIX		Hospital		Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	662,235	1,143	579.38	539	312,286	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	5,924,637	2,186	2,710.26	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,404,516	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,890,347	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,406	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,289.61	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,813,192	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021

Worksheet D-1

Date/Time Prepared:
2/27/2022 2:59 pm

		Title XIX		Hospital	Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,584,238	23,032,388	0.068783	1,813,192	124,717
91.00	Nursing Program cost	0	23,032,388	0.000000	1,813,192	0
92.00	Allied health cost	0	23,032,388	0.000000	1,813,192	0
93.00	All other Medical Education	0	23,032,388	0.000000	1,813,192	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0025 Component CCN: 26-T025	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/27/2022 2:59 pm
		Title XIX	Subprovider - IRF	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)			2,948 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,948 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)			2,948 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)			49 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)			1,143 15.00
16.00	Nursery days (title V or XIX only)			539 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)			4,301,165 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)			4,301,165 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)			4,301,165 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)			1,459.01 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			71,491 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)			71,491 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-0025 Component CCN: 26-T025		Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/27/2022 2:59 pm
		Title XIX		Subprovider - IRF	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)	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)					0
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					71,491
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
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00 Total Program excludable cost (sum of lines 50 and 51)					0
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
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 10/01/2020 To 09/30/2021		Worksheet D-1 Date/Time Prepared: 2/27/2022 2:59 pm	
		Title XIX		Subprovider - IRF		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	220,265	4,301,165	0.051211	0	0	90.00
91.00	Nursing Program cost	0	4,301,165	0.000000	0	0	91.00
92.00	Allied health cost	0	4,301,165	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,301,165	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 26-0025	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/27/2022 2:59 pm	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		4,343,920		30.00
31.00	03100	INTENSIVE CARE UNIT		2,038,809		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	0.087505	10,589,203	926,608	50.00
51.00	05100	RECOVERY ROOM	0.551524	604,416	333,350	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.285751	7,502	9,646	52.00
53.00	05300	ANESTHESIOLOGY	0.028058	2,458,999	68,995	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.258771	3,226,240	834,857	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.502378	13,638	6,851	55.00
56.00	05600	RADIOISOTOPE	0.300652	122,891	36,947	56.00
57.00	05700	CT SCAN	0.029966	4,503,694	134,958	57.00
58.00	05800	MRI	0.110375	440,198	48,587	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.160059	2,350,915	376,285	59.00
60.00	06000	LABORATORY	0.131385	9,489,641	1,246,796	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.342537	517,846	177,381	62.00
64.00	06400	INTRAVENOUS THERAPY	0.809133	21,044	17,027	64.00
65.00	06500	RESPIRATORY THERAPY	1.044966	719,291	751,635	65.00
66.00	06600	PHYSICAL THERAPY	0.742796	619,712	460,320	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.417833	267,263	111,671	67.00
68.00	06800	SPEECH PATHOLOGY	0.339948	89,289	30,354	68.00
69.00	06900	ELECTROCARDIOLOGY	0.044691	699,276	31,251	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.404697	6,205	2,511	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.088513	13,209,342	1,169,198	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.347876	1,716,487	597,125	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.201258	16,026,445	3,225,450	73.00
74.00	07400	RENAL DIALYSIS	1.122559	125,799	141,217	74.00
76.00	03950	DIABETES CENTER	3.296289	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.718721	675	485	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	218.813158	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	0.321805	3,615,080	1,163,351	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.484092	275,200	133,222	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		71,716,291	12,036,078	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)		71,716,291		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 26-0025 Component CCN: 26-T025	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/27/2022 2:59 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				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
41.00	04100 SUBPROVIDER - IRF		1,908,900		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.087505	669	59	50.00
51.00	05100 RECOVERY ROOM	0.551524	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.285751	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.028058	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.258771	65,744	17,013	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.502378	0	0	55.00
56.00	05600 RADIOISOTOPE	0.300652	0	0	56.00
57.00	05700 CT SCAN	0.029966	59,806	1,792	57.00
58.00	05800 MRI	0.110375	15,911	1,756	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.160059	1,191	191	59.00
60.00	06000 LABORATORY	0.131385	268,384	35,262	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.342537	8,257	2,828	62.00
64.00	06400 INTRAVENOUS THERAPY	0.809133	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	1.044966	27,331	28,560	65.00
66.00	06600 PHYSICAL THERAPY	0.742796	842,506	625,810	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.417833	802,301	335,228	67.00
68.00	06800 SPEECH PATHOLOGY	0.339948	105,259	35,783	68.00
69.00	06900 ELECTROCARDIOLOGY	0.044691	11,100	496	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.404697	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.088513	162,979	14,426	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.347876	354	123	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.201258	400,265	80,557	73.00
74.00	07400 RENAL DIALYSIS	1.122559	18,411	20,667	74.00
76.00	03950 DIABETES CENTER	3.296289	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.718721	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	218.813158	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	0.321805	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.484092	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,790,468	1,200,551	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)		2,790,468		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 26-0025	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/27/2022 2:59 pm	
Cost Center Description			Title XIX	Hospital	Cost	
			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		1,327,852		30.00
31.00	03100	INTENSIVE CARE UNIT		163,462		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		21,417		43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.087505	1,415	124	50.00
51.00	05100	RECOVERY ROOM	0.551524	57,789	31,872	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.285751	41,679	53,589	52.00
53.00	05300	ANESTHESIOLOGY	0.028058	205,828	5,775	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.258771	386,292	99,961	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.502378	0	0	55.00
56.00	05600	RADIOISOTOPE	0.300652	32,489	9,768	56.00
57.00	05700	CT SCAN	0.029966	680,888	20,403	57.00
58.00	05800	MRI	0.110375	81,774	9,026	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.160059	326,251	52,219	59.00
60.00	06000	LABORATORY	0.130593	1,301,370	169,950	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.342537	31,740	10,872	62.00
64.00	06400	INTRAVENOUS THERAPY	0.809133	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1.044966	71,042	74,236	65.00
66.00	06600	PHYSICAL THERAPY	0.742796	44,212	32,840	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.417833	18,385	7,682	67.00
68.00	06800	SPEECH PATHOLOGY	0.339948	9,618	3,270	68.00
69.00	06900	ELECTROCARDIOLOGY	0.044691	97,260	4,347	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.404697	1,095	443	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.088513	1,339,068	118,525	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.347876	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.201258	2,294,169	461,720	73.00
74.00	07400	RENAL DIALYSIS	1.122559	10,404	11,679	74.00
76.00	03950	DIABETES CENTER	3.296289	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.718721	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	218.813158	0	0	76.98
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1.270878	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.332800	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1.543325	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1.738206	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	1.391142	0	0	88.04
88.05	08805	RURAL HEALTH CLINIC VI	1.181781	0	0	88.05
88.06	08806	RURAL HEALTH CLINIC VII	1.051487	0	0	88.06
88.07	08807	RURAL HEALTH CLINIC VIII	0.858288	0	0	88.07
88.08	08808	RURAL HEALTH CLINIC IX	1.910898	0	0	88.08
88.09	08809	RURAL HEALTH CLINIC X	1.734884	0	0	88.09
91.00	09100	EMERGENCY	0.319677	624,530	199,648	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.484092	54,880	26,567	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,712,178	1,404,516	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)		7,712,178		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet E
Part A
Date/Time Prepared:
2/27/2022 2:59 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)			17,637,155	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)			0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			385,451	2.04
3.00	Managed Care Simulated Payments			0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			82.15	4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)			0.00	5.00
6.00	FTE count for allopathic and osteopathic programs 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)			14.10	31.00
32.00	Sum of lines 30 and 31			19.40	32.00
33.00	Allowable disproportionate share percentage (see instructions)			5.36	33.00
34.00	Disproportionate share adjustment (see instructions)			236,338	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0025	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part A Date/Time Prepared: 2/27/2022 2:59 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	8,290,014,521	35.00
35.01	Factor 3 (see instructions)	0.000000000	0	0.000212510	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	1,761,711	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	1,761,711	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,761,711		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges (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 (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)		20,020,655		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		22,760,633		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)		22,760,633		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,324,430		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		447,930		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)		24,532,993		59.00
60.00	Primary payer payments		22,798		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		24,510,195		61.00
62.00	Deductibles billed to program beneficiaries		1,986,512		62.00
63.00	Coinsurance billed to program beneficiaries		28,824		63.00
64.00	Allowable bad debts (see instructions)		660,725		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		429,471		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		541,257		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		22,924,330		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)		-144,158		70.93
70.94	HRR adjustment amount (see instructions)		-162,766		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0025	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part A Date/Time Prepared: 2/27/2022 2:59 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)		242,261	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		22,375,145	71.00	
71.01	Sequestration adjustment (see instructions)		0	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		22,565,203	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)		-190,058	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	

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
2/27/2022 2:59 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	17,637,155		17,637,155	17,637,155	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	385,451		385,451	385,451	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0536	0.0536	0.0536		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	236,338	0	236,338	236,338	11.00
11.01	Uncompensated care payments	36.00	1,761,711	0	1,761,711	1,761,711	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	20,020,655	0	20,020,655	20,020,655	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	22,760,633	0	22,760,633	22,760,633	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	22,760,633	0	22,760,633	22,760,633	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,324,430	0	1,324,430	1,324,430	16.00
17.00	Special add-on payments for new technologies	54.00	447,930	0	447,930	447,930	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	24,532,993	24,532,993	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
2/27/2022 2:59 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,306,582	0	1,306,582	1,306,582	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	17,848	0	17,848	17,848	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,324,430	0	1,324,430	1,324,430	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-144,158	0	-144,158	-144,158	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-162,766	0	-162,766	-162,766	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	242,261	242,261	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0025	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part B Date/Time Prepared: 2/27/2022 2:59 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		805	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		17,195,303	2.00
3.00	OPPS payments		16,428,157	3.00
4.00	Outlier payment (see instructions)		129,860	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		15,166,257	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)		805	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		4,000	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)		4,000	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)		4,000	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		3,195	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)		805	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)		16,558,017	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,642,951	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)		13,915,871	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)		13,915,871	30.00
31.00	Primary payer payments		901	31.00
32.00	Subtotal (line 30 minus line 31)		13,914,970	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)		242,840	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		157,846	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		140,168	36.00
37.00	Subtotal (see instructions)		14,072,816	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-238	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)		14,073,054	40.00
40.01	Sequestration adjustment (see instructions)		0	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		14,068,696	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)		4,358	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 10/01/2020
To 09/30/2021Worksheet E-1
Part I
Date/Time Prepared:
2/27/2022 2:59 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		22,529,803		14,068,696	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	07/28/2021	35,400		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)		35,400		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)		22,565,203		14,068,696	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		4,358	6.01
6.02	SETTLEMENT TO PROGRAM		190,058		0	6.02
7.00	Total Medicare program liability (see instructions)		22,375,145		14,073,054	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 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/27/2022 2:59 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		3,950,020		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,950,020		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		18,660		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,968,680		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 10/01/2020
To 09/30/2021Worksheet E-1
Part II
Date/Time Prepared:
2/27/2022 2:59 pm

Title XVIII		Hospital	PPS
			1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS			
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8 through 12, and 32.		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 through 12, and 32.		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 10/01/2020 To 09/30/2021	Worksheet E-3 Part III Date/Time Prepared: 2/27/2022 2:59 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			3,659,053 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0301 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			53,422 3.00
4.00	Outlier Payments			295,446 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)			8.076712 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)			4,007,921 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)			4,007,921 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			4,007,921 19.00
20.00	Deductibles			26,408 20.00
21.00	Subtotal (line 19 minus line 20)			3,981,513 21.00
22.00	Coinsurance			12,833 22.00
23.00	Subtotal (line 21 minus line 22)			3,968,680 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			0 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			3,968,680 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
31.98	Recovery of accelerated depreciation.			0 31.98
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			3,968,680 32.00
32.01	Sequestration adjustment (see instructions)			0 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			3,950,020 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)			18,660 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			295,446 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 10/01/2020 To 09/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 2/27/2022 2:59 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services	2,890,347			1.00
2.00	Medical and other services			3,184,045	2.00
3.00	Organ acquisition (certified transplant centers only)	0			3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	2,890,347		3,184,045	4.00
5.00	Inpatient primary payer payments	0			5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	2,890,347		3,184,045	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges	1,512,731			8.00
9.00	Ancillary service charges	7,712,178		18,063,431	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)	9,224,909		18,063,431	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)	9,224,909		18,063,431	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	6,334,562		14,879,386	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0		0	18.00
19.00	Interns and Residents (see instructions)	0		0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	2,890,347		3,184,045	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments	0		0	22.00
23.00	Outlier payments	0		0	23.00
24.00	Program capital payments	0			24.00
25.00	Capital exception payments (see instructions)	0			25.00
26.00	Routine and Ancillary service other pass through costs	0		0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0			28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	2,890,347		3,184,045	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)	0		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	2,890,347		3,184,045	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			35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	2,890,347		3,184,045	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		0	37.00
38.00	Subtotal (line 36 ± line 37)	2,890,347		3,184,045	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0			39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	2,890,347		3,184,045	40.00
41.00	Interim payments	2,890,347		3,185,028	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0		-983	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 10/01/2020 To 09/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 2/27/2022 2:59 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	71,491		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)	71,491	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)	71,491	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)	71,491	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		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	71,491	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		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		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 10/01/2020
To 09/30/2021

Worksheet G

Date/Time Prepared:
2/27/2022 2:59 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	32,902,827	0	0	0	1.00
2.00	Temporary investments	1,677,050	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	25,476,361	0	0	0	4.00
5.00	Other receivable	2,360,891	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	5,688,488	0	0	0	7.00
8.00	Prepaid expenses	1,927,085	0	0	0	8.00
9.00	Other current assets	882,497	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)	70,915,199	0	0	0	11.00
FIXED ASSETS						
12.00	Land	3,880,386	0	0	0	12.00
13.00	Land improvements	10,160,826	0	0	0	13.00
14.00	Accumulated depreciation	-7,523,553	0	0	0	14.00
15.00	Buildings	87,180,580	0	0	0	15.00
16.00	Accumulated depreciation	-46,383,302	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	25,540,636	0	0	0	19.00
20.00	Accumulated depreciation	-7,653,969	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	81,482,631	0	0	0	23.00
24.00	Accumulated depreciation	-65,377,032	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	1,975,777	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	83,282,980	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	65,511,954	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	4,011,499	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	69,523,453	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	223,721,632	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	9,440,951	0	0	0	37.00
38.00	Salaries, wages, and fees payable	15,721,104	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	3,063,659	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	14,676,549	0	0	0	42.00
43.00	Due to other funds	4,843,696	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)	47,745,959	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	41,490,567	0	0	0	47.00
48.00	Unsecured loans	523,395	0	0	0	48.00
49.00	Other long term liabilities	2,956,205	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	44,970,167	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	92,716,126	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	131,005,506	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)	131,005,506	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	223,721,632	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021

Worksheet G-1

Date/Time Prepared:
2/27/2022 2:59 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		117,692,331		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		13,204,871				2.00
3.00	Total (sum of line 1 and line 2)		130,897,202		0		3.00
4.00	FOUNDATION NET INCOME	342,657		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)		342,657		0		10.00
11.00	Subtotal (line 3 plus line 10)		131,239,859		0		11.00
12.00	TEMPORARILY & PERMANENTLY RESTRICTED	234,353		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)		234,353		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		131,005,506		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	TEMPORARILY & PERMANENTLY RESTRICTED		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 10/01/2020
To 09/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
2/27/2022 2:59 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	13,217,460		13,217,460	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	2,710,991		2,710,991	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)	15,928,451		15,928,451	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	2,237,855		2,237,855	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)	2,237,855		2,237,855	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	18,166,306		18,166,306	17.00
18.00	Ancillary services	156,561,161	281,884,050	438,445,211	18.00
19.00	Outpatient services	8,261,199	22,879,401	31,140,600	19.00
20.00	RURAL HEALTH CLINIC	0	1,031,032	1,031,032	20.00
20.01	RURAL HEALTH CLINIC II	0	602,136	602,136	20.01
20.02	RURAL HEALTH CLINIC III	0	797,576	797,576	20.02
20.03	RURAL HEALTH CLINIC IV	0	1,079,175	1,079,175	20.03
20.04	RURAL HEALTH CLINIC V	0	2,118,569	2,118,569	20.04
20.05	RURAL HEALTH CLINIC VI	0	316,534	316,534	20.05
20.06	RURAL HEALTH CLINIC VII	0	423,505	423,505	20.06
20.07	RURAL HEALTH CLINIC VIII	0	423,240	423,240	20.07
20.08	RURAL HEALTH CLINIC IX	0	4,760,094	4,760,094	20.08
20.09	RURAL HEALTH CLINIC X	0	403,375	403,375	20.09
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,607,972	2,607,972	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	2,446,607	8,270,102	10,716,709	27.00
27.01	PHYSICIAN REVENUE - NRCC	2,048,317	44,258,942	46,307,259	27.01
27.02	RESEARCH & INNOVATION	0	109,738	109,738	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	187,483,590	371,965,441	559,449,031	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		204,706,526		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)		204,706,526		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 26-0025

Period:
From 10/01/2020
To 09/30/2021

Worksheet G-3

Date/Time Prepared:
2/27/2022 2:59 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	559,449,031	1.00
2.00	Less contractual allowances and discounts on patients' accounts	359,728,153	2.00
3.00	Net patient revenues (line 1 minus line 2)	199,720,878	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	204,706,526	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,985,648	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	768,944	6.00
7.00	Income from investments	2,669,499	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	823,622	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	0	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	477,240	22.00
23.00	Governmental appropriations	0	23.00
24.00	DAYCARE INCOME	863,463	24.00
24.01	NON OPERATING INCOME	5,479,996	24.01
24.02	OTHER REVENUE	2,553,834	24.02
24.50	COVID-19 PHE Funding	4,553,921	24.50
25.00	Total other income (sum of lines 6-24)	18,190,519	25.00
26.00	Total (line 5 plus line 25)	13,204,871	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	13,204,871	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 26-0025

Period: From 10/01/2020

Worksheet H

HHA CCN: 26-7282

To 09/30/2021

Date/Time Prepared: 2/27/2022 2:59 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
2.00	Capital Related - Movable Equipment		0		0	0
3.00	Plant Operation & Maintenance	0	0	0	1,255	1,255
4.00	Transportation	0	0	0	0	0
5.00	Administrative and General	263,987	30,119	0	36,052	373,592
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	610,857	69,694	0	4,296	684,847
7.00	Physical Therapy	309,912	35,358	0	0	345,270
8.00	Occupational Therapy	19,079	2,177	0	0	21,256
9.00	Speech Pathology	133,556	15,238	0	68,149	216,943
10.00	Medical Social Services	69,782	7,962	0	0	77,744
11.00	Home Health Aide	27,872	3,180	0	0	31,052
12.00	Supplies (see instructions)	0	0	0	13,924	13,924
13.00	Drugs	0	0	0	9	9
14.00	DME	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0
18.00	Clinic	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0
23.50	Telemedicine	0	0	0	0	0
24.00	Total (sum of lines 1-23)	1,435,045	163,728	0	104,201	396,076
	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	1,255	0	1,255	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	0	703,750	0	703,750	5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	0	684,847	0	684,847	6.00
7.00	Physical Therapy	0	345,270	0	345,270	7.00
8.00	Occupational Therapy	0	21,256	0	21,256	8.00
9.00	Speech Pathology	0	216,943	0	216,943	9.00
10.00	Medical Social Services	0	77,744	0	77,744	10.00
11.00	Home Health Aide	0	31,052	0	31,052	11.00
12.00	Supplies (see instructions)	0	13,924	0	13,924	12.00
13.00	Drugs	0	9	0	9	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	2,099,050	0	2,099,050	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 10/01/2020

Part I

To 09/30/2021

Date/Time Prepared:

2/27/2022 2:59 pm

Home Health
Agency I

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
	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	1,255	0	0	1,255		0	3.00	
4.00	Transportation	0	0	0	0	0		4.00	
5.00	Administrative and General	703,750	3,000	0	1,255	0	708,005	5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	684,847	0	0	0	0	684,847	6.00	
7.00	Physical Therapy	345,270	0	0	0	0	345,270	7.00	
8.00	Occupational Therapy	21,256	0	0	0	0	21,256	8.00	
9.00	Speech Pathology	216,943	0	0	0	0	216,943	9.00	
10.00	Medical Social Services	77,744	0	0	0	0	77,744	10.00	
11.00	Home Health Aide	31,052	0	0	0	0	31,052	11.00	
12.00	Supplies (see instructions)	13,924	0	0	0	0	13,924	12.00	
13.00	Drugs	9	0	0	0	0	9	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)	2,099,050	3,000	0	1,255	0	2,099,050	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	708,005						5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	348,568	1,033,415					6.00	
7.00	Physical Therapy	175,733	521,003					7.00	
8.00	Occupational Therapy	10,819	32,075					8.00	
9.00	Speech Pathology	110,418	327,361					9.00	
10.00	Medical Social Services	39,570	117,314					10.00	
11.00	Home Health Aide	15,805	46,857					11.00	
12.00	Supplies (see instructions)	7,087	21,011					12.00	
13.00	Drugs	5	14					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)		2,099,050					24.00	

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 26-0025

Period:

Worksheet H-1

HHA CCN: 26-7282

From 10/01/2020
To 09/30/2021Part II
Date/Time Prepared:
2/27/2022 2:59 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	- 708,005	1,391,045 5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	684,847	6.00
7.00	Physical Therapy	0	0	0	0	345,270	7.00
8.00	Occupational Therapy	0	0	0	0	21,256	8.00
9.00	Speech Pathology	0	0	0	0	216,943	9.00
10.00	Medical Social Services	0	0	0	0	77,744	10.00
11.00	Home Health Aide	0	0	0	0	31,052	11.00
12.00	Supplies (see instructions)	0	0	0	0	13,924	12.00
13.00	Drugs	0	0	0	0	9	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	- 708,005	1,391,045 24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	3,000	0	1,255	0	708,005	708,005 25.00
26.00	Unit Cost Multiplier	1.000000	0.000000	0.418333	0.000000		0.508973 26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 26-0025

Period:

Worksheet H-2

HHA CCN: 26-7282

From 10/01/2020

Part I

To 09/30/2021

Date/Time Prepared:

						Home 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	33,748	6,453	58,934	99,135	25,204
2.00	Skilled Nursing Care	1,033,415	0	0	136,371	1,169,786	297,409
3.00	Physical Therapy	521,003	0	0	69,187	590,190	150,052
4.00	Occupational Therapy	32,075	0	0	4,259	36,334	9,238
5.00	Speech Pathology	327,361	0	0	29,816	357,177	90,810
6.00	Medical Social Services	117,314	0	0	15,579	132,893	33,787
7.00	Home Health Aide	46,857	0	0	6,222	53,079	13,495
8.00	Supplies (see instructions)	21,011	0	0	0	21,011	5,342
9.00	Drugs	14	0	0	0	14	4
10.00	DME	0	0	0	0	0	0
11.00	Home Dialysis Aide Services	0	0	0	0	0	0
12.00	Respiratory Therapy	0	0	0	0	0	0
13.00	Private Duty Nursing	0	0	0	0	0	0
14.00	Clinic	0	0	0	0	0	0
15.00	Health Promotion Activities	0	0	0	0	0	0
16.00	Day Care Program	0	0	0	0	0	0
17.00	Home Delivered Meals Program	0	0	0	0	0	0
18.00	Homemaker Service	0	0	0	0	0	0
19.00	All Others (specify)	0	0	0	0	0	0
19.50	Telemedicine	0	0	0	0	0	0
20.00	Total (sum of lines 1-19) (2)	2,099,050	33,748	6,453	320,368	2,459,619	625,341
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	
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	7,847	55,980	0	17,634	0	0
2.00	Skilled Nursing Care	0	0	0	0	0	0
3.00	Physical Therapy	0	0	0	0	0	0
4.00	Occupational Therapy	0	0	0	0	0	0
5.00	Speech Pathology	0	0	0	0	0	0
6.00	Medical Social Services	0	0	0	0	0	0
7.00	Home Health Aide	0	0	0	0	0	0
8.00	Supplies (see instructions)	0	0	0	0	0	0
9.00	Drugs	0	0	0	0	0	0
10.00	DME	0	0	0	0	0	0
11.00	Home Dialysis Aide Services	0	0	0	0	0	0
12.00	Respiratory Therapy	0	0	0	0	0	0
13.00	Private Duty Nursing	0	0	0	0	0	0
14.00	Clinic	0	0	0	0	0	0
15.00	Health Promotion Activities	0	0	0	0	0	0
16.00	Day Care Program	0	0	0	0	0	0
17.00	Home Delivered Meals Program	0	0	0	0	0	0
18.00	Homemaker Service	0	0	0	0	0	0
19.00	All Others (specify)	0	0	0	0	0	0
19.50	Telemedicine	0	0	0	0	0	0
20.00	Total (sum of lines 1-19) (2)	7,847	55,980	0	17,634	0	0
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.						

(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 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/27/2022 2:59 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	207,398	0	0	0	413,198	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	1,467,195	0	2.00
3.00	Physical Therapy	0	0	0	0	740,242	0	3.00
4.00	Occupational Therapy	0	0	0	0	45,572	0	4.00
5.00	Speech Pathology	0	0	0	0	447,987	0	5.00
6.00	Medical Social Services	0	0	0	0	166,680	0	6.00
7.00	Home Health Aide	0	0	0	0	66,574	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	26,353	0	8.00
9.00	Drugs	0	0	0	0	18	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)	207,398	0	0	0	3,373,819	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	413,198						1.00
2.00	Skilled Nursing Care	1,467,195	204,768	1,671,963				2.00
3.00	Physical Therapy	740,242	103,312	843,554				3.00
4.00	Occupational Therapy	45,572	6,360	51,932				4.00
5.00	Speech Pathology	447,987	62,523	510,510				5.00
6.00	Medical Social Services	166,680	23,263	189,943				6.00
7.00	Home Health Aide	66,574	9,291	75,865				7.00
8.00	Supplies (see instructions)	26,353	3,678	30,031				8.00
9.00	Drugs	18	3	21				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)	3,373,819	413,198	3,373,819				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.		0.139565					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 10/01/2020
To 09/30/2021Part II
Date/Time Prepared:
2/27/2022 2:59 pmHome 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	6,341	263,987	0	99,135	3,000	1.00
2.00	Skilled Nursing Care	0	0	610,858	0	1,169,786	0	2.00
3.00	Physical Therapy	0	0	309,912	0	590,190	0	3.00
4.00	Occupational Therapy	0	0	19,079	0	36,334	0	4.00
5.00	Speech Pathology	0	0	133,556	0	357,177	0	5.00
6.00	Medical Social Services	0	0	69,782	0	132,893	0	6.00
7.00	Home Health Aide	0	0	27,872	0	53,079	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	21,011	0	8.00
9.00	Drugs	0	0	0	0	14	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	6,341	1,435,046		2,459,619	3,000	20.00
21.00	Total cost to be allocated	33,748	6,453	320,368		625,341	7,847	21.00
22.00	Unit cost multiplier	11.249333	1.017663	0.223246		0.254243	2.615667	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	39,671	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	39,671	20.00
21.00	Total cost to be allocated	55,980	0	17,634	0	0	207,398	21.00
22.00	Unit cost multiplier	18.660000	0.000000	5.878000	0.000000	0.000000	5.227950	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 10/01/2020
To 09/30/2021Part II
Date/Time Prepared:
2/27/2022 2:59 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 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/27/2022 2:59 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	1,671,963		1,671,963	6,542	255.57	1.00	
2.00	Physical Therapy	3.00	843,554	0	843,554	3,606	233.93	2.00	
3.00	Occupational Therapy	4.00	51,932	0	51,932	222	233.93	3.00	
4.00	Speech Pathology	5.00	510,510	0	510,510	1,554	328.51	4.00	
5.00	Medical Social Services	6.00	189,943		189,943	16	11,871.44	5.00	
6.00	Home Health Aide	7.00	75,865		75,865	1,047	72.46	6.00	
7.00	Total (sum of lines 1-6)		3,343,767	0	3,343,767	12,987		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	414			8.00	
8.01	Skilled Nursing Care		99926	0	2,921			8.01	
9.00	Physical Therapy		99914	0	252			9.00	
9.01	Physical Therapy		99926	0	1,846			9.01	
10.00	Occupational Therapy		99914	0	84			10.00	
10.01	Occupational Therapy		99926	0	874			10.01	
11.00	Speech Pathology		99914	0	4			11.00	
11.01	Speech Pathology		99926	0	117			11.01	
12.00	Medical Social Services		99914	0	0			12.00	
12.01	Medical Social Services		99926	0	3			12.01	
13.00	Home Health Aide		99914	0	55			13.00	
13.01	Home Health Aide		99926	0	673			13.01	
14.00	Total (sum of lines 8-13)			0	7,243			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	30,031	795	30,826	8,984	3.431211	15.00	
16.00	Cost of Drugs	9.00	21	0	21	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				8.00
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	3,335		0	852,326		1.00	
2.00	Physical Therapy	0	2,098		0	490,785		2.00	
3.00	Occupational Therapy	0	958		0	224,105		3.00	
4.00	Speech Pathology	0	121		0	39,750		4.00	
5.00	Medical Social Services	0	3		0	35,614		5.00	
6.00	Home Health Aide	0	728		0	52,751		6.00	
7.00	Total (sum of lines 1-6)	0	7,243		0	1,695,331		7.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 26-0025

Period:

Worksheet H-3

HHA CCN: 26-7282

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/27/2022 2:59 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	10,945	0	0	37,555	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	852,326							1.00
2.00	Physical Therapy	490,785							2.00
3.00	Occupational Therapy	224,105							3.00
4.00	Speech Pathology	39,750							4.00
5.00	Medical Social Services	35,614							5.00
6.00	Home Health Aide	52,751							6.00
7.00	Total (sum of lines 1-6)	1,695,331							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 10/01/2020

Part II

To 09/30/2021

Date/Time Prepared:

2/27/2022 2:59 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	0.742796	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.417833	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.339948	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.088513	8,984	795	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.201258	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 26-0025 HHA CCN: 26-7282	Period: From 10/01/2020 To 09/30/2021	Worksheet H-4 Part I-II Date/Time Prepared: 2/27/2022 2:59 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
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
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
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			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
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	947,862
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	145,203
13.00	Total PPS Reimbursement - LUPA Episodes		0	17,444
14.00	Total PPS Reimbursement - PEP Episodes		0	10,032
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	41,214
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	169
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	1,161,924
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	1,161,924
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	1,161,924
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	1,161,924
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
30.99	Demonstration payment adjustment amount before sequestration		0	0
31.00	Subtotal (see instructions)		0	1,161,924
31.01	Sequestration adjustment (see instructions)		0	0
31.02	Demonstration payment adjustment amount after sequestration		0	0
31.75	Sequestration adjustment for non-claims based amounts (see instructions)		0	0
32.00	Interim payments (see instructions)		0	1,161,924
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

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 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 pmHome 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		1,161,924	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		1,161,924	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		1,161,924	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 10/01/2020 To 09/30/2021	Worksheet L Parts I-III Date/Time Prepared: 2/27/2022 2:59 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,306,582	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		17,848	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)		51.55	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)		1,324,430	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 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 pm

						RHC I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassification 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	232,683	0	232,683	0	232,683	1.00		
2.00	Physician Assistant	0	0	0	0	0	2.00		
3.00	Nurse Practitioner	147,861	0	147,861	0	147,861	3.00		
4.00	Visiting Nurse	0	0	0	0	0	4.00		
5.00	Other Nurse	149,772	0	149,772	0	149,772	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)	530,316	0	530,316	0	530,316	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	4,422	4,422	0	4,422	15.00		
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00		
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00		
18.00	Professional Liability Insurance	0	0	0	0	0	18.00		
19.00	Other Health Care Costs	0	0	0	0	0	19.00		
20.00	Allowable GME Costs						20.00		
21.00	Subtotal (sum of lines 15 through 20)	0	4,422	4,422	0	4,422	21.00		
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	530,316	4,422	534,738	0	534,738	22.00		
	COSTS OTHER THAN RHC/FQHC SERVICES								
23.00	Pharmacy	0	10,032	10,032	0	10,032	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	10,032	10,032	0	10,032	28.00		
	FACILITY OVERHEAD								
29.00	Facility Costs	0	29,809	29,809	0	29,809	29.00		
30.00	Administrative Costs	131,984	154,831	286,815	23,416	310,231	30.00		
31.00	Total Facility Overhead (sum of lines 29 and 30)	131,984	184,640	316,624	23,416	340,040	31.00		
32.00	Total facility costs (sum of lines 22, 28 and 31)	662,300	199,094	861,394	23,416	884,810	32.00		

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8512

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 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	-75,689	156,994	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	-5,073	142,788	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	149,772	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)	-80,762	449,554	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	4,422	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	4,422	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-80,762	453,976	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	10,032	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	2,344	2,344	25.01
25.02	Chronic Care Management	78,418	78,418	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)	80,762	90,794	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	29,809	29.00
30.00	Administrative Costs	0	310,231	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	340,040	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	884,810	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-3984

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 pm

		RHC II		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	0	0 1.00
2.00	Physician Assistant	0	0	0	0	0 2.00
3.00	Nurse Practitioner	152,027	0	152,027	0	152,027 3.00
4.00	Visiting Nurse	0	0	0	0	0 4.00
5.00	Other Nurse	61,999	0	61,999	0	61,999 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)	214,026	0	214,026	0	214,026 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	6,793	6,793	0	6,793 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	6,793	6,793	0	6,793 21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	214,026	6,793	220,819	0	220,819 22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	12,766	12,766	0	12,766 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	12,766	12,766	0	12,766 28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	69,811	69,811	0	69,811 29.00
30.00	Administrative Costs	96,798	115,774	212,572	34,843	247,415 30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	96,798	185,585	282,383	34,843	317,226 31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	310,824	205,144	515,968	34,843	550,811 32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-3984

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC II	Cost
		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	-33,468	118,559		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	61,999		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)	-33,468	180,558		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	6,793		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	6,793		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-33,468	187,351		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	12,766		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	100	100		25.01
25.02	Chronic Care Management	33,368	33,368		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)	33,468	46,234		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	69,811		29.00
30.00	Administrative Costs	0	247,415		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	317,226		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	550,811		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8513

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 pm

		RHC III		Cost	
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
	1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS					
1.00 Physician	120,196	0	120,196	0	120,196
2.00 Physician Assistant	0	0	0	0	0
3.00 Nurse Practitioner	129,976	0	129,976	0	129,976
4.00 Visiting Nurse	0	0	0	0	0
5.00 Other Nurse	96,095	0	96,095	0	96,095
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)	346,267	0	346,267	0	346,267
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	5,572	5,572	0	5,572
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	5,572	5,572	0	5,572
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	346,267	5,572	351,839	0	351,839
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00 Pharmacy	0	23,409	23,409	0	23,409
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	23,409	23,409	0	23,409
FACILITY OVERHEAD					
29.00 Facility Costs	0	13,280	13,280	0	13,280
30.00 Administrative Costs	128,876	140,260	269,136	23,416	292,552
31.00 Total Facility Overhead (sum of lines 29 and 30)	128,876	153,540	282,416	23,416	305,832
32.00 Total facility costs (sum of lines 22, 28 and 31)	475,143	182,521	657,664	23,416	681,080

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8513

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 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	-2,919	117,277	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	-29,718	100,258	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	96,095	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)	-32,637	313,630	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	5,572	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	5,572	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-32,637	319,202	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	23,409	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	3,018	3,018	25.01
25.02	Chronic Care Management	29,619	29,619	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)	32,637	56,046	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	13,280	29.00
30.00	Administrative Costs	0	292,552	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	305,832	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	681,080	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8723

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 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	403,052	403,052
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	90,052	0	90,052	22,490	112,542
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	138,549	138,549
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)	90,052	0	90,052	564,091	654,143
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	6,339	6,339	0	6,339
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	6,339	6,339	0	6,339
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	90,052	6,339	96,391	564,091	660,482
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	28,862	28,862	0	28,862
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	28,862	28,862	0	28,862
FACILITY OVERHEAD						
29.00	Facility Costs	0	60,287	60,287	0	60,287
30.00	Administrative Costs	110,838	147,352	258,190	268,681	526,871
31.00	Total Facility Overhead (sum of lines 29 and 30)	110,838	207,639	318,477	268,681	587,158
32.00	Total facility costs (sum of lines 22, 28 and 31)	200,890	242,840	443,730	832,772	1,276,502

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8723

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 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	-104,375	298,677	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	-2,445	110,097	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	138,549	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)	-106,820	547,323	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	6,339	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	6,339	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-106,820	553,662	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	28,862	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	3,000	3,000	25.01
25.02	Chronic Care Management	103,820	103,820	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)	106,820	135,682	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	60,287	29.00
30.00	Administrative Costs	0	526,871	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	587,158	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,276,502	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8724

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 pm

		RHC V		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	833,893	0	833,893	-403,052	430,841
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	437,446	0	437,446	-22,490	414,956
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	443,687	0	443,687	-138,549	305,138
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)	1,715,026	0	1,715,026	-564,091	1,150,935
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	43,954	43,954	0	43,954
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	43,954	43,954	0	43,954
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,715,026	43,954	1,758,980	-564,091	1,194,889
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	63,235	63,235	0	63,235
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	63,235	63,235	0	63,235
FACILITY OVERHEAD						
29.00	Facility Costs	0	287,983	287,983	0	287,983
30.00	Administrative Costs	241,218	424,537	665,755	-190,847	474,908
31.00	Total Facility Overhead (sum of lines 29 and 30)	241,218	712,520	953,738	-190,847	762,891
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,956,244	819,709	2,775,953	-754,938	2,021,015

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8724

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 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	-70,317	360,524	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	-401	414,555	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	305,138	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)	-70,718	1,080,217	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	43,954	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	43,954	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-70,718	1,124,171	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	63,235	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	970	970	25.01
25.02	Chronic Care Management	67,593	67,593	25.02
26.00	All other nonreimbursable costs	2,155	2,155	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	70,718	133,953	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	287,983	29.00
30.00	Administrative Costs	0	474,908	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	762,891	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,021,015	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8756

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 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	48,873	0	48,873	0	48,873
2.00 Physician Assistant	0	0	0	0	0
3.00 Nurse Practitioner	94,366	0	94,366	0	94,366
4.00 Visiting Nurse	0	0	0	0	0
5.00 Other Nurse	55,373	0	55,373	0	55,373
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)	198,612	0	198,612	0	198,612
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	716	716	0	716
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	716	716	0	716
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	198,612	716	199,328	0	199,328
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00 Pharmacy	0	254	254	0	254
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	254	254	0	254
FACILITY OVERHEAD					
29.00 Facility Costs	0	14,018	14,018	0	14,018
30.00 Administrative Costs	2,194	37,624	39,818	0	39,818
31.00 Total Facility Overhead (sum of lines 29 and 30)	2,194	51,642	53,836	0	53,836
32.00 Total facility costs (sum of lines 22, 28 and 31)	200,806	52,612	253,418	0	253,418

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8756

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 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	48,873	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	94,366	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	55,373	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	198,612	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	716	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	716	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	199,328	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	254	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	254	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	14,018	29.00
30.00	Administrative Costs	0	39,818	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	53,836	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	253,418	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8757

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 pm

				RHC VII		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	48,873	0	48,873	0	48,873	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	96,880	0	96,880	0	96,880	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	64,247	0	64,247	0	64,247	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)	210,000	0	210,000	0	210,000	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	2,272	2,272	0	2,272	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	2,272	2,272	0	2,272	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	210,000	2,272	212,272	0	212,272	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	723	723	0	723	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	723	723	0	723	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	56,081	56,081	0	56,081	29.00
30.00	Administrative Costs	2,127	36,483	38,610	0	38,610	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	2,127	92,564	94,691	0	94,691	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	212,127	95,559	307,686	0	307,686	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8757

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 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	48,873		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	96,880		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	64,247		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	210,000		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	2,272		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	2,272		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	212,272		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	723		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	723		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	56,081		29.00
30.00	Administrative Costs	0	38,610		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	94,691		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	307,686		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8758

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 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	0	0	0	0	0 1.00
2.00	Physician Assistant	0	0	0	0	0 2.00
3.00	Nurse Practitioner	99,902	0	99,902	0	99,902 3.00
4.00	Visiting Nurse	0	0	0	0	0 4.00
5.00	Other Nurse	87,056	0	87,056	0	87,056 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)	186,958	0	186,958	0	186,958 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	822	822	0	822 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	822	822	0	822 21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	186,958	822	187,780	0	187,780 22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	1,739	1,739	0	1,739 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	1,739	1,739	0	1,739 28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	2,920	2,920	0	2,920 29.00
30.00	Administrative Costs	0	29,285	29,285	923	30,208 30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	32,205	32,205	923	33,128 31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	186,958	34,766	221,724	923	222,647 32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8758

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 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	0	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	99,902	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	87,056	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	186,958	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	822	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	822	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	187,780	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	1,739	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	1,739	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	2,920	29.00
30.00	Administrative Costs	0	30,208	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	33,128	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	222,647	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8754

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 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	2,948,580	0	2,948,580	-21,375	2,927,205
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	310,903	0	310,903	0	310,903
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	644,164	0	644,164	0	644,164
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)	3,903,647	0	3,903,647	-21,375	3,882,272
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	53,667	53,667	0	53,667
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	53,667	53,667	0	53,667
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,903,647	53,667	3,957,314	-21,375	3,935,939
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	395,128	395,128	0	395,128
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	395,128	395,128	0	395,128
FACILITY OVERHEAD						
29.00	Facility Costs	0	1,285	1,285	0	1,285
30.00	Administrative Costs	338,389	672,310	1,010,699	136,289	1,146,988
31.00	Total Facility Overhead (sum of lines 29 and 30)	338,389	673,595	1,011,984	136,289	1,148,273
32.00	Total facility costs (sum of lines 22, 28 and 31)	4,242,036	1,122,390	5,364,426	114,914	5,479,340

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8754

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 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	-645,776	2,281,429	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	-61,213	249,690	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	644,164	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)	-706,989	3,175,283	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	53,667	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	53,667	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-706,989	3,228,950	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	395,128	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	58,267	58,267	25.01
25.02	Chronic Care Management	485,339	485,339	25.02
26.00	All other nonreimbursable costs	163,383	163,383	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	706,989	1,102,117	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	1,285	29.00
30.00	Administrative Costs	-6,750	1,140,238	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-6,750	1,141,523	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-6,750	5,472,590	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8759

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 pm

				RHC X		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	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	228,785	0	228,785	0	228,785	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	48,900	0	48,900	0	48,900	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)	277,685	0	277,685	0	277,685	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	2,536	2,536	0	2,536	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	2,536	2,536	0	2,536	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	277,685	2,536	280,221	0	280,221	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	2,820	2,820	0	2,820	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	2,820	2,820	0	2,820	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	11,489	11,489	0	11,489	29.00
30.00	Administrative Costs	89,578	79,244	168,822	0	168,822	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	89,578	90,733	180,311	0	180,311	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	367,263	96,089	463,352	0	463,352	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 26-0025

Period:

Worksheet M-1

Component CCN: 26-8759

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 pm

		RHC X		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	-11,776	217,009	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	48,900	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)	-11,776	265,909	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	2,536	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	2,536	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-11,776	268,445	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	2,820	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	11,776	11,776	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)	11,776	14,596	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	11,489	29.00
30.00	Administrative Costs	0	168,822	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	180,311	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	463,352	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025

Period:

Worksheet M-2

Component CCN: 26-8512

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 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	0.71	1,817	4,200	2,982		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.85	2,533	2,100	1,785		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.56	4,350		4,767	4,767	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)	1.56	4,350			4,767	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)					453,976	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					90,794	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					544,770	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.833335	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					340,040	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					425,506	15.00
16.00	Total overhead (sum of lines 14 and 15)					765,546	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					765,546	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					637,956	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,091,932	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025

Period:

Worksheet M-2

Component CCN: 26-3984

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 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		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.83	2,377	2,100	1,743		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.83	2,377		1,743	2,377	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.83	2,377			2,377	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)					187,351	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					46,234	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					233,585	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.802068	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					317,226	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					251,716	15.00
16.00	Total overhead (sum of lines 14 and 15)					568,942	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					568,942	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					456,330	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					643,681	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025

Period:

Worksheet M-2

Component CCN: 26-8513

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 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	0.53	1,406	4,200	2,226		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.70	2,031	2,100	1,470		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.23	3,437		3,696	3,696	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)	1.23	3,437			3,696	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)					319,202	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					56,046	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					375,248	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.850643	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					305,832	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					549,839	15.00
16.00	Total overhead (sum of lines 14 and 15)					855,671	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					855,671	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					727,871	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,047,073	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025

Period:

Worksheet M-2

Component CCN: 26-8723

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 pm

				RHC IV		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	1.40	3,142	4,200	5,880		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	2.72	1,666	2,100	5,712		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.12	4,808		11,592	11,592	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.12	4,808			11,592	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)					553,662	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					135,682	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					689,344	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.803172	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					587,158	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					599,326	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,186,484	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,186,484	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					952,951	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,506,613	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025

Period:

Worksheet M-2

Component CCN: 26-8724

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 pm

				RHC V		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.70	4,517	4,200	2,940		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.17	7,235	2,100	2,457		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.87	11,752		5,397	11,752	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)	1.87	11,752			11,752	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)					1,124,171	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					133,953	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,258,124	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.893530	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					762,891	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					926,216	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,689,107	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,689,107	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,509,268	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,633,439	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025

Period:

Worksheet M-2

Component CCN: 26-8756

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 pm

		RHC VI		Cost	
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
	1.00	2.00	3.00	4.00	5.00
VISITS AND PRODUCTIVITY					
Positions					
1.00	Physician	0.20	777	4,200	840
2.00	Physician Assistant	0.00	0	2,100	0
3.00	Nurse Practitioner	0.87	738	2,100	1,827
4.00	Subtotal (sum of lines 1 through 3)	1.07	1,515		2,667
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)	1.07	1,515		2,667
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)				199,328
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				254
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				199,582
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.998727
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				53,836
15.00	Parent provider overhead allocated to facility (see instructions)				120,656
16.00	Total overhead (sum of lines 14 and 15)				174,492
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				174,492
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				174,270
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				373,598

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025

Period:

Worksheet M-2

Component CCN: 26-8757

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 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	542	4,200	840
2.00	Physician Assistant	0.00	0	2,100	0
3.00	Nurse Practitioner	0.93	1,857	2,100	1,953
4.00	Subtotal (sum of lines 1 through 3)	1.13	2,399		2,793
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)	1.13	2,399		2,793
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)				212,272
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				723
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				212,995
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.996606
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				94,691
15.00	Parent provider overhead allocated to facility (see instructions)				137,624
16.00	Total overhead (sum of lines 14 and 15)				232,315
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				232,315
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				231,527
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				443,799

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025

Period:

Worksheet M-2

Component CCN: 26-8758

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 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	0.00	11	4,200	0		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.94	2,094	2,100	1,974		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.94	2,105		1,974	2,105	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.94	2,105			2,105	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)					187,780	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					1,739	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					189,519	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.990824	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					33,128	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					140,615	15.00
16.00	Total overhead (sum of lines 14 and 15)					173,743	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					173,743	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					172,149	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					359,929	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025

Period:

Worksheet M-2

Component CCN: 26-8754

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 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	8.00	18,823	4,200	33,936		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.70	1,032	2,100	3,570		3.00
4.00	Subtotal (sum of lines 1 through 3)	9.78	19,855		37,506	37,506	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)	9.78	19,855			37,506	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)					3,228,950	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					1,102,117	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					4,331,067	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.745532	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					1,141,523	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					3,623,462	15.00
16.00	Total overhead (sum of lines 14 and 15)					4,764,985	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					4,764,985	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					3,552,449	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					6,781,399	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 26-0025

Period:

Worksheet M-2

Component CCN: 26-8759

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 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	1.65	2,414	2,100	3,465		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.65	2,414		3,465	3,465	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)	1.65	2,414			3,465	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)					268,445	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					14,596	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					283,041	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.948431	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					180,311	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					236,457	15.00
16.00	Total overhead (sum of lines 14 and 15)					416,768	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					416,768	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					395,276	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					663,721	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 26-0025 Component CCN: 26-8512	Period: From 10/01/2020 To 09/30/2021	Worksheet M-3 Date/Time Prepared: 2/27/2022 2:59 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)			1,091,932	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			30,045	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,061,887	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,767	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)			4,767	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			222.76	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	86.31	87.52	100.00	8.00
9.00	Rate for Program covered visits (see instructions)	86.31	87.52	100.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	276	302	546	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	23,822	26,431	54,600	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	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	104,853		16.00
16.01	Total program charges (see instructions)(from contractor's records)		196,948		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		10,126		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		5,391		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.)		59,093		16.04
16.05	Total program cost (see instructions)	0	64,484		16.05
17.00	Primary payer amounts		59		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		25,596		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		32,245		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		64,425		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		18,312		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		82,737		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)		82,737		26.00
26.01	Sequestration adjustment (see instructions)		0		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		62,586		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		20,151		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

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 10/01/2020 To 09/30/2021	Worksheet M-3	
		Component CCN: 26-3984		Date/Time Prepared: 2/27/2022 2:59 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)			643,681	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			37,728	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			605,953	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,377	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)			2,377	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			254.92	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, \$20.6 or your contractor)	86.31	87.52	100.00	8.00
9.00	Rate for Program covered visits (see instructions)	86.31	87.52	100.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	183	170	385	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	15,795	14,878	38,500	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	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	69,173		16.00
16.01	Total program charges (see instructions)(from contractor's records)		123,085		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		7,250		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		4,074		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.)		37,326		16.04
16.05	Total program cost (see instructions)	0	41,400		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		18,441		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		19,479		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		41,400		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		21,585		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		62,985		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)		62,985		26.00
26.01	Sequestration adjustment (see instructions)		0		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		39,968		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		23,017		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 10/01/2020 To 09/30/2021	Worksheet M-3 Date/Time Prepared: 2/27/2022 2:59 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)			1,047,073	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			80,816	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			966,257	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,696	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)			3,696	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			261.43	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	86.31	87.52	100.00	8.00
9.00	Rate for Program covered visits (see instructions)	86.31	87.52	100.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	230	210	470	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	19,851	18,379	47,000	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	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	85,230		16.00
16.01	Total program charges (see instructions)(from contractor's records)		156,495		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		8,363		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		4,555		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.)		50,726		16.04
16.05	Total program cost (see instructions)	0	55,281		16.05
17.00	Primary payer amounts		49		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		17,268		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		26,173		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		55,232		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		38,999		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		94,231		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)		94,231		26.00
26.01	Sequestration adjustment (see instructions)		0		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		54,064		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)		40,167		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 26-0025 Component CCN: 26-8723	Period: From 10/01/2020 To 09/30/2021	Worksheet M-3 Date/Time Prepared: 2/27/2022 2:59 pm	
		Title XVIII	RHC IV	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,506,613	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			62,595	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			1,444,018	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			11,592	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)			11,592	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			124.57	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	86.31	87.52	100.00	8.00
9.00	Rate for Program covered visits (see instructions)	86.31	87.52	100.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	363	392	762	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	31,331	34,308	76,200	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	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	141,839		16.00
16.01	Total program charges (see instructions)(from contractor's records)		259,782		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		4,610		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		2,517		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		88,249		16.04
16.05	Total program cost (see instructions)	0	90,766		16.05
17.00	Primary payer amounts		231		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		29,011		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		45,232		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		90,535		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		43,130		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		133,665		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		133,665		26.00
26.01	Sequestration adjustment (see instructions)		0		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		88,292		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)		45,373		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 Component CCN: 26-8724		Period: From 10/01/2020 To 09/30/2021 Worksheet M-3 Date/Time Prepared: 2/27/2022 2:59 pm	
		Title XVIII		RHC V	
				Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,633,439	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			72,164	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,561,275	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			11,752	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)			11,752	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			217.94	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	86.31	87.52	100.00	8.00
9.00	Rate for Program covered visits (see instructions)	86.31	87.52	100.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	434	344	945	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	37,459	30,107	94,500	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	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	162,066		16.00
16.01	Total program charges (see instructions)(from contractor's records)		311,198		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		40,744		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		21,219		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		90,469		16.04
16.05	Total program cost (see instructions)	0	111,688		16.05
17.00	Primary payer amounts		563		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		27,761		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		48,539		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		111,125		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		27,783		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		138,908		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)		138,908		26.00
26.01	Sequestration adjustment (see instructions)		0		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		108,870		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)		30,038		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 26-0025 Component CCN: 26-8756	Period: From 10/01/2020 To 09/30/2021	Worksheet M-3 Date/Time Prepared: 2/27/2022 2:59 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)			373,598	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			4,140	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			369,458	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,667	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)			2,667	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			138.53	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	86.31	87.52	100.00	8.00
9.00	Rate for Program covered visits (see instructions)	86.31	87.52	100.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	69	92	165	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	5,955	8,052	16,500	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	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	30,507		16.00
16.01	Total program charges (see instructions)(from contractor's records)		71,629		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,411		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,027		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.)		18,630		16.04
16.05	Total program cost (see instructions)	0	19,657		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		6,193		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		12,605		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		19,657		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)		19,657		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		19,657		26.00
26.01	Sequestration adjustment (see instructions)		0		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		19,242		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)		415		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 10/01/2020 To 09/30/2021	Worksheet M-3	
		Component CCN: 26-8757		Date/Time Prepared: 2/27/2022 2:59 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)			443,799	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			3,822	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			439,977	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,793	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)			2,793	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			157.53	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	86.31	87.52	100.00	8.00
9.00	Rate for Program covered visits (see instructions)	86.31	87.52	100.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	266	232	529	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	22,958	20,305	52,900	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	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	96,163		16.00
16.01	Total program charges (see instructions)(from contractor's records)		192,871		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		4,788		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		2,387		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.)		55,129		16.04
16.05	Total program cost (see instructions)	0	57,516		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		24,865		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		32,644		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		57,516		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,188		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		58,704		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		58,704		26.00
26.01	Sequestration adjustment (see instructions)		0		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		55,778		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		2,926		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 26-0025 Component CCN: 26-8758	Period: From 10/01/2020 To 09/30/2021	Worksheet M-3 Date/Time Prepared: 2/27/2022 2:59 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)			359,929	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			4,997	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			354,932	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,105	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)			2,105	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			168.61	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, \$20.6 or your contractor)	86.31	87.52	100.00	8.00
9.00	Rate for Program covered visits (see instructions)	86.31	87.52	100.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	79	84	178	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	6,818	7,352	17,800	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	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	31,970		16.00
16.01	Total program charges (see instructions)(from contractor's records)		65,519		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		3,636		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,774		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.)		18,315		16.04
16.05	Total program cost (see instructions)	0	20,089		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		7,302		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		10,916		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		20,089		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)		20,089		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)		20,089		26.00
26.01	Sequestration adjustment (see instructions)		0		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		19,564		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)		525		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 26-0025 Component CCN: 26-8754	Period: From 10/01/2020 To 09/30/2021	Worksheet M-3 Date/Time Prepared: 2/27/2022 2:59 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)			6,781,399	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			322,300	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			6,459,099	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			37,506	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)			37,506	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			172.22	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	86.31	87.52	100.00	8.00
9.00	Rate for Program covered visits (see instructions)	86.31	87.52	100.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	981	998	1,800	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	84,670	87,345	180,000	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	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	352,015		16.00
16.01	Total program charges (see instructions)(from contractor's records)		697,824		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		4,235		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		2,136		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.)		245,108		16.04
16.05	Total program cost (see instructions)	0	247,244		16.05
17.00	Primary payer amounts		1,211		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		43,494		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		130,019		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		246,033		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		38,303		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		284,336		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)		284,336		26.00
26.01	Sequestration adjustment (see instructions)		0		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		242,979		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)		41,357		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 10/01/2020 To 09/30/2021	Worksheet M-3	
		Component CCN: 26-8759		Date/Time Prepared: 2/27/2022 2:59 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)			663,721	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			9,830	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			653,891	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,465	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)			3,465	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			188.71	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		86.31	87.52	100.00
9.00	Rate for Program covered visits (see instructions)		86.31	87.52	100.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		27	24	107
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		2,330	2,100	10,700
12.00	Program covered visits for mental health services (from contractor records)		0	0	0
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	0
14.00	Limit adjustment for mental health services (see instructions)		0	0	0
15.00	Graduate Medical Education Pass Through Cost (see instructions)				
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	15,130	
16.01	Total program charges (see instructions)(from contractor's records)			23,649	
16.02	Total program preventive charges (see instructions)(from provider's records)			4,678	
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			2,993	
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			7,516	
16.05	Total program cost (see instructions)		0	10,509	
17.00	Primary payer amounts			0	
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			2,742	
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			3,246	
20.00	Net Medicare cost excluding vaccines (see instructions)			10,509	
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			4,473	
22.00	Total reimbursable Program cost (line 20 plus line 21)			14,982	
23.00	Allowable bad debts (see instructions)			0	
23.01	Adjusted reimbursable bad debts (see instructions)			0	
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	
25.99	Demonstration payment adjustment amount before sequestration			0	
26.00	Net reimbursable amount (see instructions)			14,982	
26.01	Sequestration adjustment (see instructions)			0	
26.02	Demonstration payment adjustment amount after sequestration			0	
27.00	Interim payments			10,267	
28.00	Tentative settlement (for contractor use only)			0	
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			4,715	
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 26-0025

Period:

Worksheet M-4

Component CCN: 26-8512

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 pm

		Title XVIII		RHC I	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	449,554	449,554	449,554	449,554	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000378	0.004673	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	170	2,101	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	2,822	7,398	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	2,992	9,499	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	453,976	453,976	453,976	453,976	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	637,956	637,956	637,956	637,956	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.006591	0.020924	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	4,205	13,349	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	7,197	22,848	0	0	10.00
11.00	Total number of injections/infusions (from your records)	19	235	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	378.79	97.23	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	16	126	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	6,061	12,251	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		30,045			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		18,312			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 26-0025

Period:

Worksheet M-4

Component CCN: 26-3984

From 10/01/2020

Date/Time Prepared:

To 09/30/2021

2/27/2022 2:59 pm

		Title XVIII		RHC II	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	180,558	180,558	180,558	180,558	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000568	0.007027	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	103	1,269	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	4,847	4,762	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	4,950	6,031	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	187,351	187,351	187,351	187,351	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	456,330	456,330	456,330	456,330	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.026421	0.032191	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	12,057	14,690	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	17,007	20,721	0	0	10.00
11.00	Total number of injections/infusions (from your records)	32	163	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	531.47	127.12	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	21	82	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	11,161	10,424	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		37,728			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		21,585			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 26-0025

Period:

Worksheet M-4

Component CCN: 26-8513

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 pm

		Title XVIII		RHC III	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	313,630	313,630	313,630	313,630	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000408	0.005049	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	128	1,584	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	10,938	11,987	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	11,066	13,571	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	319,202	319,202	319,202	319,202	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	727,871	727,871	727,871	727,871	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.034668	0.042515	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	25,234	30,945	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	36,300	44,516	0	0	10.00
11.00	Total number of injections/infusions (from your records)	75	439	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	484.00	101.40	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	37	208	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	17,908	21,091	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		80,816			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		38,999			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 26-0025

Period:

Worksheet M-4

Component CCN: 26-8723

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 pm

		Title XVIII		RHC IV	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	547,323	547,323	547,323	547,323	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000642	0.007946	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	351	4,349	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	10,427	7,876	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	10,778	12,225	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	553,662	553,662	553,662	553,662	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	952,951	952,951	952,951	952,951	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.019467	0.022080	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	18,551	21,041	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	29,329	33,266	0	0	10.00
11.00	Total number of injections/infusions (from your records)	74	256	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	396.34	129.95	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	58	155	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	22,988	20,142	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		62,595			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		43,130			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 26-0025

Period:

Worksheet M-4

Component CCN: 26-8724

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 pm

		Title XVIII		RHC V	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,080,217	1,080,217	1,080,217	1,080,217	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000113	0.001392	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	122	1,504	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	18,342	10,837	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	18,464	12,341	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,124,171	1,124,171	1,124,171	1,124,171	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,509,268	1,509,268	1,509,268	1,509,268	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.016425	0.010978	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	24,790	16,569	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	43,254	28,910	0	0	10.00
11.00	Total number of injections/infusions (from your records)	112	420	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	386.20	68.83	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	42	168	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	16,220	11,563	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		72,164			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		27,783			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 26-0025

Period:

Worksheet M-4

Component CCN: 26-8756

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 pm

		Title XVIII		RHC VI	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	198,612	198,612	198,612	198,612	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000590	0.007299	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	117	1,450	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	536	106	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	653	1,556	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	199,328	199,328	199,328	199,328	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	174,270	174,270	174,270	174,270	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.003276	0.007806	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	571	1,360	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	1,224	2,916	0	0	10.00
11.00	Total number of injections/infusions (from your records)	6	4	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	204.00	729.00	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	0	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	0	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		4,140			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		0			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 26-0025

Period:

Worksheet M-4

Component CCN: 26-8757

From 10/01/2020

Date/Time Prepared:

To 09/30/2021

2/27/2022 2:59 pm

		Title XVIII		RHC VII	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	210,000	210,000	210,000	210,000	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000588	0.007271	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	123	1,527	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	178	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	123	1,705	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	212,272	212,272	212,272	212,272	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	231,527	231,527	231,527	231,527	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000579	0.008032	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	134	1,860	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	257	3,565	0	0	10.00
11.00	Total number of injections/infusions (from your records)	0	6	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	594.17	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	2	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	1,188	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		3,822			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		1,188			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 26-0025

Period:

Worksheet M-4

Component CCN: 26-8758

From 10/01/2020

Date/Time Prepared:

To 09/30/2021

2/27/2022 2:59 pm

		Title XVIII		RHC VIII	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	186,958	186,958	186,958	186,958	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000516	0.006384	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	96	1,194	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	1,283	34	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	1,379	1,228	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	187,780	187,780	187,780	187,780	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	172,149	172,149	172,149	172,149	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.007344	0.006540	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	1,264	1,126	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	2,643	2,354	0	0	10.00
11.00	Total number of injections/infusions (from your records)	6	2	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	440.50	1,177.00	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	0	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	0	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		4,997			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		0			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 26-0025

Period:

Worksheet M-4

Component CCN: 26-8754

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/27/2022 2:59 pm

		Title XVIII		RHC IX	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	3,175,283	3,175,283	3,175,283	3,175,283	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000064	0.000788	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	203	2,502	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	124,833	25,925	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	125,036	28,427	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3,228,950	3,228,950	3,228,950	3,228,950	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	3,552,449	3,552,449	3,552,449	3,552,449	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.038723	0.008804	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	137,561	31,276	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	262,597	59,703	0	0	10.00
11.00	Total number of injections/infusions (from your records)	712	1,730	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	368.82	34.51	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	77	287	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	28,399	9,904	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		322,300			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		38,303			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 26-0025

Period:

Worksheet M-4

Component CCN: 26-8759

From 10/01/2020

Date/Time Prepared:

To 09/30/2021

2/27/2022 2:59 pm

		Title XVIII		RHC X	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	265,909	265,909	265,909	265,909	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000527	0.006516	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	140	1,733	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	374	1,729	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	514	3,462	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	268,445	268,445	268,445	268,445	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	395,276	395,276	395,276	395,276	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.001915	0.012896	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	757	5,097	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	1,271	8,559	0	0	10.00
11.00	Total number of injections/infusions (from your records)	2	58	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	635.50	147.57	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	1	26	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	636	3,837	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		9,830			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		4,473			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 10/01/2020 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 2/27/2022 2:59 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		62,586	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)		62,586	4.00	
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00	
Program to Provider					
5.01			0	5.01	
5.02			0	5.02	
5.03			0	5.03	
Provider to Program					
5.50			0	5.50	
5.51			0	5.51	
5.52			0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00	
6.01	SETTLEMENT TO PROVIDER		20,151	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		82,737	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 10/01/2020 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 2/27/2022 2:59 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		39,968	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00	
Program to Provider					
3.01			0	3.01	
3.02			0	3.02	
3.03			0	3.03	
3.04			0	3.04	
3.05			0	3.05	
Provider to Program					
3.50			0	3.50	
3.51			0	3.51	
3.52			0	3.52	
3.53			0	3.53	
3.54			0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		39,968	4.00	
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00	
Program to Provider					
5.01			0	5.01	
5.02			0	5.02	
5.03			0	5.03	
Provider to Program					
5.50			0	5.50	
5.51			0	5.51	
5.52			0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00	
6.01	SETTLEMENT TO PROVIDER		23,017	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		62,985	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 10/01/2020 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 2/27/2022 2:59 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		54,064	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)		54,064		4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01			0		5.01
5.02			0		5.02
5.03			0		5.03
Provider to Program					
5.50			0		5.50
5.51			0		5.51
5.52			0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER		40,167		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		94,231		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 10/01/2020 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 2/27/2022 2:59 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			88,292	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)			88,292	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			45,373	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			133,665	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 10/01/2020 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 2/27/2022 2:59 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		108,870	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		108,870	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		30,038	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		138,908	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 10/01/2020 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 2/27/2022 2:59 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		19,242	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)		19,242	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		415	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		19,657	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 10/01/2020 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 2/27/2022 2:59 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		55,778	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		55,778	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		2,926	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		58,704	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 10/01/2020 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 2/27/2022 2:59 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		19,564	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)		19,564	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		525	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		20,089	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 10/01/2020 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 2/27/2022 2:59 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		242,979	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)		242,979	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		41,357	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		284,336	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 10/01/2020 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 2/27/2022 2:59 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			10,267	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)			10,267	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			4,715	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			14,982	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00