

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION
AND SETTLEMENT SUMMARY

Provider CCN: 14-1313

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

Worksheet S
Parts I-III
Date/Time Prepared:
2/21/2019 9:43 am

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 2/21/2019	Time: 9:43 am
	2. ☐ Manually submitted 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	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☐ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.
	(3) Settled with Audit	9. ☐ Final Report for this Provider CCN	
	(4) Reopened		
	(5) Amended		

PART II - CERTIFICATION

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MASON DISTRICT HOSPITAL (14-1313) for the cost reporting period beginning 10/01/2017 and ending 09/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		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	36,903	-1,831	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	31,446	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	-2		0	9.00
10.00	HAVANA MEDICAL ASSOCIATES RHC I	0		131,371		0	10.00
10.01	MASON CITY MEDICAL ASSOCIATES II	0		764		0	10.01
10.02	MANITO MEDICAL CLINIC RHC III	0		0		0	10.02
200.00	Total	0	68,349	130,302	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1313		Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part I Date/Time Prepared: 2/21/2019 9:43 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 615 NORTH PROMENADE STREET			PO Box:				1.00	
2.00	City: HAVANA			State: IL		Zip Code: 62644-0530		County: MASON 2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
								8.00	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital		MASON DISTRICT HOSPITAL	141313	99914	1	07/01/2001	N	O
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF		MASON DISTRICT HOSPITAL	142313	99914		07/01/2001	N	O
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLT								
12.00	Hospital-Based HHA		MASON DISTRICT HHA	147202	99914		01/09/1982	N	P
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC		HAVANA MEDICAL ASSOCIATES RHC	143457	99914		02/01/2001	O	O
15.01	Hospital-Based Health Clinic - RHC II		MASON CITY MEDICAL ASSOCIATES	143462	99914		03/03/2003	O	O
15.02	Hospital-Based Health Clinic - RHC III		MANITO MEDICAL ASSOCIATES	148592	99914		04/19/2018	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)						10/01/2017	09/30/2018	20.00
21.00	Type of Control (see instructions)						11		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.					N	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	N		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
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

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		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.	0	0	0	0	0	0	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00	
					Urban/Rural S	Date of Geogr			
					1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2						26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2						27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0						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.							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					N	40.00	
					V	XVIII	XIX		
					1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N					N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N					N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.	N					N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N					N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N							56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N							58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N							59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1313		Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part I Date/Time Prepared: 2/21/2019 9:43 am	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)		N			60.00	
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)					0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1313

Period:
From 10/01/2017
To 09/30/2018Worksheet S-2
Part I
Date/Time Prepared:
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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		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
					1.00	2.00	3.00
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.				N	75.00	

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			1.00	2.00	3.00
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)			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	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		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	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y			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)	Y			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N			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.	Y			108.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1313		Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part I Date/Time Prepared: 2/21/2019 9:43 am		
		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.	Y	Y	N	N			109.00
					1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N			110.00
					1.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.				N			111.00
					1.00			
					2.00			
					3.00			
Miscellaneous Cost Reporting Information								
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.				N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.				N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.				Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.				1			118.00
		Premiums		Losses		Insurance		
		1.00		2.00		3.00		
118.01	List amounts of malpractice premiums and paid losses:	90,982		0		0		118.01
					1.00			
					2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.				N			118.02
119.00	DO NOT USE THIS LINE							119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.				N	N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.				N			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.				N			122.00
Transplant Center Information								
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.				N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.							134.00
All Providers								

MCRIF32 - 15.3.166.2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1313	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part I Date/Time Prepared: 2/21/2019 9:43 am
		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	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1313		Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part II Date/Time Prepared: 2/21/2019 9:43 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date	V/I			
		1.00	2.00	3.00			
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				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.	Y					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y					12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N					13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N					14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N					15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	01/08/2019	Y	01/08/2019		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1313

Period:
From 10/01/2017
To 09/30/2018Worksheet S-2
Part II
Date/Time Prepared:
2/21/2019 9:43 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		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.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		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.		Y		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		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		Y		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		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.		N		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.		N		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.		Y		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.		Y		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.		N		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.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		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.	DAN		LINHART	41.00
42.00	Enter the employer/company name of the cost report preparer.	RSM US LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563.888.4404		DAN.LINHART@RSMUS.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1313

Period:
From 10/01/2017
To 09/30/2018Worksheet S-2
Part II
Date/Time Prepared:
2/21/2019 9:43 am

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER	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: 14-1313

Period:
From 10/01/2017
To 09/30/2018Worksheet S-3
Part I
Date/Time Prepared:
2/21/2019 9:43 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
1.00 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	25	9,125	13,443.93	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)		25	9,125	13,443.93	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	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						13.00
14.00 Total (see instructions)		25	9,125	13,443.93	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						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 HAVANA MEDICAL ASSOCIATES RHC	88.00				0	26.00
26.01 MASON CITY MEDICAL ASSOCIATES	88.01				0	26.01
26.02 MANITO MEDICAL CLINIC RHC	88.02				0	26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				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: 14-1313

Period:
From 10/01/2017
To 09/30/2018Worksheet S-3
Part I
Date/Time Prepared:
2/21/2019 9:43 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	352	51	569		1.00
2.00	HMO and other (see instructions)	83	0			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	499	0	565		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	32		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	851	51	1,166		7.00
8.00	INTENSIVE CARE UNIT	0	0	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					13.00
14.00	Total (see instructions)	851	51	1,166	0.00	14.00
15.00	CAH visits	0	0	0		15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY					19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY	5,568	0	20,154	0.00	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	HAVANA MEDICAL ASSOCIATES RHC	4,822	4,275	15,463	0.00	26.00
26.01	MASON CITY MEDICAL ASSOCIATES	218	691	1,716	0.00	26.01
26.02	MANITO MEDICAL CLINIC RHC	80	634	1,302	0.00	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	27.00
28.00	Observation Bed Days		0	121		28.00
29.00	Ambulance Trips	702				29.00
30.00	Employee discount days (see instruction)			6		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	0	0		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: 14-1313

Period:
From 10/01/2017
To 09/30/2018Worksheet S-3
Part I
Date/Time Prepared:
2/21/2019 9:43 am

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	100	15	165	1.00
2.00 HMO and other (see instructions)			28	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	100	15	165	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						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 HAVANA MEDICAL ASSOCIATES RHC	0.00					26.00
26.01 MASON CITY MEDICAL ASSOCIATES	0.00					26.01
26.02 MANITO MEDICAL CLINIC RHC	0.00					26.02
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

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 14-1313 Component CCN: 14-7202		Period: From 10/01/2017 To 09/30/2018		Worksheet S-4 Date/Time Prepared: 2/21/2019 9:43 am	
				Home Health Agency I		PPS	
				1.00			
0.00	County			MASON		0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	1,466	73	554	2,093	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	187.00	9.00	71.00	267.00	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		1.00	0.00	1.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			2.12	0.00	2.12	5.00
6.00	Direct Nursing Service			7.00	0.00	7.00	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.01	0.00	1.01	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			3			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			37900			20.00
20.01				44100			20.01
20.02				99914			20.02
		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	2,483	807	46	42	3,378	21.00
22.00	Skilled Nursing Visit Charges	689,345	224,891	10,305	11,697	936,238	22.00
23.00	Physical Therapy Visits	809	253	6	18	1,086	23.00
24.00	Physical Therapy Visit Charges	247,319	77,635	307	5,526	330,787	24.00
25.00	Occupational Therapy Visits	344	142	2	4	492	25.00
26.00	Occupational Therapy Visit Charges	105,311	43,495	307	1,228	150,341	26.00
27.00	Speech Pathology Visits	38	15	1	1	55	27.00
28.00	Speech Pathology Visit Charges	11,630	4,605	0	307	16,542	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	335	219	3	0	557	31.00
32.00	Home Health Aide Visit Charges	51,306	33,680	154	0	85,140	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,009	1,436	58	65	5,568	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)	1,104,911	384,306	11,073	18,758	1,519,048	35.00
36.00	Total Number of Episodes (standard/non outlier)	228		16	4	248	36.00
37.00	Total Number of Outlier Episodes		44		1	45	37.00
38.00	Total Non-Routine Medical Supply Charges	13,294	4,502	375	69	18,240	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1313 Component CCN: 14-3457		Period: From 10/01/2017 To 09/30/2018		Worksheet S-8 Date/Time Prepared: 2/21/2019 9:43 am	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			615 PROMENADE BOX 530			1.00		
			City	State	ZIP Code				
			1.00	2.00	3.00				
2.00	City, State, ZIP Code, County			HAVANA IL 62644-0530		2.00			
				1.00					
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0		3.00	
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)							4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)							5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)							6.00	
7.00	Appalachian Regional Commission							7.00	
8.00	Look-Alikes							8.00	
9.00	OTHER (SPECIFY)							9.00	
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0		10.00	
				Sunday		Monday		Tuesday	
				from	to	from	to	from	
				1.00	2.00	3.00	4.00	5.00	
Facility hours of operations (1)									
11.00	CLINIC			08:00		18:00		08:00	
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?			N				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0		13.00	
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number							14.00	
				Y/N	V	XVIII	XIX	Total Visits	
				1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							15.00	
				County					
				4.00					
2.00	City, State, ZIP Code, County			MASON				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			18:00		08:00		18:00	
				18:00		08:00		18:00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1313 Component CCN: 14-3457		Period: From 10/01/2017 To 09/30/2018		Worksheet S-8 Date/Time Prepared: 2/21/2019 9:43 am	
						RHC I		Cost	
				Friday		Saturday			
				from	to	from	to		
				11.00	12.00	13.00	14.00		
Facility hours of operations (1)									
11.00	CLINIC	08:00	18:00						11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1313 Component CCN: 14-3462		Period: From 10/01/2017 To 09/30/2018		Worksheet S-8 Date/Time Prepared: 2/21/2019 9:43 am	
				RHC II		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street				122 EAST ELM STREET				1.00
				City	State	ZIP Code			
				1.00	2.00	3.00			
2.00	City, State, ZIP Code, County				MASON CITY		IL 62664-0530		2.00
						1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0		3.00
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)								4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)								5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)								6.00
7.00	Appalachian Regional Commission								7.00
8.00	Look-Alikes								8.00
9.00	OTHER (SPECIFY)								9.00
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N		0		10.00
				Sunday		Monday		Tuesday	
				from	to	from	to	from	
				1.00	2.00	3.00	4.00	5.00	
Facility hours of operations (1)									
11.00	CLINIC				08:00		16:00		08:00
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?				N				12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N		0		13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number								14.00
				Y/N	V	XVIII	XIX	Total Visits	
				1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)								15.00
				County					
				4.00					
2.00	City, State, ZIP Code, County				MASON				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				16:00		08:00		16:00
				08:00		16:00		08:00	
				16:00		08:00		16:00	
				11.00					

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1313	Period: From 10/01/2017	Worksheet S-8	
			Component CCN: 14-3462	To 09/30/2018	Date/Time Prepared: 2/21/2019 9:43 am	
			RHC II			Cost
			Friday		Saturday	
			from	to	from	to
			11.00	12.00	13.00	14.00
Facility hours of operations (1)						
11.00	CLINIC	08:00	16:00			11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1313 Component CCN: 14-8592		Period: From 10/01/2017 To 09/30/2018		Worksheet S-8 Date/Time Prepared: 2/21/2019 9:43 am	
				RHC III		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street				1301 S. EAST AVENUE		1.00		
				City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County				MANITO IL 61546		2.00		
				1.00					
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0		3.00		
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)						4.00		
5.00	Migrant Health Center (Section 329(d), PHS Act)						5.00		
6.00	Health Services for the Homeless (Section 340(d), PHS Act)						6.00		
7.00	Appalachian Regional Commission						7.00		
8.00	Look-Alikes						8.00		
9.00	OTHER (SPECIFY)						9.00		
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N		0		10.00
				Sunday		Monday		Tuesday	
				from to		from to		from	
				1.00 2.00		3.00 4.00		5.00	
Facility hours of operations (1)									
11.00	CLINIC				08:00		16:00		08:00
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?				N		0		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.								13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number								14.00
				Y/N		V		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				MASON				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				16:00		08:00		16:00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1313 Component CCN: 14-8592	Period: From 10/01/2017 To 09/30/2018	Worksheet S-8 Date/Time Prepared: 2/21/2019 9:43 am
			RHC III		Cost
			Friday		Saturday
			from	to	from
			11.00	12.00	13.00
Facility hours of operations (1)					
11.00	CLINIC	08:00	16:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1313	Period: From 10/01/2017 To 09/30/2018	Worksheet S-10 Date/Time Prepared: 2/21/2019 9:43 am
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.573432 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	877,514		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?			4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1,526,416		5.00
6.00	Medicaid charges	4,209,735		6.00
7.00	Medicaid cost (line 1 times line 6)	2,413,997		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)	10,067		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	11,082		9.00
10.00	Stand-alone CHIP charges	37,981		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	21,780		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	10,698		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	1,151,660		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	20,765		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	74,578	13,366	87,944 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	42,765	13,366	56,131 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	42,765	13,366	56,131 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	614,335		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	203,250		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	312,693		27.01
28.00	Non-Medicare bad debt expense (see instructions)	301,642		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	282,414		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	338,545		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	359,310		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1313

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

Worksheet A

Date/Time Prepared:
2/21/2019 9:43 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (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		0	0	368,536	368,536	1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING		0	0	56,966	56,966	1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG		0	0	473,004	473,004	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,088,355	1,088,355	-643,000	445,355	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,012,125	3,012,125	0	3,012,125	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	766,305	1,151,023	1,917,328	0	1,917,328	5.01
5.02	00591	A&G HOSPITAL ONLY	338,232	183,643	521,875	0	521,875	5.02
6.00	00600	MAINTENANCE & REPAIRS	218,661	247,570	466,231	0	466,231	6.00
7.00	00700	OPERATION OF PLANT	0	233,187	233,187	0	233,187	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	23,455	23,455	0	23,455	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	26,654	18,001	44,655	0	44,655	8.00
9.00	00900	HOUSEKEEPING	237,557	70,431	307,988	0	307,988	9.00
10.00	01000	DIETARY	225,342	209,499	434,841	0	434,841	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	183,007	21,840	204,847	0	204,847	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	75,888	9,389	85,277	0	85,277	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	134,816	84,570	219,386	0	219,386	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	301,602	301,602	0	301,602	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	952,662	243,331	1,195,993	0	1,195,993	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	178,218	53,570	231,788	0	231,788	50.00
53.00	05300	ANESTHESIOLOGY	0	75	75	0	75	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	602,443	273,909	876,352	-81,561	794,791	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	65,952	60,467	126,419	2,958	129,377	54.01
56.00	05600	RADIOISOTOPE	28,432	90,517	118,949	465	119,414	56.00
58.00	05800	MRI	0	111,020	111,020	1,172	112,192	58.00
60.00	06000	LABORATORY	652,379	689,624	1,342,003	62,001	1,404,004	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	54,606	54,606	0	54,606	62.00
64.00	06400	INTRAVENOUS THERAPY	0	21,142	21,142	0	21,142	64.00
66.00	06600	PHYSICAL THERAPY	498,716	185,335	684,051	0	684,051	66.00
67.00	06700	OCCUPATIONAL THERAPY	163,692	64,890	228,582	0	228,582	67.00
68.00	06800	SPEECH PATHOLOGY	51,827	15,316	67,143	0	67,143	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	430,105	123,395	553,500	14,965	568,465	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	338,634	338,634	0	338,634	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	299,638	508,992	808,630	0	808,630	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	193,497	123,187	316,684	0	316,684	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	7,495	18,160	25,655	0	25,655	76.01
76.02	03950	DIABETIC EDUCATION	37,677	10,942	48,619	0	48,619	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	3,660,047	704,478	4,364,525	-128,101	4,236,424	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	323,733	72,793	396,526	0	396,526	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	295,252	71,925	367,177	0	367,177	88.02
91.00	09100	EMERGENCY	427,940	1,815,282	2,243,222	627,806	2,871,028	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	948,888	107,224	1,056,112	-627,806	428,306	95.00
101.00	10100	HOME HEALTH AGENCY	598,546	125,223	723,769	0	723,769	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		255,506	255,506	-255,506	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,623,601	12,794,233	25,417,834	-128,101	25,289,733	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	49,930	3,899	53,829	128,101	181,930	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	MANITO MED ASSOCIATES	357,881	87,181	445,062	0	445,062	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	13,031,412	12,885,313	25,916,725	0	25,916,725	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1313

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

Worksheet A

Date/Time Prepared:
2/21/2019 9:43 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-49,362	319,174	1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	0	56,966	1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	-55,612	417,392	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-4,779	440,576	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-930,004	2,082,121	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	-52,804	1,864,524	5.01
5.02	00591	A&G HOSPITAL ONLY	-98	521,777	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	466,231	6.00
7.00	00700	OPERATION OF PLANT	-422	232,765	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	23,455	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	44,655	8.00
9.00	00900	HOUSEKEEPING	0	307,988	9.00
10.00	01000	DIETARY	-145,130	289,711	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	204,847	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	85,277	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,721	215,665	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-32,014	269,588	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,195,993	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	231,788	50.00
53.00	05300	ANESTHESIOLOGY	0	75	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-10,561	784,230	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	129,377	54.01
56.00	05600	RADIOISOTOPE	0	119,414	56.00
58.00	05800	MRI	0	112,192	58.00
60.00	06000	LABORATORY	-47	1,403,957	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	54,606	62.00
64.00	06400	INTRAVENOUS THERAPY	0	21,142	64.00
66.00	06600	PHYSICAL THERAPY	0	684,051	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	228,582	67.00
68.00	06800	SPEECH PATHOLOGY	-29,500	37,643	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	03160	CARDIOPULMONARY	-41,793	526,672	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	338,634	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	808,630	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	316,684	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	25,655	76.01
76.02	03950	DIABETIC EDUCATION	0	48,619	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	-681	4,235,743	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0	396,526	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0	367,177	88.02
91.00	09100	EMERGENCY	-338,744	2,532,284	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	428,306	95.00
101.00	10100	HOME HEALTH AGENCY	0	723,769	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,695,272	23,594,461	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	181,930	192.00
194.00	07950	HOSPICE	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	194.02
194.03	07954	MANITO MED ASSOCIATES	0	445,062	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,695,272	24,221,453	200.00

Provider CCN: 14-1313

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

Worksheet A-6

Date/Time Prepared:
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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	44,288	1.00	
2.00	NEW CAP REL COSTS-NEW MED	1.02	0	211,218	2.00	
	SURG					
	TOTALS		0	255,506		
	B - EMS SALARY TO ER					
1.00	EMERGENCY	91.00	627,806	0	1.00	
	TOTALS		627,806	0		
	C - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	324,248	1.00	
2.00	NEW CAP REL COSTS-CLINIC	1.01	0	56,966	2.00	
	BUILDING					
3.00	NEW CAP REL COSTS-NEW MED	1.02	0	261,786	3.00	
	SURG					
	TOTALS		0	643,000		
	D - RHC PHYSICIAN					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	128,101	0	1.00	
	TOTALS		128,101	0		
	E - OP REGISTRATION					
1.00	LABORATORY	60.00	50,542	11,459	1.00	
2.00	CARDIOPULMONARY	69.01	12,199	2,766	2.00	
3.00	RADIOLOGY-ULTRASOUND	54.01	2,411	547	3.00	
4.00	RADIOISOTOPE	56.00	379	86	4.00	
5.00	RADIOLOGY-DIAGNOSTIC	54.00	3,457	784	5.00	
6.00	MRI	58.00	955	217	6.00	
	TOTALS		69,943	15,859		
500.00	Grand Total: Increases		825,850	914,365	500.00	

Decreases						
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	255,506	11	1.00
2.00		0.00	0	0	11	2.00
	TOTALS		0	255,506		
B - EMS SALARY TO ER						
1.00	AMBULANCE SERVICES	95.00	627,806	0	0	1.00
	TOTALS		627,806	0		
C - DEPRECIATION						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	643,000	9	1.00
2.00		0.00	0	0	9	2.00
3.00		0.00	0	0	9	3.00
	TOTALS		0	643,000		
D - RHC PHYSICIAN						
1.00	HAVANA MEDICAL ASSOCIATES	88.00	128,101	0	0	1.00
	RHC					
	TOTALS		128,101	0		
E - OP REGISTRATION						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	69,943	15,859	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
	TOTALS		69,943	15,859		
500.00	Grand Total: Decreases		825,850	914,365		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1313

Period:
From 10/01/2017
To 09/30/2018Worksheet A-7
Part I
Date/Time Prepared:
2/21/2019 9:43 am

		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	163,928	0	0	0	0	1.00	
2.00	Land Improvements	603,633	0	0	0	0	2.00	
3.00	Buildings and Fixtures	16,448,537	179,582	0	179,582	0	3.00	
4.00	Building Improvements	44,894	321,883	0	321,883	0	4.00	
5.00	Fixed Equipment	3,578,865	0	0	0	0	5.00	
6.00	Movable Equipment	9,298,428	656,657	0	656,657	0	6.00	
7.00	HIT designated Assets	810,377	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	30,948,662	1,158,122	0	1,158,122	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	30,948,662	1,158,122	0	1,158,122	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	163,928	0				1.00	
2.00	Land Improvements	603,633	0				2.00	
3.00	Buildings and Fixtures	16,628,119	0				3.00	
4.00	Building Improvements	366,777	0				4.00	
5.00	Fixed Equipment	3,578,865	0				5.00	
6.00	Movable Equipment	9,955,085	0				6.00	
7.00	HIT designated Assets	810,377	0				7.00	
8.00	Subtotal (sum of lines 1-7)	32,106,784	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	32,106,784	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1313

Period:
From 10/01/2017
To 09/30/2018Worksheet A-7
Part II
Date/Time Prepared:
2/21/2019 9:43 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	1,088,355	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,088,355	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1)				
		Capital-Relat	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		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	0				1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0				1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0				1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,088,355				2.00
3.00	Total (sum of lines 1-2)	0	1,088,355				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1313

Period:
From 10/01/2017
To 09/30/2018Worksheet A-7
Part III
Date/Time Prepared:
2/21/2019 9:43 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	21,341,322	0	21,341,322	0.664698	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	0.000000	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	0	0.000000	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	10,765,462	0	10,765,462	0.335302	0	2.00
3.00	Total (sum of lines 1-2)	32,106,784	0	32,106,784	1.000000	0	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	0	266,201	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	56,966	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	0	260,584	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	440,576	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,024,327	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	32,879	0	0	20,094	319,174	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	0	56,966	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	156,808	0	0	0	417,392	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	440,576	2.00
3.00	Total (sum of lines 1-2)	189,687	0	0	20,094	1,234,108	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1313

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

Worksheet A-8

Date/Time Prepared:
2/21/2019 9:43 am

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	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP REL COSTS-CLINIC BUILDING (chapter 2)			0NEW CAP REL COSTS-CLINIC BUILDING	1.01	0	1.01
1.02	Investment income - NEW CAP REL COSTS-NEW MED SURG (chapter 2)			0NEW CAP REL COSTS-NEW MED SURG	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP 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)	0	0.00	0	8.00		
9.00	Parking lot (chapter 21)	0	0.00	0	9.00		
10.00	Provider-based physician adjustment	A-8-2	-378,837			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		0		0.00	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		0		0.00	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	*** Cost Center Deleted ***	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
26.01	Depreciation - NEW CAP REL COSTS-CLINIC BUILDING		0	NEW CAP REL COSTS-CLINIC BUILDING	1.01	0	26.01
26.02	Depreciation - NEW CAP REL COSTS-NEW MED SURG		0	NEW CAP REL COSTS-NEW MED SURG	1.02	0	26.02

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1313

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

Worksheet A-8

Date/Time Prepared:
2/21/2019 9:43 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00		0 27.00
28.00	Non-physician Anesthetist			0NONPHYSICIAN ANESTHETISTS	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		0OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-4,779	CAP REL COSTS-MVBLE EQUIP	2.00		9 32.00
33.00	MEDICAL RECORD FEES -OTHER OP	B	-3,721	MEDICAL RECORDS & LIBRARY	16.00		0 33.00
33.01	CAFETERIA SALES -OTHER OP	B	-145,130	DIETARY	10.00		0 33.01
33.02	DIETARY CONSULT -OTHER OP	B		0DIETARY	10.00		0 33.02
33.03	SALE OF NON-PAT SUPP-OTHER OP	B	1,209	ADMINISTRATIVE AND GENERAL	5.01		0 33.03
33.04	ON-CALL CRNA SERVICES	A	-32,014	NONPHYSICIAN ANESTHETISTS	19.00		0 33.04
33.05	PROF BUILDING RENT -OTHER OP	B	-51,447	CAP REL COSTS-BLDG & FIXT	1.00		9 33.05
33.06	MISCELLANEOUS REVENUE	B	-11,502	ADMINISTRATIVE AND GENERAL	5.01		0 33.06
33.07	RENTAL INCOME	B	-6,600	CAP REL COSTS-BLDG & FIXT	1.00		9 33.07
33.08	COMMUNITY ED FEES -OTHER OP	B	-1,380	ADMINISTRATIVE AND GENERAL	5.01		0 33.08
33.09	LAB OUTREACH REV -OTHER OP	B	-47	LABORATORY	60.00		0 33.09
33.10	INTEREST INCOME -NON OPER	B	-11,409	CAP REL COSTS-BLDG & FIXT	1.00		11 33.10
33.11	INTEREST INCOME -NON OPER	B	-54,410	NEW CAP REL COSTS-NEW MED SURG	1.02		11 33.11
33.12	FITNESS CENTER EXP	A	-12,261	CARDIOPULMONARY	69.01		0 33.12
33.13	FITNESS CENTER REV	B		0CARDIOPULMONARY	69.01		0 33.13
33.14	HOME HEALTH BLDG RENT	B		0HOME HEALTH AGENCY	101.00		0 33.14
33.15	TELEPHONE OFFSET - OPERATIONS	A	-422	OPERATION OF PLANT	7.00		0 33.15
33.16	TELEPHONE OFFSET - SALARIES	A	-106	ADMINISTRATIVE AND GENERAL	5.01		0 33.16
33.17	TELEPHONE OFFSET - BENEFITS	A	-21	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 33.17
33.18	MEDICAR - EXPENSES	A	-12,728	ADMINISTRATIVE AND GENERAL	5.01		0 33.18
33.19	MEDICAR - BENEFITS	A	-1,738	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 33.19
33.20	LOBBYING DUES	A	-11,998	ADMINISTRATIVE AND GENERAL	5.01		0 33.20
33.21	ADVERTISING	A	-9,477	ADMINISTRATIVE AND GENERAL	5.01		0 33.21
33.22	ADVERTISING	A	-98	A&G HOSPITAL ONLY	5.02		0 33.22
33.25	ADVERTISING	A	-681	HAVANA MEDICAL ASSOCIATES RHC	88.00		0 33.25
33.27	SPEECH THERAPY IN SCHOOLS	B	-14,750	SPEECH PATHOLOGY	68.00		0 33.27
33.34	SPEECH THERAPY IN SCHOOLS	B	-14,750	SPEECH PATHOLOGY	68.00		0 33.34
33.35	TELEVISIONS	A	-1,202	NEW CAP REL COSTS-NEW MED SURG	1.02		9 33.35
33.36	SELF INSURANCE	A	-546,818	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 33.36
33.37	UNFUNDED POST-EMPLOYMENT BENEFIT	A	-21,267	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 33.37
33.38	NON-ALLOW DONATION EXP	A	-6,822	ADMINISTRATIVE AND GENERAL	5.01		0 33.38
33.39	BOND AMORTIZTION COST FY14	A	20,094	CAP REL COSTS-BLDG & FIXT	1.00		14 33.39
33.40	IMRF CONTRIBUTION	A	-360,160	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 33.40
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,695,272				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: 14-1313

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

Worksheet A-8-2

Date/Time Prepared:
2/21/2019 9:43 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,655,640	338,744	1,316,896	0	0	1.00
2.00	60.00	LABORATORY	48,000	0	48,000	0	0	2.00
3.00	69.01	CARDIOPULMONARY	29,532	29,532	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	10,561	10,561	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,743,733	378,837	1,364,896	0	0	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	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	69.01	CARDIOPULMONARY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	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	91.00	EMERGENCY	0	0	0	338,744		1.00
2.00	60.00	LABORATORY	0	0	0	0		2.00
3.00	69.01	CARDIOPULMONARY	0	0	0	29,532		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	10,561		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	378,837		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1313		Period: From 10/01/2017 To 09/30/2018		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/21/2019 9:43 am	
				Physical Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					21	1.00
2.00	Line 1 multiplied by 15 hours per week					315	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	821.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	83.90	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	41.95	41.95	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					68,882	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					68,882	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					68,882	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					68,882	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1313		Period: From 10/01/2017 To 09/30/2018		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/21/2019 9:43 am		
				Physical Therapy		Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	83.90	0.00	0.00	0.00	0.00	52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0	54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0	55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						68,882	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						68,882	63.00
64.00	Total cost of outside supplier services (from your records)						59,277	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						0	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						0	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1313		Period: From 10/01/2017 To 09/30/2018		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/21/2019 9:43 am	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					15	1.00
2.00	Line 1 multiplied by 15 hours per week					225	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	583.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	79.51	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.76	39.76	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					46,354	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					46,354	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					46,354	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					46,354	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1313		Period: From 10/01/2017 To 09/30/2018		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/21/2019 9:43 am		
				Occupational Therapy		Cost		
						1.00		
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	79.51	0.00	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						46,354	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						46,354	63.00
64.00	Total cost of outside supplier services (from your records)						41,337	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						0	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						0	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1313

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part I
Date/Time Prepared:
2/21/2019 9:43 am

Cost Center Description			CAPITAL RELATED COSTS					
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	MVBLE EQUIP	
0			1.00	1.01	1.02	2.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	319,174	319,174			1.00	
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	56,966	0	56,966		1.01	
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	417,392	0	0	417,392	1.02	
2.00	00200	CAP REL COSTS-MVBLE EQUIP	440,576				2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,082,121	0	0	0	4.00	
5.01	00590	ADMINISTRATIVE AND GENERAL	1,864,524	70,122	3,022	0	5.01	
5.02	00591	A&G HOSPITAL ONLY	521,777	3,591	3,722	3,426	5.02	
6.00	00600	MAINTENANCE & REPAIRS	466,231	0	0	0	6.00	
7.00	00700	OPERATION OF PLANT	232,765	31,330	477	9,136	7.00	
7.01	00701	OPERATION OF PLANT-CLINIC	23,455	0	0	0	7.01	
8.00	00800	LAUNDRY & LINEN SERVICE	44,655	9,432	0	3,395	8.00	
9.00	00900	HOUSEKEEPING	307,988	2,092	0	2,006	9.00	
10.00	01000	DIETARY	289,711	15,332	0	0	743	10.00
11.00	01100	CAFETERIA	0	6,517	0	2,315	0	11.00
13.00	01300	NURSING ADMINISTRATION	204,847	4,788	0	4,969	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	85,277	8,712	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	215,665	7,128	579	0	40,700	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	269,588	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,195,993	4,661	0	325,383	31,541	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	231,788	37,738	0	0	32,405	50.00
53.00	05300	ANESTHESIOLOGY	75	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	784,230	29,419	0	0	92,311	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	129,377	1,469	0	0	0	54.01
56.00	05600	RADIOISOTOPE	119,414	3,192	0	0	0	56.00
58.00	05800	MRI	112,192	0	0	0	0	58.00
60.00	06000	LABORATORY	1,403,957	17,291	0	0	22,079	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	54,606	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	21,142	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	684,051	6,227	0	0	63,681	66.00
67.00	06700	OCCUPATIONAL THERAPY	228,582	1,306	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	37,643	943	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	526,672	29,589	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	338,634	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	808,630	0	0	57,718	1,569	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	316,684	0	2,424	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	25,655	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	48,619	3,585	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	4,235,743	0	41,806	0	26,323	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	396,526	0	0	0	1,016	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	367,177	0	0	0	0	88.02
91.00	09100	EMERGENCY	2,532,284	24,710	0	0	2,406	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	428,306	0	0	0	62,586	95.00
101.00	10100	HOME HEALTH AGENCY	723,769	0	4,936	0	7,111	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,594,461	319,174	56,966	408,348	440,576	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	9,044	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	181,930	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	MANITO MED ASSOCIATES	445,062	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	24,221,453	319,174	56,966	417,392	440,576	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1313

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part I
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Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE AND GENERAL	Subtotal	A&G HOSPITAL ONLY	
			4.00	4A	5.01	5A.01	5.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,082,121					4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	125,613	2,113,600	2,113,600			5.01
5.02	00591	A&G HOSPITAL ONLY	56,109	588,625	56,275	644,900	644,900	5.02
6.00	00600	MAINTENANCE & REPAIRS	36,274	502,505	48,041	550,546	22,155	6.00
7.00	00700	OPERATION OF PLANT	0	276,303	26,416	302,719	12,182	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	23,455	2,242	25,697	1,034	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	4,422	65,095	6,223	71,318	2,870	8.00
9.00	00900	HOUSEKEEPING	39,408	351,494	33,604	385,098	15,497	9.00
10.00	01000	DIETARY	37,382	343,168	32,808	375,976	15,130	10.00
11.00	01100	CAFETERIA	0	8,832	844	9,676	389	11.00
13.00	01300	NURSING ADMINISTRATION	30,359	244,963	23,419	268,382	10,800	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,589	106,578	10,189	116,767	4,699	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	22,365	286,437	27,385	313,822	12,629	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	269,588	25,774	295,362	11,886	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	158,037	1,715,615	164,020	1,879,635	75,640	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	29,565	331,496	31,692	363,188	14,615	50.00
53.00	05300	ANESTHESIOLOGY	0	75	7	82	3	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	88,910	994,870	95,114	1,089,984	43,863	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	11,341	142,187	13,594	155,781	6,269	54.01
56.00	05600	RADIOISOTOPE	0	122,606	11,722	134,328	5,406	56.00
58.00	05800	MRI	158	112,350	10,741	123,091	4,953	58.00
60.00	06000	LABORATORY	116,608	1,559,935	149,136	1,709,071	68,776	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	54,606	5,221	59,827	2,408	62.00
64.00	06400	INTRAVENOUS THERAPY	0	21,142	2,021	23,163	932	64.00
66.00	06600	PHYSICAL THERAPY	82,732	836,691	79,991	916,682	36,889	66.00
67.00	06700	OCCUPATIONAL THERAPY	27,155	257,043	24,574	281,617	11,333	67.00
68.00	06800	SPEECH PATHOLOGY	8,598	47,184	4,511	51,695	2,080	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	556,261	53,181	609,442	24,525	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	338,634	32,375	371,009	14,930	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	49,707	917,624	87,729	1,005,353	40,457	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	32,099	351,207	33,577	384,784	15,484	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	1,243	26,898	2,572	29,470	1,186	76.01
76.02	03950	DIABETIC EDUCATION	6,250	58,454	5,588	64,042	2,577	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	585,916	4,889,788	467,483	5,357,271	0	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	53,704	451,246	43,141	494,387	0	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	48,979	416,156	39,786	455,942	18,348	88.02
91.00	09100	EMERGENCY	175,138	2,734,538	261,433	2,995,971	120,565	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		0		92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	53,264	544,156	52,023	596,179	23,991	95.00
101.00	10100	HOME HEALTH AGENCY	99,293	835,109	79,840	914,949	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,993,218	23,496,514	2,044,292	23,427,206	644,501	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,044	865	9,909	399	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	29,534	211,464	20,217	231,681	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	MANITO MED ASSOCIATES	59,369	504,431	48,226	552,657	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments		0		0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,082,121	24,221,453	2,113,600	24,221,453	644,900	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1313

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part I
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Cost Center Description			MAINTENANCE & REPAIRS	OPERATION OF PLANT	OPERATION OF PLANT-CLINIC	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			6.00	7.00	7.01	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS	572,701					6.00
7.00	00700	OPERATION OF PLANT	45,926	360,827				7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	26,731			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	13,610	12,408	0	100,206		8.00
9.00	00900	HOUSEKEEPING	3,360	3,063	0	0	407,018	9.00
10.00	01000	DIETARY	20,680	18,854	0	0	16,510	10.00
11.00	01100	CAFETERIA	9,402	8,572	0	0	7,506	11.00
13.00	01300	NURSING ADMINISTRATION	7,771	7,085	0	0	6,204	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,751	10,713	0	0	9,381	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,139	8,765	345	0	8,893	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	92,251	84,106	0	45,544	73,651	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	50,900	46,406	0	12,687	40,637	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	39,679	36,176	0	12,971	31,679	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	1,982	1,807	0	0	1,582	54.01
56.00	05600	RADIOISOTOPE	4,306	3,925	0	0	3,437	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	23,322	21,263	0	91	18,619	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
66.00	06600	PHYSICAL THERAPY	8,399	7,658	0	3,413	6,706	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,761	1,606	0	0	1,406	67.00
68.00	06800	SPEECH PATHOLOGY	1,272	1,160	0	0	1,016	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	39,908	36,385	0	1,669	31,861	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,249	13,903	0	0	12,174	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	6,385	0	1,446	0	5,098	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	4,836	4,409	0	0	3,861	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	110,098	0	24,940	605	87,904	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0	0	0	25	0	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	33,327	30,385	0	22,734	26,608	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	365	0	95.00
101.00	10100	HOME HEALTH AGENCY	12,998	0	0	28	10,377	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	570,312	358,649	26,731	100,132	405,110	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,389	2,178	0	0	1,908	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	74	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	MANITO MED ASSOCIATES	0	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
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)	572,701	360,827	26,731	100,206	407,018	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1313

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To 09/30/2018Worksheet B
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	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
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	447,150					10.00
11.00	01100	CAFETERIA	357,594	393,139				11.00
13.00	01300	NURSING ADMINISTRATION	0	4,679	304,921			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,790	0	160,101		14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,367	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	70,287	52,744	163,949	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	923	8,469	27,978	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	26,932	0	2,370	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	2,823	0	450	0	54.01
56.00	05600	RADIOISOTOPE	0	1,094	0	11,384	0	56.00
58.00	05800	MRI	0	102	0	766	0	58.00
60.00	06000	LABORATORY	0	39,266	0	67,105	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	10,461	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,693	0	64.00
66.00	06600	PHYSICAL THERAPY	0	18,158	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,163	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,289	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	20,014	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	64,872	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,384	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	17,621	9,435	31,158	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	458	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	1,195	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0	103,807	0	0	0	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0	0	0	0	0	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	725	71,970	81,836	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	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)	447,150	393,139	304,921	160,101	0	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	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	MANITO MED ASSOCIATES	0	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
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)	447,150	393,139	304,921	160,101	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1313

Period:
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To 09/30/2018Worksheet B
Part I
Date/Time Prepared:
2/21/2019 9:43 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
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	363,960					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	307,248				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	21,710	0	2,559,517	0	2,559,517	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,457	0	576,260	0	576,260	50.00
53.00	05300	ANESTHESIOLOGY	6,466	307,248	313,799	0	313,799	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	55,617	0	1,339,271	0	1,339,271	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	7,458	0	178,152	0	178,152	54.01
56.00	05600	RADIOISOTOPE	5,013	0	168,893	0	168,893	56.00
58.00	05800	MRI	11,370	0	140,282	0	140,282	58.00
60.00	06000	LABORATORY	72,643	0	2,020,156	0	2,020,156	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	915	0	73,611	0	73,611	62.00
64.00	06400	INTRAVENOUS THERAPY	4,571	0	31,359	0	31,359	64.00
66.00	06600	PHYSICAL THERAPY	16,128	0	1,014,033	0	1,014,033	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,152	0	310,038	0	310,038	67.00
68.00	06800	SPEECH PATHOLOGY	1,784	0	61,296	0	61,296	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	16,312	0	780,116	0	780,116	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,575	0	456,386	0	456,386	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,003	0	1,107,523	0	1,107,523	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	6,262	0	477,673	0	477,673	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	463	0	31,577	0	31,577	76.01
76.02	03950	DIABETIC EDUCATION	181	0	81,101	0	81,101	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	32,335	0	5,716,960	0	5,716,960	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	2,754	0	497,166	0	497,166	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	2,589	0	476,879	0	476,879	88.02
91.00	09100	EMERGENCY	24,903	0	3,409,024	0	3,409,024	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	21,955	0	642,490	0	642,490	95.00
101.00	10100	HOME HEALTH AGENCY	18,344	0	956,696	0	956,696	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	363,960	307,248	23,420,258	0	23,420,258	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	16,783	0	16,783	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	231,755	0	231,755	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	MANITO MED ASSOCIATES	0	0	552,657	0	552,657	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	363,960	307,248	24,221,453	0	24,221,453	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1313

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part II
Date/Time Prepared:
2/21/2019 9:43 am

Cost Center Description			CAPITAL RELATED COSTS					
			Directly Assigned New Capital Related Costs	BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG		MVBLE EQUIP
			0	1.00	1.01	1.02	2.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	0	70,122	3,022	0	50,319	5.01
5.02	00591	A&G HOSPITAL ONLY	0	3,591	3,722	3,426	0	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	31,330	477	9,136	2,595	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	9,432	0	3,395	3,191	8.00
9.00	00900	HOUSEKEEPING	0	2,092	0	2,006	0	9.00
10.00	01000	DIETARY	0	15,332	0	0	743	10.00
11.00	01100	CAFETERIA	0	6,517	0	2,315	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,788	0	4,969	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,712	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,128	579	0	40,700	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	4,661	0	325,383	31,541	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	37,738	0	0	32,405	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	29,419	0	0	92,311	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	1,469	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	3,192	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	17,291	0	0	22,079	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
66.00	06600	PHYSICAL THERAPY	0	6,227	0	0	63,681	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,306	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	943	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	29,589	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	57,718	1,569	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	2,424	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	3,585	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0	0	41,806	0	26,323	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0	0	0	0	1,016	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	0	24,710	0	0	2,406	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	62,586	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	4,936	0	7,111	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	319,174	56,966	408,348	440,576	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	9,044	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	MANITO MED ASSOCIATES	0	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	319,174	56,966	417,392	440,576	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1313

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part II
Date/Time Prepared:
2/21/2019 9:43 am

Cost Center Description			Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE AND GENERAL	A&G HOSPITAL ONLY	MAINTENANCE & REPAIRS	
			2A	4.00	5.01	5.02	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0				4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	123,463	0	123,463			5.01
5.02	00591	A&G HOSPITAL ONLY	10,739	0	3,287	14,026		5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	2,806	482	3,288	6.00
7.00	00700	OPERATION OF PLANT	43,538	0	1,543	265	264	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	131	22	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	16,018	0	364	62	78	8.00
9.00	00900	HOUSEKEEPING	4,098	0	1,963	337	19	9.00
10.00	01000	DIETARY	16,075	0	1,917	329	119	10.00
11.00	01100	CAFETERIA	8,832	0	49	8	54	11.00
13.00	01300	NURSING ADMINISTRATION	9,757	0	1,368	235	45	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,712	0	595	102	67	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	48,407	0	1,600	275	64	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	1,506	258	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	361,585	0	9,582	1,645	530	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	70,143	0	1,851	318	292	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	121,730	0	5,556	954	228	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	1,469	0	794	136	11	54.01
56.00	05600	RADIOISOTOPE	3,192	0	685	118	25	56.00
58.00	05800	MRI	0	0	627	108	0	58.00
60.00	06000	LABORATORY	39,370	0	8,712	1,495	134	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	305	52	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	118	20	0	64.00
66.00	06600	PHYSICAL THERAPY	69,908	0	4,673	802	48	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,306	0	1,436	246	10	67.00
68.00	06800	SPEECH PATHOLOGY	943	0	264	45	7	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	29,589	0	3,107	533	229	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,891	325	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,287	0	5,125	880	88	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,424	0	1,961	337	37	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	150	26	0	76.01
76.02	03950	DIABETIC EDUCATION	3,585	0	326	56	28	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	68,129	0	27,303	0	631	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	1,016	0	2,520	0	0	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0	0	2,324	399	0	88.02
91.00	09100	EMERGENCY	27,116	0	15,272	2,625	191	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	62,586	0	3,039	522	0	95.00
101.00	10100	HOME HEALTH AGENCY	12,047	0	4,664	0	75	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,225,064	0	119,414	14,017	3,274	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,044	0	51	9	14	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,181	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	MANITO MED ASSOCIATES	0	0	2,817	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,234,108	0	123,463	14,026	3,288	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1313

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part II
Date/Time Prepared:
2/21/2019 9:43 am

Cost Center Description			OPERATION OF PLANT	OPERATION OF PLANT-CLINIC	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			7.00	7.01	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	45,610					7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	153				7.01
8.00	00800	LAUNDRY & LINEN SERVICE	1,568	0	18,090			8.00
9.00	00900	HOUSEKEEPING	387	0	0	6,804		9.00
10.00	01000	DIETARY	2,383	0	0	276	21,099	10.00
11.00	01100	CAFETERIA	1,084	0	0	125	16,873	11.00
13.00	01300	NURSING ADMINISTRATION	896	0	0	104	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,354	0	0	157	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,108	2	0	149	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,632	0	8,224	1,231	3,317	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,866	0	2,290	679	44	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,573	0	2,342	530	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	228	0	0	26	0	54.01
56.00	05600	RADIOISOTOPE	496	0	0	57	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,688	0	16	311	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
66.00	06600	PHYSICAL THERAPY	968	0	616	112	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	203	0	0	24	0	67.00
68.00	06800	SPEECH PATHOLOGY	147	0	0	17	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	4,599	0	301	533	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,757	0	0	204	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	8	0	85	831	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	557	0	0	65	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0	143	109	1,469	0	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0	0	4	0	0	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	3,841	0	4,104	445	34	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	66	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	5	173	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,335	153	18,077	6,772	21,099	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	275	0	0	32	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	13	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	MANITO MED ASSOCIATES	0	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
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)	45,610	153	18,090	6,804	21,099	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1313

Period:
From 10/01/2017
To 09/30/2018Worksheet B
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	27,025					11.00
13.00	01300	NURSING ADMINISTRATION	322	12,727				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	467	0	11,454			14.00
15.00	01500	PHARMACY	0	0	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	575	0	0	0	52,180	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,626	6,843	0	0	3,114	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	582	1,168	0	0	1,500	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	927	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,851	0	170	0	7,977	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	194	0	32	0	1,070	54.01
56.00	05600	RADIOISOTOPE	75	0	814	0	719	56.00
58.00	05800	MRI	7	0	55	0	1,631	58.00
60.00	06000	LABORATORY	2,699	0	4,801	0	10,398	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	748	0	131	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	193	0	656	64.00
66.00	06600	PHYSICAL THERAPY	1,248	0	0	0	2,313	66.00
67.00	06700	OCCUPATIONAL THERAPY	355	0	0	0	1,026	67.00
68.00	06800	SPEECH PATHOLOGY	157	0	0	0	256	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	1,376	0	0	0	2,339	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	4,641	0	800	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	645	0	0	0	1,578	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	649	1,300	0	0	898	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	31	0	0	0	66	76.01
76.02	03950	DIABETIC EDUCATION	82	0	0	0	26	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	7,137	0	0	0	4,637	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0	0	0	0	395	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0	0	0	0	371	88.02
91.00	09100	EMERGENCY	4,947	3,416	0	0	3,572	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	3,149	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	2,631	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,025	12,727	11,454	0	52,180	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	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	MANITO MED ASSOCIATES	0	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
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)	27,025	12,727	11,454	0	52,180	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1313

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING					1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG					1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	ADMINISTRATIVE AND GENERAL					5.01
5.02	00591	A&G HOSPITAL ONLY					5.02
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT-CLINIC					7.01
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					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,764				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		410,329	0	410,329	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		84,733	0	84,733	50.00
53.00	05300	ANESTHESIOLOGY		927	0	927	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		145,911	0	145,911	54.00
54.01	05401	RADIOLOGY-ULTRASOUND		3,960	0	3,960	54.01
56.00	05600	RADIOISOTOPE		6,181	0	6,181	56.00
58.00	05800	MRI		2,428	0	2,428	58.00
60.00	06000	LABORATORY		70,624	0	70,624	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		1,236	0	1,236	62.00
64.00	06400	INTRAVENOUS THERAPY		987	0	987	64.00
66.00	06600	PHYSICAL THERAPY		80,688	0	80,688	66.00
67.00	06700	OCCUPATIONAL THERAPY		4,606	0	4,606	67.00
68.00	06800	SPEECH PATHOLOGY		1,836	0	1,836	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	69.00
69.01	03160	CARDIOPULMONARY		42,606	0	42,606	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		7,657	0	7,657	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		69,564	0	69,564	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		8,530	0	8,530	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES		273	0	273	76.01
76.02	03950	DIABETIC EDUCATION		4,725	0	4,725	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC		109,558	0	109,558	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES		3,935	0	3,935	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC		3,094	0	3,094	88.02
91.00	09100	EMERGENCY		65,563	0	65,563	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES		69,362	0	69,362	95.00
101.00	10100	HOME HEALTH AGENCY		19,595	0	19,595	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,218,908	0	1,218,908	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		9,425	0	9,425	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		1,194	0	1,194	192.00
194.00	07950	HOSPICE		0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER		0	0	0	194.01
194.02	07952	MEALS ON WHEELS		0	0	0	194.02
194.03	07954	MANITO MED ASSOCIATES		2,817	0	2,817	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS		0	0	0	194.04
200.00		Cross Foot Adjustments	1,764	1,764	0	1,764	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,764	1,234,108	0	1,234,108	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1313

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALA RIE)	
			BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)		
			1.00	1.01	1.02	2.00	4.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	52,792					1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	0	18,398				1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	0	0	13,523			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				423,696		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	12,551,200	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	11,598	976	0	48,391	757,208	5.01
5.02	00591	A&G HOSPITAL ONLY	594	1,202	111	0	338,232	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	218,661	6.00
7.00	00700	OPERATION OF PLANT	5,182	154	296	2,496	0	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	1,560	0	110	3,069	26,654	8.00
9.00	00900	HOUSEKEEPING	346	0	65	0	237,557	9.00
10.00	01000	DIETARY	2,536	0	0	715	225,342	10.00
11.00	01100	CAFETERIA	1,078	0	75	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	792	0	161	0	183,007	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,441	0	0	0	75,888	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,179	187	0	39,141	134,816	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	771	0	10,542	30,333	952,662	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,242	0	0	31,163	178,218	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,866	0	0	88,773	535,957	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	243	0	0	0	68,363	54.01
56.00	05600	RADIOISOTOPE	528	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	955	58.00
60.00	06000	LABORATORY	2,860	0	0	21,233	702,921	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
66.00	06600	PHYSICAL THERAPY	1,030	0	0	61,241	498,716	66.00
67.00	06700	OCCUPATIONAL THERAPY	216	0	0	0	163,692	67.00
68.00	06800	SPEECH PATHOLOGY	156	0	0	0	51,827	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	4,894	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,870	1,509	299,638	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	783	0	0	193,497	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	7,495	76.01
76.02	03950	DIABETIC EDUCATION	593	0	0	0	37,677	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0	13,502	0	25,314	3,531,946	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0	0	0	977	323,733	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0	0	0	0	295,252	88.02
91.00	09100	EMERGENCY	4,087	0	0	2,314	1,055,746	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	60,188	321,082	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,594	0	6,839	598,546	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,792	18,398	13,230	423,696	12,015,288	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	293	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	178,031	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	MANITO MED ASSOCIATES	0	0	0	0	357,881	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	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)	319,174	56,966	417,392	440,576	2,082,121	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.045878	3.096315	30.865341	1.039840	0.165890	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1313

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALA RIE)	
			BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)		
			1.00	1.01	1.02	2.00	4.00	
204.00		Cost to be allocated (per Wkst. B, Part II)					0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000000	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: 14-1313

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	A&G HOSPITAL ONLY (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
			5A.01	5.01	5A.02	5.02	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	-2,113,600	22,107,853				5.01
5.02	00591	A&G HOSPITAL ONLY	0	588,625	-644,900	16,025,608		5.02
6.00	00600	MAINTENANCE & REPAIRS	0	502,505	0	550,546	70,232	6.00
7.00	00700	OPERATION OF PLANT	0	276,303	0	302,719	5,632	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	23,455	0	25,697	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	65,095	0	71,318	1,669	8.00
9.00	00900	HOUSEKEEPING	0	351,494	0	385,098	412	9.00
10.00	01000	DIETARY	0	343,168	0	375,976	2,536	10.00
11.00	01100	CAFETERIA	0	8,832	0	9,676	1,153	11.00
13.00	01300	NURSING ADMINISTRATION	0	244,963	0	268,382	953	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	106,578	0	116,767	1,441	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	286,437	0	313,822	1,366	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	269,588	0	295,362	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	1,715,615	0	1,879,635	11,313	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	331,496	0	363,188	6,242	50.00
53.00	05300	ANESTHESIOLOGY	0	75	0	82	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	994,870	0	1,089,984	4,866	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	142,187	0	155,781	243	54.01
56.00	05600	RADIOISOTOPE	0	122,606	0	134,328	528	56.00
58.00	05800	MRI	0	112,350	0	123,091	0	58.00
60.00	06000	LABORATORY	0	1,559,935	0	1,709,071	2,860	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	54,606	0	59,827	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	21,142	0	23,163	0	64.00
66.00	06600	PHYSICAL THERAPY	0	836,691	0	916,682	1,030	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	257,043	0	281,617	216	67.00
68.00	06800	SPEECH PATHOLOGY	0	47,184	0	51,695	156	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	556,261	0	609,442	4,894	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	338,634	0	371,009	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	917,624	0	1,005,353	1,870	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	351,297	0	384,784	783	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	26,898	0	29,470	0	76.01
76.02	03950	DIABETIC EDUCATION	0	58,454	0	64,042	593	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0	4,889,788	-5,357,271	0	13,502	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0	451,246	-494,387	0	0	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0	416,156	0	455,942	0	88.02
91.00	09100	EMERGENCY	0	2,734,538	0	2,995,971	4,087	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	544,156	0	596,179	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	835,109	-914,949	0	1,594	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,113,600	21,382,914	-7,411,507	16,015,699	69,939	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,044	0	9,909	293	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	211,464	-231,681	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	MANITO MED ASSOCIATES	0	504,431	-552,657	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	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)		2,113,600		644,900	572,701	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.095604		0.040242	8.154417	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		123,463		14,026	3,288	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.005585		0.000875	0.046816	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1313

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

Worksheet B-1

Date/Time Prepared:
2/21/2019 9:43 am

Cost Center Description		Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	A&G HOSPITAL ONLY (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		5A.01	5.01	5A.02	5.02	6.00	
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: 14-1313

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

Worksheet B-1

Date/Time Prepared:
2/21/2019 9:43 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-CLINIC (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		7.00	7.01	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING					1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG					1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	ADMINISTRATIVE AND GENERAL					5.01
5.02	00591	A&G HOSPITAL ONLY					5.02
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT	48,534				7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	14,472			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	1,669	0	64,741		8.00
9.00	00900	HOUSEKEEPING	412	0	0	62,519	9.00
10.00	01000	DIETARY	2,536	0	0	2,536	10.00
11.00	01100	CAFETERIA	1,153	0	0	1,153	11.00
13.00	01300	NURSING ADMINISTRATION	953	0	0	953	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,441	0	0	1,441	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,179	187	0	1,366	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	11,313	0	29,425	11,313	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,242	0	8,197	6,242	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,866	0	8,380	4,866	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	243	0	0	243	54.01
56.00	05600	RADIOISOTOPE	528	0	0	528	56.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	2,860	0	59	2,860	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,030	0	2,205	1,030	66.00
67.00	06700	OCCUPATIONAL THERAPY	216	0	0	216	67.00
68.00	06800	SPEECH PATHOLOGY	156	0	0	156	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	4,894	0	1,078	4,894	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,870	0	0	1,870	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	783	0	783	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	593	0	0	593	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0	13,502	391	13,502	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0	0	16	0	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0	0	0	0	88.02
91.00	09100	EMERGENCY	4,087	0	14,688	4,087	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	236	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	18	1,594	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	48,241	14,472	64,693	62,226	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	293	0	0	293	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	48	0	192.00
194.00	07950	HOSPICE	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	194.02
194.03	07954	MANITO MED ASSOCIATES	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	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)	360,827	26,731	100,206	407,018	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.434520	1.847084	1.547798	6.510309	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	45,610	153	18,090	6,804	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.939754	0.010572	0.279421	0.108831	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1313

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

Worksheet B-1

Date/Time Prepared:
2/21/2019 9:43 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-CLINIC (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		7.00	7.01	8.00	9.00	10.00	
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: 14-1313

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

Worksheet B-1

Date/Time Prepared:
2/21/2019 9:43 am

Cost Center Description			CAFETERIA (FTE'S)	NURSING ADMINISTRATIO N (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQ UIISI)	PHARMACY (COSTED REQ UIISI)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	15,459					11.00
13.00	01300	NURSING ADMINISTRATION	184	75,560				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	267	0	835,737			14.00
15.00	01500	PHARMACY	0	0	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	329	0	0	0	40,842,256	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,074	40,627	0	0	2,436,344	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	333	6,933	0	0	1,173,480	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	725,598	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,059	0	12,371	0	6,241,407	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	111	0	2,349	0	836,969	54.01
56.00	05600	RADIOISOTOPE	43	0	59,425	0	562,574	56.00
58.00	05800	MRI	4	0	4,000	0	1,276,004	58.00
60.00	06000	LABORATORY	1,544	0	350,293	0	8,150,401	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	54,606	0	102,689	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	14,059	0	512,987	64.00
66.00	06600	PHYSICAL THERAPY	714	0	0	0	1,809,901	66.00
67.00	06700	OCCUPATIONAL THERAPY	203	0	0	0	802,558	67.00
68.00	06800	SPEECH PATHOLOGY	90	0	0	0	200,237	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	787	0	0	0	1,830,548	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	338,634	0	625,592	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	369	0	0	0	1,234,739	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	371	7,721	0	0	702,744	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	18	0	0	0	51,913	76.01
76.02	03950	DIABETIC EDUCATION	47	0	0	0	20,295	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	4,082	0	0	0	3,628,637	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0	0	0	0	309,039	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0	0	0	0	290,577	88.02
91.00	09100	EMERGENCY	2,830	20,279	0	0	2,794,675	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	2,463,796	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	2,058,552	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,459	75,560	835,737	0	40,842,256	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	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	MANITO MED ASSOCIATES	0	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	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)	393,139	304,921	160,101	0	363,960	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	25.431076	4.035482	0.191569	0.000000	0.008911	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	27,025	12,727	11,454	0	52,180	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1313

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

Worksheet B-1

Date/Time Prepared:
2/21/2019 9:43 am

Cost Center Description		CAFETERIA (FTE'S)	NURSING ADMINISTRATIO N (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQ UISI)	PHARMACY (COSTED REQ UISI)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	
		11.00	13.00	14.00	15.00	16.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	1.748173	0.168436	0.013705	0.000000	0.001278	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: 14-1313

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

Worksheet B-1

Date/Time Prepared:
2/21/2019 9:43 am

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	5.01
5.02	00591	A&G HOSPITAL ONLY	5.02
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	7.01
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	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	54.01
56.00	05600	RADIOISOTOPE	56.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00
64.00	06400	INTRAVENOUS THERAPY	64.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
69.01	03160	CARDIOPULMONARY	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	76.01
76.02	03950	DIABETIC EDUCATION	76.02
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	88.02
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	HOSPICE	194.00
194.01	07951	FAMILY MEDICAL CENTER	194.01
194.02	07952	MEALS ON WHEELS	194.02
194.03	07954	MANITO MED ASSOCIATES	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	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)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1313

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

Worksheet B-1

Date/Time Prepared:
2/21/2019 9:43 am

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
		19.00		
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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1313

Period:
From 10/01/2017
To 09/30/2018Worksheet C
Part I
Date/Time Prepared:
2/21/2019 9:43 am

			Title XVIII		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	2,559,517		2,559,517	0	0
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	576,260		576,260	0	0
53.00	05300	ANESTHESIOLOGY	313,799		313,799	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,339,271		1,339,271	0	0
54.01	05401	RADIOLOGY-ULTRASOUND	178,152		178,152	0	0
56.00	05600	RADIOISOTOPE	168,893		168,893	0	0
58.00	05800	MRI	140,282		140,282	0	0
60.00	06000	LABORATORY	2,020,156		2,020,156	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	73,611		73,611	0	0
64.00	06400	INTRAVENOUS THERAPY	31,359		31,359	0	0
66.00	06600	PHYSICAL THERAPY	1,014,033	0	1,014,033	0	0
67.00	06700	OCCUPATIONAL THERAPY	310,038	0	310,038	0	0
68.00	06800	SPEECH PATHOLOGY	61,296	0	61,296	0	0
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0
69.01	03160	CARDIOPULMONARY	780,116		780,116	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	456,386		456,386	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,107,523		1,107,523	0	0
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	477,673		477,673	0	0
76.01	03952	TELEMEDICINE PSYCH SERVICES	31,577		31,577	0	0
76.02	03950	DIABETIC EDUCATION	81,101		81,101	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	5,716,960		5,716,960	0	0
88.01	08801	MASON CITY MEDICAL ASSOCIATES	497,166		497,166	0	0
88.02	08802	MANITO MEDICAL CLINIC RHC	476,879		476,879	0	0
91.00	09100	EMERGENCY	3,409,024		3,409,024	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	246,296		246,296	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	642,490		642,490	0	0
101.00	10100	HOME HEALTH AGENCY	956,696		956,696	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	23,666,554	0	23,666,554	0	0
201.00		Less Observation Beds	246,296		246,296		0
202.00		Total (see instructions)	23,420,258	0	23,420,258	0	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1313

Period:
From 10/01/2017
To 09/30/2018Worksheet C
Part I
Date/Time Prepared:
2/21/2019 9:43 am

			Title XVIII		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	1,861,723		1,861,723		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	46,038	1,127,442	1,173,480	0.491069	50.00
53.00	05300	ANESTHESIOLOGY	31,607	693,991	725,598	0.432469	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	211,854	6,029,553	6,241,407	0.214578	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	38,473	798,496	836,969	0.212854	54.01
56.00	05600	RADIOISOTOPE	2,270	560,304	562,574	0.300215	56.00
58.00	05800	MRI	46,029	1,229,975	1,276,004	0.109939	58.00
60.00	06000	LABORATORY	593,579	7,556,822	8,150,401	0.247860	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	42,413	60,276	102,689	0.716834	62.00
64.00	06400	INTRAVENOUS THERAPY	41,982	471,005	512,987	0.061130	64.00
66.00	06600	PHYSICAL THERAPY	294,150	1,515,751	1,809,901	0.560270	66.00
67.00	06700	OCCUPATIONAL THERAPY	256,749	545,809	802,558	0.386312	67.00
68.00	06800	SPEECH PATHOLOGY	16,436	183,801	200,237	0.306117	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
69.01	03160	CARDIOPULMONARY	266,462	1,564,086	1,830,548	0.426165	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	228,897	396,695	625,592	0.729527	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	305,350	929,389	1,234,739	0.896969	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	702,744	702,744	0.679725	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	51,913	51,913	0.608268	76.01
76.02	03950	DIABETIC EDUCATION	0	20,295	20,295	3.996107	76.02
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0	3,628,637	3,628,637		88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0	309,039	309,039		88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0	290,577	290,577		88.02
91.00	09100	EMERGENCY	11,545	2,783,130	2,794,675	1.219828	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	574,621	574,621	0.428623	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,480	2,462,316	2,463,796	0.260772	95.00
101.00	10100	HOME HEALTH AGENCY	0	2,058,552	2,058,552		101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	4,297,037	36,545,219	40,842,256		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	4,297,037	36,545,219	40,842,256		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1313

Period:
From 10/01/2017
To 09/30/2018Worksheet C
Part I
Date/Time Prepared:
2/21/2019 9:43 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.000000			54.01
56.00	05600	RADIOISOTOPE	0.000000			56.00
58.00	05800	MRI	0.000000			58.00
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
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
69.01	03160	CARDIOPULMONARY	0.000000			69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000			76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.000000			76.01
76.02	03950	DIABETIC EDUCATION	0.000000			76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC				88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES				88.01
88.02	08802	MANITO MEDICAL CLINIC RHC				88.02
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
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: 14-1313

Period:
From 10/01/2017
To 09/30/2018Worksheet C
Part I
Date/Time Prepared:
2/21/2019 9:43 am

			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	2,559,517		2,559,517	0	2,559,517	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	576,260		576,260	0	576,260	50.00
53.00	05300	ANESTHESIOLOGY	313,799		313,799	0	313,799	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,339,271		1,339,271	0	1,339,271	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	178,152		178,152	0	178,152	54.01
56.00	05600	RADIOISOTOPE	168,893		168,893	0	168,893	56.00
58.00	05800	MRI	140,282		140,282	0	140,282	58.00
60.00	06000	LABORATORY	2,020,156		2,020,156	0	2,020,156	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	73,611		73,611	0	73,611	62.00
64.00	06400	INTRAVENOUS THERAPY	31,359		31,359	0	31,359	64.00
66.00	06600	PHYSICAL THERAPY	1,014,033	0	1,014,033	0	1,014,033	66.00
67.00	06700	OCCUPATIONAL THERAPY	310,038	0	310,038	0	310,038	67.00
68.00	06800	SPEECH PATHOLOGY	61,296	0	61,296	0	61,296	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	03160	CARDIOPULMONARY	780,116		780,116	0	780,116	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	456,386		456,386	0	456,386	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,107,523		1,107,523	0	1,107,523	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	477,673		477,673	0	477,673	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	31,577		31,577	0	31,577	76.01
76.02	03950	DIABETIC EDUCATION	81,101		81,101	0	81,101	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	5,716,960		5,716,960	0	5,716,960	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	497,166		497,166	0	497,166	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	476,879		476,879	0	476,879	88.02
91.00	09100	EMERGENCY	3,409,024		3,409,024	0	3,409,024	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	246,296		246,296		246,296	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	642,490		642,490	0	642,490	95.00
101.00	10100	HOME HEALTH AGENCY	956,696		956,696		956,696	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	23,666,554	0	23,666,554	0	23,666,554	200.00
201.00		Less Observation Beds	246,296		246,296		246,296	201.00
202.00		Total (see instructions)	23,420,258	0	23,420,258	0	23,420,258	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1313

Period:
From 10/01/2017
To 09/30/2018Worksheet C
Part I
Date/Time Prepared:
2/21/2019 9:43 am

			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	1,861,723		1,861,723			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	46,038	1,127,442	1,173,480	0.491069	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	31,607	693,991	725,598	0.432469	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	211,854	6,029,553	6,241,407	0.214578	0.000000	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	38,473	798,496	836,969	0.212854	0.000000	54.01
56.00	05600	RADIOISOTOPE	2,270	560,304	562,574	0.300215	0.000000	56.00
58.00	05800	MRI	46,029	1,229,975	1,276,004	0.109939	0.000000	58.00
60.00	06000	LABORATORY	593,579	7,556,822	8,150,401	0.247860	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	42,413	60,276	102,689	0.716834	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	41,982	471,005	512,987	0.061130	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	294,150	1,515,751	1,809,901	0.560270	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	256,749	545,809	802,558	0.386312	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	16,436	183,801	200,237	0.306117	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	03160	CARDIOPULMONARY	266,462	1,564,086	1,830,548	0.426165	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	228,897	396,695	625,592	0.729527	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	305,350	929,389	1,234,739	0.896969	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	702,744	702,744	0.679725	0.000000	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	51,913	51,913	0.608268	0.000000	76.01
76.02	03950	DIABETIC EDUCATION	0	20,295	20,295	3.996107	0.000000	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0	3,628,637	3,628,637	1.575512	0.000000	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0	309,039	309,039	1.608748	0.000000	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0	290,577	290,577	1.641145	0.000000	88.02
91.00	09100	EMERGENCY	11,545	2,783,130	2,794,675	1.219828	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	574,621	574,621	0.428623	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,480	2,462,316	2,463,796	0.260772	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	2,058,552	2,058,552			101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	4,297,037	36,545,219	40,842,256			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,297,037	36,545,219	40,842,256			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1313

Period:
From 10/01/2017
To 09/30/2018Worksheet C
Part I
Date/Time Prepared:
2/21/2019 9:43 am

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
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.000000			54.01
56.00	05600	RADIOISOTOPE	0.000000			56.00
58.00	05800	MRI	0.000000			58.00
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
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
69.01	03160	CARDIOPULMONARY	0.000000			69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000			76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.000000			76.01
76.02	03950	DIABETIC EDUCATION	0.000000			76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0.000000			88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0.000000			88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0.000000			88.02
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
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 ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1313

Period:
From 10/01/2017
To 09/30/2018Worksheet D
Part II
Date/Time Prepared:
2/21/2019 9:43 am

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	84,733	1,173,480	0.072207	19,469	1,406	50.00
53.00	05300 ANESTHESIOLOGY	927	725,598	0.001278	14,643	19	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	145,911	6,241,407	0.023378	107,607	2,516	54.00
54.01	05401 RADIOLOGY-ULTRASOUND	3,960	836,969	0.004731	25,135	119	54.01
56.00	05600 RADIOISOTOPE	6,181	562,574	0.010987	0	0	56.00
58.00	05800 MRI	2,428	1,276,004	0.001903	16,837	32	58.00
60.00	06000 LABORATORY	70,624	8,150,401	0.008665	264,392	2,291	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1,236	102,689	0.012036	30,560	368	62.00
64.00	06400 INTRAVENOUS THERAPY	987	512,987	0.001924	12,083	23	64.00
66.00	06600 PHYSICAL THERAPY	80,688	1,809,901	0.044581	62,551	2,789	66.00
67.00	06700 OCCUPATIONAL THERAPY	4,606	802,558	0.005739	46,395	266	67.00
68.00	06800 SPEECH PATHOLOGY	1,836	200,237	0.009169	3,800	35	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	03160 CARDIOPULMONARY	42,606	1,830,548	0.023275	103,745	2,415	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	7,657	625,592	0.012240	90,707	1,110	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	69,564	1,234,739	0.056339	89,965	5,069	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	8,530	702,744	0.012138	0	0	76.00
76.01	03952 TELEMEDICINE PSYCH SERVICES	273	51,913	0.005259	0	0	76.01
76.02	03950 DIABETIC EDUCATION	4,725	20,295	0.232816	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 HAVANA MEDICAL ASSOCIATES RHC	109,558	3,628,637	0.030193	0	0	88.00
88.01	08801 MASON CITY MEDICAL ASSOCIATES	3,935	309,039	0.012733	0	0	88.01
88.02	08802 MANITO MEDICAL CLINIC RHC	3,094	290,577	0.010648	0	0	88.02
91.00	09100 EMERGENCY	65,563	2,794,675	0.023460	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	39,485	574,621	0.068715	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	759,107	34,458,185		887,889	18,458	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1313

Period:
From 10/01/2017
To 09/30/2018Worksheet D
Part IV
Date/Time Prepared:
2/21/2019 9:43 am

Cost Center Description			Title XVIII		Hospital		Cost
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health
			1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	307,248	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0	0	0 54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0 56.00
58.00	05800	MRI	0	0	0	0	0 58.00
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
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
69.01	03160	CARDIOPULMONARY	0	0	0	0	0 69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0 76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0 76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	0	0 76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0	0	0	0	0 88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0	0	0	0	0 88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0	0	0	0	0 88.02
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
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
200.00		Total (lines 50 through 199)	307,248	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1313

Period:
From 10/01/2017
To 09/30/2018Worksheet D
Part IV
Date/Time Prepared:
2/21/2019 9:43 am

				Title XVIII		Hospital	Cost		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
			4.00	5.00	6.00	7.00	8.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	1,173,480	0.000000	50.00	
53.00	05300	ANESTHESIOLOGY	0	307,248	0	725,598	0.423441	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,241,407	0.000000	54.00	
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0	836,969	0.000000	54.01	
56.00	05600	RADIOISOTOPE	0	0	0	562,574	0.000000	56.00	
58.00	05800	MRI	0	0	0	1,276,004	0.000000	58.00	
60.00	06000	LABORATORY	0	0	0	8,150,401	0.000000	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	102,689	0.000000	62.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	512,987	0.000000	64.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	1,809,901	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	802,558	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	200,237	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00	
69.01	03160	CARDIOPULMONARY	0	0	0	1,830,548	0.000000	69.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	625,592	0.000000	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,234,739	0.000000	73.00	
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	702,744	0.000000	76.00	
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	51,913	0.000000	76.01	
76.02	03950	DIABETIC EDUCATION	0	0	0	20,295	0.000000	76.02	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0	0	0	3,628,637	0.000000	88.00	
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0	0	0	309,039	0.000000	88.01	
88.02	08802	MANITO MEDICAL CLINIC RHC	0	0	0	290,577	0.000000	88.02	
91.00	09100	EMERGENCY	0	0	0	2,794,675	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	574,621	0.000000	92.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00	
200.00		Total (lines 50 through 199)	0	307,248	0	34,458,185		200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1313

Period:
From 10/01/2017
To 09/30/2018Worksheet D
Part IV
Date/Time Prepared:
2/21/2019 9:43 am

Cost Center Description		Title XVIII			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	19,469	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	14,643	6,200	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	107,607	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.000000	25,135	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
58.00	05800	MRI	0.000000	16,837	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	264,392	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	30,560	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	12,083	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.000000	62,551	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	46,395	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	3,800	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.000000	103,745	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	90,707	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	89,965	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.000000	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0.000000	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0.000000	0	0	0	0	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0.000000	0	0	0	0	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0.000000	0	0	0	0	88.02
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
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		887,889	6,200	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1313

Period:
From 10/01/2017
To 09/30/2018Worksheet D
Part V
Date/Time Prepared:
2/21/2019 9:43 am

			Title XVIII		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	0.491069	0	468,554	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.432469	0	291,260	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.214578	0	2,541,503	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.212854	0	310,529	0	0	54.01
56.00	05600	RADIOISOTOPE	0.300215	0	285,299	0	0	56.00
58.00	05800	MRI	0.109939	0	495,169	0	0	58.00
60.00	06000	LABORATORY	0.247860	0	3,513,929	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.716834	0	49,758	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.061130	0	207,093	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.560270	0	702,869	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.386312	0	63,649	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.306117	0	26,215	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.426165	0	742,258	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.729527	0	161,284	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.896969	0	653,507	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.679725	0	641,302	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.608268	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	3.996107	0	8,058	0	0	76.02
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0.000000				0	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0.000000				0	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0.000000				0	88.02
91.00	09100	EMERGENCY	1.219828	0	1,068,930	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.428623	0	92,392	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.260772		0			95.00
200.00		Subtotal (see instructions)		0	12,323,558	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	12,323,558	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1313

Period:
From 10/01/2017
To 09/30/2018Worksheet D
Part V
Date/Time Prepared:
2/21/2019 9:43 am

			Title XVIII	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	230,092	0	50.00
53.00	05300	ANESTHESIOLOGY	125,961	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	545,351	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	66,097	0	54.01
56.00	05600	RADIOISOTOPE	85,651	0	56.00
58.00	05800	MRI	54,438	0	58.00
60.00	06000	LABORATORY	870,962	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	35,668	0	62.00
64.00	06400	INTRAVENOUS THERAPY	12,660	0	64.00
66.00	06600	PHYSICAL THERAPY	393,796	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	24,588	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,025	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	03160	CARDIOPULMONARY	316,324	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	117,661	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	586,176	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	435,909	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	76.01
76.02	03950	DIABETIC EDUCATION	32,201	0	76.02
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0	0	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0	0	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0	0	88.02
91.00	09100	EMERGENCY	1,303,911	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	39,601	0	92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	5,285,072	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	5,285,072	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1313

Period:

Worksheet D

Component CCN:14-Z313

From 10/01/2017
To 09/30/2018Part V
Date/Time Prepared:
2/21/2019 9:43 am

			Title XVIII	Swing Beds - SNF		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	0.491069	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.432469	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.214578	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.212854	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.300215	0	0	0	56.00
58.00	05800	MRI	0.109939	0	0	0	58.00
60.00	06000	LABORATORY	0.247860	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.716834	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.061130	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.560270	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.386312	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.306117	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.426165	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.729527	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.896969	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.679725	0	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.608268	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	3.996107	0	0	0	76.02
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0.000000			0	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0.000000			0	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0.000000			0	88.02
91.00	09100	EMERGENCY	1.219828	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.428623	0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.260772		0		95.00
200.00		Subtotal (see instructions)		0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1313

Period:

Worksheet D

Component CCN:14-Z313

From 10/01/2017
To 09/30/2018Part V
Date/Time Prepared:
2/21/2019 9:43 am

			Title XVIII		Swing Beds - SNF		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	0	0			50.00	
53.00	05300	ANESTHESIOLOGY	0	0			53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0			54.00	
54.01	05401	RADIOLOGY-ULTRASOUND	0	0			54.01	
56.00	05600	RADIOISOTOPE	0	0			56.00	
58.00	05800	MRI	0	0			58.00	
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	
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	
69.01	03160	CARDIOPULMONARY	0	0			69.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0			73.00	
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0			76.00	
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0			76.01	
76.02	03950	DIABETIC EDUCATION	0	0			76.02	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0	0			88.00	
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0	0			88.01	
88.02	08802	MANITO MEDICAL CLINIC RHC	0	0			88.02	
91.00	09100	EMERGENCY	0	0			91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0			92.00	
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0				95.00	
200.00		Subtotal (see instructions)	0	0			200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0				201.00	
202.00		Net Charges (line 200 - line 201)	0	0			202.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1313	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/21/2019 9:43 am	
		Title XVIII	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)			1,287	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			690	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.			21	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			548	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			141	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)			424	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			8	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)			24	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			352	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)			125	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)			374	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)			21	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				17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			155.41	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			155.41	20.00
21.00	Total general inpatient routine service cost (see instructions)			2,559,517	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)			1,243	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)			3,730	25.00
26.00	Total swing-bed cost (see instructions)			1,155,025	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,404,492	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			1,048,899	28.00
29.00	Private room charges (excluding swing-bed charges)			50,225	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			998,674	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			1.339015	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			2,391.67	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			1,822.40	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			569.27	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			762.26	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			16,007	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			1,388,485	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)			2,012.30	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			708,330	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			16,007	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			724,337	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1313

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

Worksheet D-1

Date/Time Prepared:
2/21/2019 9:43 am

Cost Center Description		Title XVIII		Hospital		Cost	
		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)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					379,574	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,103,911	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)					251,538	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					752,600	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,004,138	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)					121	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,035.50	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					246,296	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1313

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

Worksheet D-1

Date/Time Prepared:
2/21/2019 9:43 am

		Title XVIII		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	410,329	2,559,517	0.160315	246,296	39,485
91.00	Nursing School cost	0	2,559,517	0.000000	246,296	0
92.00	Allied health cost	0	2,559,517	0.000000	246,296	0
93.00	All other Medical Education	0	2,559,517	0.000000	246,296	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1313	Period: From 10/01/2017 To 09/30/2018	Worksheet D-3 Date/Time Prepared: 2/21/2019 9:43 am	
			Title XVIII	Hospital	Cost	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		662,666		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.491069	19,469	9,561	50.00
53.00	05300	ANESTHESIOLOGY	0.432469	14,643	6,333	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.214578	107,607	23,090	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.212854	25,135	5,350	54.01
56.00	05600	RADIOISOTOPE	0.300215	0	0	56.00
58.00	05800	MRI	0.109939	16,837	1,851	58.00
60.00	06000	LABORATORY	0.247860	264,392	65,532	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.716834	30,560	21,906	62.00
64.00	06400	INTRAVENOUS THERAPY	0.061130	12,083	739	64.00
66.00	06600	PHYSICAL THERAPY	0.560270	62,551	35,045	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.386312	46,395	17,923	67.00
68.00	06800	SPEECH PATHOLOGY	0.306117	3,800	1,163	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.426165	103,745	44,212	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.729527	90,707	66,173	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.896969	89,965	80,696	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.679725	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.608268	0	0	76.01
76.02	03950	DIABETIC EDUCATION	3.996107	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0.000000		0	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0.000000		0	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0.000000		0	88.02
91.00	09100	EMERGENCY	1.219828	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.428623	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		887,889	379,574	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)		887,889		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1313	Period: From 10/01/2017 To 09/30/2018	Worksheet D-3
			Component CCN: 14-Z313		Date/Time Prepared: 2/21/2019 9:43 am
			Title XVIII	Swing Beds - SNF	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.491069	0	50.00
53.00	05300	ANESTHESIOLOGY	0.432469	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.214578	15,409	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.212854	2,783	54.01
56.00	05600	RADIOISOTOPE	0.300215	0	56.00
58.00	05800	MRI	0.109939	0	58.00
60.00	06000	LABORATORY	0.247860	127,136	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.716834	4,450	62.00
64.00	06400	INTRAVENOUS THERAPY	0.061130	18,361	64.00
66.00	06600	PHYSICAL THERAPY	0.560270	170,627	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.386312	163,540	67.00
68.00	06800	SPEECH PATHOLOGY	0.306117	10,751	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
69.01	03160	CARDIOPULMONARY	0.426165	48,047	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.729527	53,137	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.896969	141,163	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.679725	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.608268	0	76.01
76.02	03950	DIABETIC EDUCATION	3.996107	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0.000000		88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0.000000		88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0.000000		88.02
91.00	09100	EMERGENCY	1.219828	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.428623	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		755,404	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)		755,404	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1313	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part B Date/Time Prepared: 2/21/2019 9:43 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,285,072	1.00
2.00	Medical and other services reimbursed under OPPIs (see instructions)		0	2.00
3.00	OPPIs payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		5,285,072	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		5,337,923	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)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		32,869	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,795,098	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)		3,509,956	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)		3,509,956	30.00
31.00	Primary payer payments		1,272	31.00
32.00	Subtotal (line 30 minus line 31)		3,508,684	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)		241,374	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		156,893	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		171,715	36.00
37.00	Subtotal (see instructions)		3,665,577	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	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)		3,665,577	40.00
40.01	Sequestration adjustment (see instructions)		73,312	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		3,594,096	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-1,831	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1313

Period:
From 10/01/2017
To 09/30/2018Worksheet E-1
Part I
Date/Time Prepared:
2/21/2019 9:43 am

		Title XVIII		Hospital	Cost	
		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		973,450		3,445,396	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0	08/13/2018	148,700	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		148,700	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)		973,450		3,594,096	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		36,903		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1,831	6.02
7.00	Total Medicare program liability (see instructions)		1,010,353		3,592,265	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: 14-1313

Period:

Worksheet E-1

Component CCN: 14-Z313

From 10/01/2017

Part I

To 09/30/2018

Date/Time Prepared:

2/21/2019 9:43 am

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,334,569		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,334,569		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		31,446		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,366,015		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: 14-1313

Period:
From 10/01/2017
To 09/30/2018Worksheet E-1
Part II
Date/Time Prepared:
2/21/2019 9:43 am

		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN:14-1313

Period:

Worksheet E-2

Component CCN:14-Z313

From 10/01/2017
To 09/30/2018Date/Time Prepared:
2/21/2019 9:43 am

		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1,014,179	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)		391,523	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		499	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1,405,702	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,405,702	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		1,405,702	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		11,809	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		1,393,893	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		1,393,893	0	19.00
19.01	Sequestration adjustment (see instructions)		27,878	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
20.00	Interim payments		1,334,569	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		31,446	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
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 swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1313	Period: From 10/01/2017 To 09/30/2018	Worksheet E-3 Part V Date/Time Prepared: 2/21/2019 9:43 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,103,911	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		1,103,911	4.00
5.00	Primary payer payments		184	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,114,766	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	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	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		1,114,766	19.00
20.00	Deductibles (exclude professional component)		102,724	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,012,042	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,012,042	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		29,123	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		18,930	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		27,772	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,030,972	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		1,030,972	30.00
30.01	Sequestration adjustment (see instructions)		20,619	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		973,450	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		36,903	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1313

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

Worksheet G

Date/Time Prepared:
2/21/2019 9:43 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	6,607,901	0	0	0	1.00
2.00	Temporary investments	809,908	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,410,493	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	505,768	0	0	0	7.00
8.00	Prepaid expenses	147,657	0	0	0	8.00
9.00	Other current assets	0	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)	12,481,727	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	10,212,424	0	0	0	15.00
16.00	Accumulated depreciation	0	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	0	0	0	0	19.00
20.00	Accumulated depreciation	0	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	10,212,424	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,337,409	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	3,173,127	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,510,536	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	27,204,687	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	849,568	0	0	0	37.00
38.00	Salaries, wages, and fees payable	701,389	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	746,303	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	1,158,823	0	0	0	43.00
44.00	Other current liabilities	1,455,511	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,911,594	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	5,805,652	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	5,721,060	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	11,526,712	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	16,438,306	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	10,766,381				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	10,766,381	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	27,204,687	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1313

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

Worksheet G-1

Date/Time Prepared:
2/21/2019 9:43 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		10,874,508		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-108,127				2.00
3.00	Total (sum of line 1 and line 2)		10,766,381		0		3.00
4.00	Additions (credit adjustments) (specify)	0		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)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		10,766,381		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		10,766,381		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	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1313

Period:
From 10/01/2017
To 09/30/2018Worksheet G-2
Parts I & II
Date/Time Prepared:
2/21/2019 9:43 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,921,359		1,921,359	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	768,196		768,196	5.00
6.00	Swing bed - NF	6,890		6,890	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)	2,696,445		2,696,445	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,696,445		2,696,445	17.00
18.00	Ancillary services	2,446,764	25,136,643	27,583,407	18.00
19.00	Outpatient services	17,057	5,357,542	5,374,599	19.00
20.00	HAVANA MEDICAL ASSOCIATES RHC	0	3,628,637	3,628,637	20.00
20.01	MASON CITY MEDICAL ASSOCIATES	0	309,039	309,039	20.01
20.02	MANITO MEDICAL CLINIC RHC	0	290,577	290,577	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,058,552	2,058,552	22.00
23.00	AMBULANCE SERVICES	1,480	2,480,230	2,481,710	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER NRCC	0	266,831	266,831	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,161,746	39,528,051	44,689,797	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		25,916,725		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	EMPLOYEE PHYSICALS	4,038			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)		4,038		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		25,912,687		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1313

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

Worksheet G-3

Date/Time Prepared:
2/21/2019 9:43 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	44,689,797	1.00
2.00	Less contractual allowances and discounts on patients' accounts	19,908,693	2.00
3.00	Net patient revenues (line 1 minus line 2)	24,781,104	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	25,912,687	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,131,583	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	386,858	6.00
7.00	Income from investments	160,115	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	0	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	0	22.00
23.00	Governmental appropriations	868,660	23.00
24.00	OTHER REVENUE	516,352	24.00
24.01	GRANT REVENUE	34,939	24.01
24.02	ELECTRONIC HEALTH RECORDS INCENTIVE	25,500	24.02
24.03	OTHER (SPECIFY)	0	24.03
24.04	OTHER (SPECIFY)	0	24.04
25.00	Total other income (sum of lines 6-24)	1,992,424	25.00
26.00	Total (line 5 plus line 25)	860,841	26.00
27.00	BAD DEBTS	968,968	27.00
27.01	OTHER EXPENSES (SPECIFY)	0	27.01
27.02	OTHER EXPENSES (SPECIFY)	0	27.02
27.03	OTHER EXPENSES (SPECIFY)	0	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	968,968	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-108,127	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-1313
HHA CCN: 14-7202
Period: From 10/01/2017 To 09/30/2018
Worksheet H
Date/Time Prepared: 2/21/2019 9:43 am

					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		0	0
2.00 Capital Related - Movable Equipment			0		0	0
3.00 Plant Operation & Maintenance	0	0	0	0	0	0
4.00 Transportation	0	0	0	0	0	0
5.00 Administrative and General	153,359	11,131	47,597	0	34,181	246,268
HHA REIMBURSABLE SERVICES						
6.00 Skilled Nursing Care	413,687	30,027	0	0	0	443,714
7.00 Physical Therapy	0	0	0	0	0	0
8.00 Occupational Therapy	0	0	0	0	0	0
9.00 Speech Pathology	0	0	0	0	0	0
10.00 Medical Social Services	0	0	0	0	0	0
11.00 Home Health Aide	31,501	2,286	0	0	0	33,787
12.00 Supplies (see instructions)	0	0	0	0	0	0
13.00 Drugs	0	0	0	0	0	0
14.00 DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES						
15.00 Home Dialysis Aide Services	0	0	0	0	0	0
16.00 Respiratory Therapy	0	0	0	0	0	0
17.00 Private Duty Nursing	0	0	0	0	0	0
18.00 Clinic	0	0	0	0	0	0
19.00 Health Promotion Activities	0	0	0	0	0	0
20.00 Day Care Program	0	0	0	0	0	0
21.00 Home Delivered Meals Program	0	0	0	0	0	0
22.00 Homemaker Service	0	0	0	0	0	0
23.00 All Others (specify)	0	0	0	0	0	0
23.50 Telemedicine	0	0	0	0	0	0
24.00 Total (sum of lines 1-23)	598,547	43,444	47,597	0	34,181	723,769
	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	0	0	0		1.00
2.00 Capital Related - Movable Equipment	0	0	0	0		2.00
3.00 Plant Operation & Maintenance	0	0	0	0		3.00
4.00 Transportation	0	0	0	0		4.00
5.00 Administrative and General	0	246,268	0	246,268		5.00
HHA REIMBURSABLE SERVICES						
6.00 Skilled Nursing Care	0	443,714	0	443,714		6.00
7.00 Physical Therapy	0	0	0	0		7.00
8.00 Occupational Therapy	0	0	0	0		8.00
9.00 Speech Pathology	0	0	0	0		9.00
10.00 Medical Social Services	0	0	0	0		10.00
11.00 Home Health Aide	0	33,787	0	33,787		11.00
12.00 Supplies (see instructions)	0	0	0	0		12.00
13.00 Drugs	0	0	0	0		13.00
14.00 DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES						
15.00 Home Dialysis Aide Services	0	0	0	0		15.00
16.00 Respiratory Therapy	0	0	0	0		16.00
17.00 Private Duty Nursing	0	0	0	0		17.00
18.00 Clinic	0	0	0	0		18.00
19.00 Health Promotion Activities	0	0	0	0		19.00
20.00 Day Care Program	0	0	0	0		20.00
21.00 Home Delivered Meals Program	0	0	0	0		21.00
22.00 Homemaker Service	0	0	0	0		22.00
23.00 All Others (specify)	0	0	0	0		23.00
23.50 Telemedicine	0	0	0	0		23.50
24.00 Total (sum of lines 1-23)	0	723,769	0	723,769		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: 14-1313

Period:

Worksheet H-1

HHA CCN: 14-7202

From 10/01/2017
To 09/30/2018Part I
Date/Time Prepared:
2/21/2019 9:43 amHome Health
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PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportatio n	Subtotal (cols. 0-4)	
			Bldgs & Fixtures	Movable Equipment				
			0	1.00			2.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	246,268	0	0	0	0	246,268	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	443,714	0	0	0	0	443,714	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	33,787	0	0	0	0	33,787	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	723,769	0	0	0	0	723,769	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	246,268						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	228,843	672,557					6.00
7.00	Physical Therapy	0	0					7.00
8.00	Occupational Therapy	0	0					8.00
9.00	Speech Pathology	0	0					9.00
10.00	Medical Social Services	0	0					10.00
11.00	Home Health Aide	17,425	51,212					11.00
12.00	Supplies (see instructions)	0	0					12.00
13.00	Drugs	0	0					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
23.50	Telemedicine	0	0					23.50
24.00	Total (sum of lines 1-23)		723,769					24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-1313

Period:

Worksheet H-1

HHA CCN: 14-7202

From 10/01/2017
To 09/30/2018Part II
Date/Time Prepared:
2/21/2019 9:43 amHome Health
Agency I

PPS

		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportatio n (MILEAGE)	Reconciliatio n	Administrativ e & 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	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-246,268	477,501	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	443,714	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	33,787	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-246,268	477,501	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		246,268	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.515743	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1313

Period:

Worksheet H-2

HHA CCN: 14-7202

From 10/01/2017
To 09/30/2018Part I
Date/Time Prepared:
2/21/2019 9:43 amHome Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	MVBLE EQUIP		
		0	1.00	1.01	1.02	2.00	4.00	
1.00	Administrative and General	0	0	4,936	0	7,111	99,293	1.00
2.00	Skilled Nursing Care	672,557	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	51,212	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	723,769	0	4,936	0	7,111	99,293	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	ADMINISTRATIV E AND GENERAL	Subtotal	A&G HOSPITAL ONLY	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
		4A	5.01	5A.01	5.02	6.00	7.00	
1.00	Administrative and General	111,340	10,645	121,985	0	12,998	0	1.00
2.00	Skilled Nursing Care	672,557	64,299	736,856	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	51,212	4,896	56,108	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	835,109	79,840	914,949	0	12,998	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.	0.000000		0.000000				21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1313

Period:

Worksheet H-2

HHA CCN: 14-7202

From 10/01/2017
To 09/30/2018Part I
Date/Time Prepared:
2/21/2019 9:43 amHome Health
Agency I

PPS

Cost Center Description		OPERATION OF PLANT-CLINIC	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	
		7.01	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	28	10,377	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	28	10,377	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	15.00	16.00	19.00	24.00	25.00	
1.00	Administrative and General	0	0	18,344	0	163,732	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	736,856	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	56,108	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	18,344	0	956,696	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1313

Period:

Worksheet H-2

HHA CCN: 14-7202

From 10/01/2017
To 09/30/2018Part I
Date/Time Prepared:
2/21/2019 9:43 amHome Health
Agency I

PPS

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	163,732				1.00
2.00	Skilled Nursing Care	736,856	152,147	889,003		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	56,108	11,585	67,693		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) (2)	956,696	163,732	956,696		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.		0.206481			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: 14-1313

Period:

Worksheet H-2

HHA CCN: 14-7202

From 10/01/2017
To 09/30/2018Part II
Date/Time Prepared:
2/21/2019 9:43 amHome Health
Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	Reconciliation	
		BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			
		1.00	1.01	1.02	2.00	4.00	5A.01	
1.00	Administrative and General	0	1,594	0	6,839	598,546	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	1,594	0	6,839	598,546	0	20.00
21.00	Total cost to be allocated	0	4,936	0	7,111	99,293	0	21.00
22.00	Unit cost multiplier	0.000000	3.096612	0.000000	1.039772	0.165890	0	22.00
Cost Center Description		ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	A&G HOSPITAL ONLY (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-CLINIC (SQUARE FEET)	
		5.01	5A.02	5.02	6.00	7.00	7.01	
1.00	Administrative and General	111,340	-121,985	0	1,594	0	0	1.00
2.00	Skilled Nursing Care	672,557	-736,856	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	51,212	-56,108	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)	835,109	0	0	1,594	0	0	20.00
21.00	Total cost to be allocated	79,840	0	0	12,998	0	0	21.00
22.00	Unit cost multiplier	0.095604	0.000000	0.000000	8.154329	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1313
HHA CCN: 14-7202Period:
From 10/01/2017
To 09/30/2018Worksheet H-2
Part II
Date/Time Prepared:
2/21/2019 9:43 am

						Home Health Agency I	2/21/2019 9:43 am PPS	
Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQ UISI)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	18	1,594	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	18	1,594	0	0	0	0	20.00
21.00	Total cost to be allocated	28	10,377	0	0	0	0	21.00
22.00	Unit cost multiplier	1.555556	6.510038	0.000000	0.000000	0.000000	0.000000	22.00
Cost Center Description		PHARMACY (COSTED REQ UISI)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)				
		15.00	16.00	19.00				
1.00	Administrative and General	0	2,058,552	0				
2.00	Skilled Nursing Care	0	0	0				
3.00	Physical Therapy	0	0	0				
4.00	Occupational Therapy	0	0	0				
5.00	Speech Pathology	0	0	0				
6.00	Medical Social Services	0	0	0				
7.00	Home Health Aide	0	0	0				
8.00	Supplies (see instructions)	0	0	0				
9.00	Drugs	0	0	0				
10.00	DME	0	0	0				
11.00	Home Dialysis Aide Services	0	0	0				
12.00	Respiratory Therapy	0	0	0				
13.00	Private Duty Nursing	0	0	0				
14.00	Clinic	0	0	0				
15.00	Health Promotion Activities	0	0	0				
16.00	Day Care Program	0	0	0				
17.00	Home Delivered Meals Program	0	0	0				
18.00	Homemaker Service	0	0	0				
19.00	All Others (specify)	0	0	0				
19.50	Telemedicine	0	0	0				
20.00	Total (sum of lines 1-19)	0	2,058,552	0				
21.00	Total cost to be allocated	0	18,344	0				
22.00	Unit cost multiplier	0.000000	0.008911	0.000000				

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1313

Period:

Worksheet H-3

HHA CCN: 14-7202

From 10/01/2017
To 09/30/2018Part I
Date/Time Prepared:
2/21/2019 9:43 am

				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	889,003		889,003	11,601	76.63	1.00	
2.00	Physical Therapy	3.00	0	241,157	241,157	3,647	66.12	2.00	
3.00	Occupational Therapy	4.00	0	74,476	74,476	1,967	37.86	3.00	
4.00	Speech Pathology	5.00	0	7,255	7,255	236	30.74	4.00	
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00	
6.00	Home Health Aide	7.00	67,693		67,693	2,703	25.04	6.00	
7.00	Total (sum of lines 1-6)		956,696	322,888	1,279,584	20,154		7.00	
Cost Center Description		Cost Limits	CBSA No. (1)	Program Visits					
				Part A	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		37900	0	3,300			8.00	
8.01	Skilled Nursing Care		44100	0	66			8.01	
8.02	Skilled Nursing Care		99914	0	12			8.02	
9.00	Physical Therapy		37900	0	1,052			9.00	
9.01	Physical Therapy		44100	0	12			9.01	
9.02	Physical Therapy		99914	0	22			9.02	
10.00	Occupational Therapy		37900	0	474			10.00	
10.01	Occupational Therapy		44100	0	6			10.01	
10.02	Occupational Therapy		99914	0	12			10.02	
11.00	Speech Pathology		37900	0	55			11.00	
11.01	Speech Pathology		44100	0	0			11.01	
11.02	Speech Pathology		99914	0	0			11.02	
12.00	Medical Social Services		37900	0	0			12.00	
12.01	Medical Social Services		44100	0	0			12.01	
12.02	Medical Social Services		99914	0	0			12.02	
13.00	Home Health Aide		37900	0	542			13.00	
13.01	Home Health Aide		44100	0	5			13.01	
13.02	Home Health Aide		99914	0	10			13.02	
14.00	Total (sum of lines 8-13)			0	5,568			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	0	16,279	16,279	22,315	0.729509	15.00	
16.00	Cost of Drugs	9.00	0	22	22	25	0.880000	16.00	
Cost Center Description		Program Visits			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
	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	3,378		0	258,856		1.00	
2.00	Physical Therapy	0	1,086		0	71,806		2.00	
3.00	Occupational Therapy	0	492		0	18,627		3.00	
4.00	Speech Pathology	0	55		0	1,691		4.00	
5.00	Medical Social Services	0	0		0	0		5.00	
6.00	Home Health Aide	0	557		0	13,947		6.00	
7.00	Total (sum of lines 1-6)	0	5,568		0	364,927		7.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1313

Period:

Worksheet H-3

HHA CCN: 14-7202

From 10/01/2017
To 09/30/2018Part I
Date/Time Prepared:
2/21/2019 9:43 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description						Agency 1			
		6.00	7.00	8.00	9.00	10.00	11.00		
8.00	Limitation Cost Computation								8.00
8.01	Skilled Nursing Care							8.01	
8.02	Skilled Nursing Care							8.02	
9.00	Physical Therapy							9.00	
9.01	Physical Therapy							9.01	
9.02	Physical Therapy							9.02	
10.00	Occupational Therapy							10.00	
10.01	Occupational Therapy							10.01	
10.02	Occupational Therapy							10.02	
11.00	Speech Pathology							11.00	
11.01	Speech Pathology							11.01	
11.02	Speech Pathology							11.02	
12.00	Medical Social Services							12.00	
12.01	Medical Social Services							12.01	
12.02	Medical Social Services							12.02	
13.00	Home Health Aide							13.00	
13.01	Home Health Aide							13.01	
13.02	Home Health Aide							13.02	
14.00	Total (sum of lines 8-13)							14.00	
Cost Center Description		Program Covered Charges			Cost of Services				
		Part 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	0	0	0	0	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	258,856						1.00	
2.00	Physical Therapy	71,806						2.00	
3.00	Occupational Therapy	18,627						3.00	
4.00	Speech Pathology	1,691						4.00	
5.00	Medical Social Services	0						5.00	
6.00	Home Health Aide	13,947						6.00	
7.00	Total (sum of lines 1-6)	364,927						7.00	
Cost Center Description									
		12.00							
Limitation Cost Computation									
8.00	Skilled Nursing Care							8.00	
8.01	Skilled Nursing Care							8.01	
8.02	Skilled Nursing Care							8.02	
9.00	Physical Therapy							9.00	
9.01	Physical Therapy							9.01	
9.02	Physical Therapy							9.02	
10.00	Occupational Therapy							10.00	
10.01	Occupational Therapy							10.01	
10.02	Occupational Therapy							10.02	
11.00	Speech Pathology							11.00	
11.01	Speech Pathology							11.01	
11.02	Speech Pathology							11.02	
12.00	Medical Social Services							12.00	
12.01	Medical Social Services							12.01	
12.02	Medical Social Services							12.02	
13.00	Home Health Aide							13.00	
13.01	Home Health Aide							13.01	
13.02	Home Health Aide							13.02	
14.00	Total (sum of lines 8-13)							14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1313

Period:

Worksheet H-3

HHA CCN: 14-7202

From 10/01/2017

Part II

To 09/30/2018

Date/Time Prepared:

2/21/2019 9:43 am

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	0.560270	430,430	241,157	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.386312	192,787	74,476	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.306117	23,699	7,255	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.729527	22,315	16,279	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.896969	25	22	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1313 HHA CCN: 14-7202	Period: From 10/01/2017 To 09/30/2018	Worksheet H-4 Part I-II Date/Time Prepared: 2/21/2019 9:43 am	
		Title XVIII	Home Health Agency I	PPS	
		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES					
Reasonable Cost of Part A & Part B Services					
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
Customary Charges					
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00
			Part A Services	Part B Services	
			1.00	2.00	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
10.00	Total reasonable cost (see instructions)		0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	556,032	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	128,696	12.00
13.00	Total PPS Reimbursement - LUPA Episodes		0	6,046	13.00
14.00	Total PPS Reimbursement - PEP Episodes		0	8,851	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	32,067	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	328	16.00
17.00	Total Other Payments		0	0	17.00
18.00	DME Payments		0	0	18.00
19.00	Oxygen Payments		0	0	19.00
20.00	Prosthetic and Orthotic Payments		0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	732,020	22.00
23.00	Excess reasonable cost (from line 8)		0	0	23.00
24.00	Subtotal (line 22 minus line 23)		0	732,020	24.00
25.00	Coinsurance billed to program patients (from your records)		0	0	25.00
26.00	Net cost (line 24 minus line 25)		0	732,020	26.00
27.00	Reimbursable bad debts (from your records)				27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)				28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	732,020	29.00
30.00	OTHER ADJUSTMENTS (FROM PS&R)		0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration		0	0	30.99
31.00	Subtotal (see instructions)		0	732,020	31.00
31.01	Sequestration adjustment (see instructions)		0	14,641	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	0	31.02
32.00	Interim payments (see instructions)		0	717,381	32.00
33.00	Tentative settlement (for contractor use only)		0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	-2	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1313 HHA CCN: 14-7202		Period: From 10/01/2017 To 09/30/2018		Worksheet H-5 Date/Time Prepared: 2/21/2019 9:43 am	
				Home Health Agency I		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		0		717,381	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		717,381	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		2	6.02	
7.00	Total Medicare program liability (see instructions)		0		717,379	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1313

Period:

Worksheet M-1

Component CCN: 14-3457

From 10/01/2017

Date/Time Prepared:

To 09/30/2018

2/21/2019 9:43 am

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	2,065,066	0	2,065,066	-128,101	1,936,965
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	495,157	0	495,157	0	495,157
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	677,924	0	677,924	0	677,924
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)	3,238,147	0	3,238,147	-128,101	3,110,046
11.00	Physician Services Under Agreement	0	45,841	45,841	0	45,841
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	9,175	9,175	0	9,175
14.00	Subtotal (sum of lines 11 through 13)	0	55,016	55,016	0	55,016
15.00	Medical Supplies	0	69,846	69,846	0	69,846
16.00	Transportation (Health Care Staff)	0	8,465	8,465	0	8,465
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	90,982	90,982	0	90,982
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	169,293	169,293	0	169,293
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,238,147	224,309	3,462,456	-128,101	3,334,355
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
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	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	4,945	4,945	0	4,945
30.00	Administrative Costs	421,900	475,224	897,124	0	897,124
31.00	Total Facility Overhead (sum of lines 29 and 30)	421,900	480,169	902,069	0	902,069
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,660,047	704,478	4,364,525	-128,101	4,236,424

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1313

Period:

Worksheet M-1

Component CCN: 14-3457

From 10/01/2017
To 09/30/2018Date/Time Prepared:
2/21/2019 9:43 am

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,936,965	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	495,157	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	677,924	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	3,110,046	10.00
11.00	Physician Services Under Agreement	0	45,841	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	9,175	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	55,016	14.00
15.00	Medical Supplies	0	69,846	15.00
16.00	Transportation (Health Care Staff)	0	8,465	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	90,982	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	169,293	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	3,334,355	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	4,945	29.00
30.00	Administrative Costs	-681	896,443	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-681	901,388	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-681	4,235,743	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1313

Period:

Worksheet M-1

Component CCN: 14-3462

From 10/01/2017

Date/Time Prepared:

To 09/30/2018

2/21/2019 9:43 am

		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	40,043	0	40,043	0	40,043
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	163,459	0	163,459	0	163,459
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	64,247	0	64,247	0	64,247
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)	267,749	0	267,749	0	267,749
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	3,761	3,761	0	3,761
14.00	Subtotal (sum of lines 11 through 13)	0	3,761	3,761	0	3,761
15.00	Medical Supplies	0	5,538	5,538	0	5,538
16.00	Transportation (Health Care Staff)	0	3,660	3,660	0	3,660
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	9,198	9,198	0	9,198
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	267,749	12,959	280,708	0	280,708
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
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	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	6,864	6,864	0	6,864
30.00	Administrative Costs	55,984	52,970	108,954	0	108,954
31.00	Total Facility Overhead (sum of lines 29 and 30)	55,984	59,834	115,818	0	115,818
32.00	Total facility costs (sum of lines 22, 28 and 31)	323,733	72,793	396,526	0	396,526

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1313

Period:

Worksheet M-1

Component CCN: 14-3462

From 10/01/2017
To 09/30/2018Date/Time Prepared:
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		RHC II		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	40,043	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	163,459	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	267,749	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	3,761	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	3,761	14.00
15.00	Medical Supplies	0	5,538	15.00
16.00	Transportation (Health Care Staff)	0	3,660	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	9,198	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	280,708	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	6,864	29.00
30.00	Administrative Costs	0	108,954	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	115,818	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	396,526	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1313

Period:

Worksheet M-1

Component CCN: 14-8592

From 10/01/2017

Date/Time Prepared:

To 09/30/2018

2/21/2019 9:43 am

		RHC III		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	145,296	0	145,296	0	145,296
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	50,666	0	50,666	0	50,666
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	59,251	0	59,251	0	59,251
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)	255,213	0	255,213	0	255,213
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	2,319	2,319	0	2,319
14.00	Subtotal (sum of lines 11 through 13)	0	2,319	2,319	0	2,319
15.00	Medical Supplies	0	16,682	16,682	0	16,682
16.00	Transportation (Health Care Staff)	0	959	959	0	959
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	17,641	17,641	0	17,641
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	255,213	19,960	275,173	0	275,173
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
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	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	15,485	15,485	0	15,485
30.00	Administrative Costs	40,040	36,479	76,519	0	76,519
31.00	Total Facility Overhead (sum of lines 29 and 30)	40,040	51,964	92,004	0	92,004
32.00	Total facility costs (sum of lines 22, 28 and 31)	295,253	71,924	367,177	0	367,177

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1313

Period:

Worksheet M-1

Component CCN: 14-8592

From 10/01/2017
To 09/30/2018Date/Time Prepared:
2/21/2019 9:43 am

		RHC III		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	145,296	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	50,666	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	59,251	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	255,213	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	2,319	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	2,319	14.00
15.00	Medical Supplies	0	16,682	15.00
16.00	Transportation (Health Care Staff)	0	959	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	17,641	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	275,173	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	15,485	29.00
30.00	Administrative Costs	0	76,519	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	92,004	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	367,177	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1313

Period:

Worksheet M-2

Component CCN: 14-3457

From 10/01/2017
To 09/30/2018Date/Time Prepared:
2/21/2019 9:43 am

		RHC I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	2.48	9,199	4,200	10,416	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	2.27	5,370	2,100	4,767	3.00
4.00	Subtotal (sum of lines 1 through 3)	4.75	14,569		15,183	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	0.96	894		894	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)	5.71	15,463		16,077	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)				3,334,355	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				3,334,355	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				901,388	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,481,217	15.00
16.00	Total overhead (sum of lines 14 and 15)				2,382,605	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				2,382,605	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				2,382,605	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				5,716,960	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1313

Period:

Worksheet M-2

Component CCN: 14-3462

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

Date/Time Prepared:

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		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	0.16	209	4,200	672	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.62	1,507	2,100	1,302	3.00
4.00	Subtotal (sum of lines 1 through 3)	0.78	1,716		1,974	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)	0.78	1,716		1,974	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)				280,708	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				280,708	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				115,818	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				100,640	15.00
16.00	Total overhead (sum of lines 14 and 15)				216,458	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				216,458	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				216,458	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				497,166	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1313

Period:

Worksheet M-2

Component CCN: 14-8592

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

Date/Time Prepared:

2/21/2019 9:43 am

				RHC III		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.25	882	4,200	1,050		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.16	420	2,100	336		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.41	1,302		1,386	1,386	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)	0.41	1,302			1,386	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)					275,173	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					275,173	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					92,004	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					109,702	15.00
16.00	Total overhead (sum of lines 14 and 15)					201,706	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					201,706	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					201,706	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					476,879	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1313 Component CCN: 14-3457	Period: From 10/01/2017 To 09/30/2018	Worksheet M-3 Date/Time Prepared: 2/21/2019 9:43 am	
		Title XVIII	RHC I	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			5,716,960	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			56,663	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			5,660,297	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			16,077	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)			16,077	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			352.07	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	82.30	83.45		8.00
9.00	Rate for Program covered visits (see instructions)	352.07	352.07		9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	4,822		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,697,682		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	1,697,682		16.00
16.01	Total program charges (see instructions)(from contractor's records)		964,021		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		18,374		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		32,358		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		1,261,074		16.04
16.05	Total program cost (see instructions)	0	1,293,432		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		88,981		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		171,333		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,293,432		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		45,901		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,339,333		22.00
23.00	Allowable bad debts (see instructions)		41,114		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		26,724		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		41,114		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)		1,366,057		26.00
26.01	Sequestration adjustment (see instructions)		27,321		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		1,207,365		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)		131,371		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: 14-1313 Component CCN: 14-3462	Period: From 10/01/2017 To 09/30/2018	Worksheet M-3 Date/Time Prepared: 2/21/2019 9:43 am		
		Title XVIII	RHC II	Cost		
				1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			497,166	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			4,029	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			493,137	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,974	4.00	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00	
6.00	Total adjusted visits (line 4 plus line 5)			1,974	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			249.82	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			82.30	83.45	8.00
9.00	Rate for Program covered visits (see instructions)			249.82	249.82	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)		0	218	10.00	
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	54,461	11.00	
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00	
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00	
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00	
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00	
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	54,461	16.00	
16.01	Total program charges (see instructions)(from contractor's records)			43,397	16.01	
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02	
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	16.03	
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			39,906	16.04	
16.05	Total program cost (see instructions)		0	39,906	16.05	
17.00	Primary payer amounts			0	17.00	
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			4,579	18.00	
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			7,764	19.00	
20.00	Net Medicare cost excluding vaccines (see instructions)			39,906	20.00	
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			3,723	21.00	
22.00	Total reimbursable Program cost (line 20 plus line 21)			43,629	22.00	
23.00	Allowable bad debts (see instructions)			1,082	23.00	
23.01	Adjusted reimbursable bad debts (see instructions)			703	23.01	
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			1,082	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)			44,332	26.00	
26.01	Sequestration adjustment (see instructions)			887	26.01	
26.02	Demonstration payment adjustment amount after sequestration			0	26.02	
27.00	Interim payments			42,681	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)			764	29.00	
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00	

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN:14-1313 Component CCN:14-3457	Period: From 10/01/2017 To 09/30/2018	Worksheet M-4 Date/Time Prepared: 2/21/2019 9:43 am	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		3,110,046	3,110,046	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000503	0.001992	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		1,564	6,195	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		17,313	7,977	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		18,877	14,172	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		3,334,355	3,334,355	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		2,382,605	2,382,605	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.005661	0.004250	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		13,488	10,126	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		32,365	24,298	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		116	459	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		279.01	52.94	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		100	340	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		27,901	18,000	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			56,663	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			45,901	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN:14-1313 Component CCN:14-3462	Period: From 10/01/2017 To 09/30/2018	Worksheet M-4 Date/Time Prepared: 2/21/2019 9:43 am	
		Title XVIII	RHC II	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		267,749	267,749	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000375	0.000749	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		100	201	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		1,626	348	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		1,726	549	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		280,708	280,708	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		216,458	216,458	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.006149	0.001956	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		1,331	423	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		3,057	972	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		10	20	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		305.70	48.60	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		9	20	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		2,751	972	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			4,029	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			3,723	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN:14-1313 Component CCN:14-8592	Period: From 10/01/2017 To 09/30/2018	Worksheet M-4 Date/Time Prepared: 2/21/2019 9:43 am	
		Title XVIII	RHC III	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		255,213	255,213	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000303	0.002506	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		77	640	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		2,487	2,155	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		2,564	2,795	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		275,173	275,173	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		201,706	201,706	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.009318	0.010157	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		1,879	2,049	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		4,443	4,844	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		15	124	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		296.20	39.06	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		12	20	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		3,554	781	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			9,287	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			4,335	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1313 Component CCN: 14-3457	Period: From 10/01/2017 To 09/30/2018	Worksheet M-5 Date/Time Prepared: 2/21/2019 9:43 am	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,173,865	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		04/11/2018	33,500		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)		33,500		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,207,365		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		131,371		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		1,338,736		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:14-1313 Component CCN:14-3462	Period: From 10/01/2017 To 09/30/2018	Worksheet M-5 Date/Time Prepared: 2/21/2019 9:43 am	
			RHC II	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			42,681	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			42,681	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			764	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			43,445	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00