

State Copy

Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

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 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1302	Period: From 10/01/2018 To 09/30/2019	Worksheet S Parts I-III Date/Time Prepared: 2/27/2020 11:59 am
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically filed cost report 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.	Date: 2/27/2020	Time: 11:59 am
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MIDWEST MEDICAL CENTER (14-1302) for the cost reporting period beginning 10/01/2018 and ending 09/30/2019 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			
	PART III - SETTLEMENT SUMMARY	1.00	2.00	3.00	4.00	5.00	
1.00	Hospital	0	48,102	56,995	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I						4.00
5.00	Swing bed - SNF	0	-144,951	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
10.00	RURAL HEALTH CLINIC I	0		-38,371		0	10.00
10.01	RURAL HEALTH CLINIC II	0		11,614		0	10.01
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	-96,849	30,238	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: 14-1302		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/27/2020 11:59 am		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1 MEDICAL CENTER DRIVE			PO Box:				1.00			
2.00	City: GALENA			State: IL		Zip Code: 61036-		County: JO DAVIESS			
		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			MIDWEST MEDICAL CENTER	141302	99914	1	02/01/2000	N	O	O
4.00	Subprovider - IPF										
5.00	Subprovider - IRF										
6.00	Subprovider - (Other)										
7.00	Swing Beds - SNF			MIDWEST MEDICAL CENTER	142302	99914		02/01/2000	N	O	N
8.00	Swing Beds - NF										
9.00	Hospital-Based SNF			GALENA STAUSS NURSING HOME	146140	99914		02/17/2010	N	P	N
10.00	Hospital-Based NF										
11.00	Hospital-Based OLTC										
12.00	Hospital-Based HHA										
13.00	Separately Certified ASC										
14.00	Hospital-Based Hospice										
15.00	Hospital-Based Health Clinic - RHC			MIDWEST HEALTH CLINIC	148511	99914		12/09/2010	N	O	N
15.01	Hospital-Based Health Clinic - RHC II			MIDWEST HEALTH CLINIC OF ELIZABETH	148557	99914		07/15/2016	N	O	N
16.00	Hospital-Based Health Clinic - FQHC										
17.00	Hospital-Based (CMHC) I										
17.10	Hospital-Based (CORF) I										
18.00	Renal Dialysis										
19.00	Other										
							From:		To:		
							1.00		2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2018		09/30/2019		
21.00	Type of Control (see instructions)						2				
							1.00		2.00		
							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				
22.01	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				
22.02	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				
22.03	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			
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.					2	N				

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1302		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/27/2020 11:59 am			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	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: 14-1302		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/27/2020 11:59 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)		N			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: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part I
Date/Time Prepared:
2/27/2020 11:59 am

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
					1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N		70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				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.		Y		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

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		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	Y	Y	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	
115.00	Miscellaneous Cost Reporting Information 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.	2					118.00
		Premiums		Losses		Insurance	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	158,333		0		0	
						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.	Y				5.04	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							

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1302		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/27/2020 11:59 am		
						1.00		2.00		
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)					N		140.00		
						1.00		2.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						3.00				
141.00	Name:		Contractor's Name:		Contractor's Number:		141.00			
142.00	Street:		PO Box:				142.00			
143.00	City:		State:		Zip Code:		143.00			
						1.00				
144.00	Are provider based physicians' costs included in Worksheet A?					Y		144.00		
						1.00		2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					N		145.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							146.00		
						1.00				
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N		147.00		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N		148.00		
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N		149.00		
						Part A		Part B		
						1.00		2.00		
						Title V		Title XIX		
						3.00		4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital		Y		Y		N		155.00	
156.00	Subprovider - IPF		N		N		N		156.00	
157.00	Subprovider - IRF		N		N		N		157.00	
158.00	SUBPROVIDER								158.00	
159.00	SNF		N		N		N		159.00	
160.00	HOME HEALTH AGENCY		N		N		N		160.00	
161.00	CMHC				N		N		161.00	
161.10	CORF				N		N		161.10	
						1.00				
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N		165.00		
			Name		County		State		Zip Code	
			0		1.00		2.00		3.00	
									4.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00	
						1.00				
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					Y		167.00		
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00		
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01		
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.00		169.00		
						Beginning		Ending		
						1.00		2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1302	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part I Date/Time Prepared: 2/27/2020 11:59 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: 14-1302		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part II Date/Time Prepared: 2/27/2020 11:59 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	02/04/2020	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	02/14/2020	Y	02/14/2020 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: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part II
Date/Time Prepared:
2/27/2020 11:59 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.		Y		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.		N		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.	DAVID	GOODMAN		41.00
42.00	Enter the employer/company name of the cost report preparer.	WIPFLI LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	6082702962	DGOODMAN@WIPFLI.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part II
Date/Time Prepared:
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		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CPA		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: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/27/2020 11:59 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	10,687.20	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	10,687.20	0	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)		25	9,125	10,687.20	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY	44.00	5	1,825		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	46.00	52	18,980			21.00
22.00 HOME HEALTH AGENCY						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
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		82				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: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/27/2020 11:59 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)	311	33	469		1.00
2.00	HMO and other (see instructions)	18	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	1,417	0	1,754		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	188		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,728	33	2,411		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)	1,728	33	2,411	0.00	14.00
15.00	CAH visits	5,681	0	25,018		15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	17.00
18.00	SUBPROVIDER		0	0	0.00	18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE			17,149	0.00	21.00
22.00	HOME HEALTH AGENCY					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
25.10	CMHC - CORF	0	0	0	0.00	25.10
26.00	RURAL HEALTH CLINIC	2,313	0	9,336	0.00	26.00
26.01	RURAL HEALTH CLINIC II	618	0	2,904	0.00	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	166.69
28.00	Observation Bed Days		0	87		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			0		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	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: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/27/2020 11:59 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	102	11	146	1.00
2.00 HMO and other (see instructions)			6	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	102	11	146	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00 SUBPROVIDER	0.00	0		0	0	18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	0.00				37	21.00
22.00 HOME HEALTH AGENCY						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
25.10 CMHC - CORF	0.00					25.10
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 RURAL HEALTH CLINIC II	0.00					26.01
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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019

Worksheet S-7

Date/Time Prepared:
2/27/2020 11:59 am

		1.00	2.00	3.00	4.00
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	L			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	02/01/2000		2.00
		1.00	2.00	3.00	4.00
3.00	RUX	0	0	0	3.00
4.00	RUL	0	0	0	4.00
5.00	RVX	0	0	0	5.00
6.00	RVL	0	0	0	6.00
7.00	RHX	0	0	0	7.00
8.00	RHL	0	0	0	8.00
9.00	RMX	0	0	0	9.00
10.00	RML	0	0	0	10.00
11.00	RLX	0	0	0	11.00
12.00	RUC	0	0	0	12.00
13.00	RUB	0	0	0	13.00
14.00	RUA	0	0	0	14.00
15.00	RVC	0	0	0	15.00
16.00	RVB	0	0	0	16.00
17.00	RVA	0	0	0	17.00
18.00	RHC	0	0	0	18.00
19.00	RHB	0	0	0	19.00
20.00	RHA	0	0	0	20.00
21.00	RMC	0	0	0	21.00
22.00	RMB	0	0	0	22.00
23.00	RMA	0	0	0	23.00
24.00	RLB	0	0	0	24.00
25.00	RLA	0	0	0	25.00
26.00	ES3	0	0	0	26.00
27.00	ES2	0	0	0	27.00
28.00	ES1	0	0	0	28.00
29.00	HE2	0	0	0	29.00
30.00	HE1	0	0	0	30.00
31.00	HD2	0	0	0	31.00
32.00	HD1	0	0	0	32.00
33.00	HC2	0	0	0	33.00
34.00	HC1	0	0	0	34.00
35.00	HB2	0	0	0	35.00
36.00	HB1	0	0	0	36.00
37.00	LE2	0	0	0	37.00
38.00	LE1	0	0	0	38.00
39.00	LD2	0	0	0	39.00
40.00	LD1	0	0	0	40.00
41.00	LC2	0	0	0	41.00
42.00	LC1	0	0	0	42.00
43.00	LB2	0	0	0	43.00
44.00	LB1	0	0	0	44.00
45.00	CE2	0	0	0	45.00
46.00	CE1	0	0	0	46.00
47.00	CD2	0	0	0	47.00
48.00	CD1	0	0	0	48.00
49.00	CC2	0	0	0	49.00
50.00	CC1	0	0	0	50.00
51.00	CB2	0	0	0	51.00
52.00	CB1	0	0	0	52.00
53.00	CA2	0	0	0	53.00
54.00	CA1	0	0	0	54.00
55.00	SE3	0	0	0	55.00
56.00	SE2	0	0	0	56.00
57.00	SE1	0	0	0	57.00
58.00	SSC	0	0	0	58.00
59.00	SSB	0	0	0	59.00
60.00	SSA	0	0	0	60.00
61.00	IB2	0	0	0	61.00
62.00	IB1	0	0	0	62.00
63.00	IA2	0	0	0	63.00
64.00	IA1	0	0	0	64.00
65.00	BB2	0	0	0	65.00
66.00	BB1	0	0	0	66.00
67.00	BA2	0	0	0	67.00
68.00	BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019

Worksheet S-7

Date/Time Prepared:
2/27/2020 11:59 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	0	0	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
201.00	SNF SERVICES					
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).			99914	0	201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		1,551,890	0.00	Y	202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		0			207.00

Health Financial Systems		MIDWEST MEDICAL CENTER		In Lieu of Form CMS-2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1302 Component CCN: 14-8511		Period: From 10/01/2018 To 09/30/2019 Worksheet S-8 Date/Time Prepared: 2/27/2020 11:59 am		
		RHC I		Cost		
		1.00				
1.00	Clinic Address and Identification	ONE MEDICAL CENTER DRIVE				1.00
	Street	City	State	ZIP Code		
		1.00	2.00	3.00		
2.00	City, State, ZIP Code, County	GALENA	IL	61036	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	
9.01					9.01	
9.02					9.02	
9.03					9.03	
9.04					9.04	
9.05					9.05	
9.06					9.06	
9.07					9.07	
9.08					9.08	
9.09					9.09	
9.10					9.10	
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N	0	10.00	
		Sunday	Monday	Tuesday		
		from	to	from	to	
		1.00	2.00	3.00	4.00	
	Facility hours of operations (1)					
11.00	CLINIC		07:30	17:00	07:30	
				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?		N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N	0	13.00	
		Provider name		CCN number		
		1.00		2.00		
14.00	RHC/FQHC name, CCN number				14.00	
		Y/N	V	XVIII	XIX	
		1.00	2.00	3.00	4.00	
					Total Visits	
					5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				15.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1302

Period:

Worksheet S-8

Component CCN: 14-8511

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 11:59 am

RHC I

Cost

				County				
				4.00				
2.00	City, State, ZIP Code, County			JO DAVIESS				2.00
			Tuesday	Wednesday		Thursday		
			to	from	to	from	to	
			6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)								
11.00	CLINIC	17:00	07:30	17:00	07:30	17:00		11.00
		Friday		Saturday				
		from	to	from	to			
		11.00	12.00	13.00	14.00			
Facility hours of operations (1)								
11.00	CLINIC	07:30	17:00	08:00	12:00			11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1302 Component CCN: 14-8557		Period: From 10/01/2018 To 09/30/2019		Worksheet S-8 Date/Time Prepared: 2/27/2020 11:59 am	
				RHC II		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street				560 PLEASANT STREET				1.00
				City	State	ZIP Code			
				1.00	2.00	3.00			
2.00	City, State, ZIP Code, County				ELIZABETH IL 61028				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				07:30		17:00		07:30
				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				JO DAVIESS				2.00
				Tuesday	Wednesday	Thursday			
				to	from	to	from	to	
				6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)									
11.00	CLINIC				17:00		07:30		17:00

Health Financial Systems		MIDWEST MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1302	Period: From 10/01/2018	Worksheet S-8
			Component CCN: 14-8557	To 09/30/2019	Date/Time Prepared: 2/27/2020 11:59 am
			RHC II		Cost
			Friday		Saturday
			from	to	from
			11.00	12.00	13.00
Facility hours of operations (1)					14.00
11.00	CLINIC	07:30	17:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1302	Period: From 10/01/2018 To 09/30/2019	Worksheet S-10 Date/Time Prepared: 2/27/2020 11:59 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)			0.742065 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	2,683,533		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0		5.00
6.00	Medicaid charges	6,251,676		6.00
7.00	Medicaid cost (line 1 times line 6)	4,639,150		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)	1,955,617		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	0		9.00
10.00	Stand-alone CHIP charges	0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0		12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,955,617		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)	156,676	0	156,676 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	116,264	0	116,264 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)	116,264	0	116,264 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)	740,171		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	25,309		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	38,937		27.01
28.00	Non-Medicare bad debt expense (see instructions)	701,234		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	533,989		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	650,253		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,605,870		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019

Worksheet A

Date/Time Prepared:
2/27/2020 11:59 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	NEW CAP REL COSTS-BLDG & FIXT		1,389,665	1,389,665	-1,338,100	51,565	1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG		0	0	63,003	63,003	1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL		0	0	3,244,361	3,244,361	1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB		0	0	0	0	1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		920,389	920,389	-899,029	21,360	2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO		0	0	1,200,546	1,200,546	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,591,005	2,591,005	-129,657	2,461,348	4.00
5.01	00570	ADMITTING	278,593	5,286	283,879	0	283,879	5.01
5.02	00550	INFORMATION TECHNOLOGY	292,761	287,470	580,231	0	580,231	5.02
5.03	00590	HOSPITAL BILLING	0	0	0	263,692	263,692	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	601,364	1,270,490	1,871,854	-316,331	1,555,523	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	84,713	556,179	640,892	0	640,892	7.00
7.01	00701	OPERATION OF PLANT-SCC	75,110	219,509	294,619	0	294,619	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	42,454	42,454	0	42,454	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	12,082	18,676	30,758	0	30,758	8.01
9.00	00900	HOUSEKEEPING	146,823	33,086	179,909	0	179,909	9.00
9.01	00901	HOUSEKEEPING-SCC	77,435	18,312	95,747	0	95,747	9.01
10.00	01000	DIETARY	197,671	166,110	363,781	0	363,781	10.00
10.01	01001	DIETARY-SCC	231,069	249,964	481,033	97,552	578,585	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	252,150	4,385	256,535	0	256,535	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	69,914	3,261	73,175	0	73,175	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	181,160	23,069	204,229	0	204,229	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	780,365	91,188	871,553	112,515	984,068	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	9,173	9,173	44.00
46.00	04600	OTHER LONG TERM CARE	1,551,890	359,215	1,911,105	74,765	1,985,870	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	212,960	464,558	677,518	50,944	728,462	50.00
53.00	05300	ANESTHESIOLOGY	202,215	48,318	250,533	0	250,533	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	319,043	770,716	1,089,759	20,221	1,109,980	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	293,223	415,507	708,730	0	708,730	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	23,461	23,461	0	23,461	64.00
65.00	06500	RESPIRATORY THERAPY	69,016	32,348	101,364	-78,905	22,459	65.00
66.00	06600	PHYSICAL THERAPY	1,052,522	110,192	1,162,714	-40,349	1,122,365	66.00
66.01	06601	CARDIAC REHAB	0	0	0	117,368	117,368	66.01
67.00	06700	OCCUPATIONAL THERAPY	67,562	9,591	77,153	29,030	106,183	67.00
68.00	06800	SPEECH PATHOLOGY	0	58,708	58,708	0	58,708	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	101,781	101,781	0	101,781	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	365,085	365,085	0	365,085	73.00
76.00	03020	SLEEP LAB	31,210	19,796	51,006	4,023	55,029	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	5,055	5,055	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,427,398	204,616	1,632,014	-78,637	1,553,377	88.00
88.01	08801	RURAL HEALTH CLINIC II	453,121	49,189	502,310	-30,680	471,630	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	405,971	405,971	-48,299	357,672	90.00
91.00	09100	EMERGENCY	382,405	1,689,169	2,071,574	0	2,071,574	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE		2,227,543	2,227,543	-2,227,543	0	113.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019

Worksheet A

Date/Time Prepared:
2/27/2020 11:59 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	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,343,775	15,246,262	24,590,037	104,718	24,694,755	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	43,278	43,278	-34,064	9,214	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	255,488	104,257	359,745	-72,204	287,541	194.01
194.02	07952	ADULT DAY CARE	91,718	30,343	122,061	-9,769	112,292	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	11,319	11,319	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	9,690,981	15,424,140	25,115,121	0	25,115,121	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019

Worksheet A

Date/Time Prepared:
2/27/2020 11:59 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	51,565	1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG	0	63,003	1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL	-11,160	3,233,201	1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB	0	0	1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	21,360	2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	-339,941	860,605	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,461,348	4.00
5.01	00570	ADMITTING	0	283,879	5.01
5.02	00550	INFORMATION TECHNOLOGY	0	580,231	5.02
5.03	00590	HOSPITAL BILLING	-32,737	230,955	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	-389,245	1,166,278	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-22,885	618,007	7.00
7.01	00701	OPERATION OF PLANT-SCC	0	294,619	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	42,454	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	30,758	8.01
9.00	00900	HOUSEKEEPING	0	179,909	9.00
9.01	00901	HOUSEKEEPING-SCC	0	95,747	9.01
10.00	01000	DIETARY	-88,529	275,252	10.00
10.01	01001	DIETARY-SCC	-150,111	428,474	10.01
11.00	01100	CAFETERIA	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	0	256,535	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	73,175	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,489	199,740	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-3,213	980,855	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	9,173	44.00
46.00	04600	OTHER LONG TERM CARE	-148,445	1,837,425	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-49,352	679,110	50.00
53.00	05300	ANESTHESIOLOGY	0	250,533	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-400,033	709,947	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	708,730	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	23,461	64.00
65.00	06500	RESPIRATORY THERAPY	0	22,459	65.00
66.00	06600	PHYSICAL THERAPY	-3,644	1,118,721	66.00
66.01	06601	CARDIAC REHAB	0	117,368	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	106,183	67.00
68.00	06800	SPEECH PATHOLOGY	0	58,708	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	101,781	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-22,450	342,635	73.00
76.00	03020	SLEEP LAB	0	55,029	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	5,055	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-23,265	1,530,112	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	471,630	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	-315,895	41,777	90.00
91.00	09100	EMERGENCY	-150,380	1,921,194	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,155,774	22,538,981	118.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019

Worksheet A

Date/Time Prepared:
2/27/2020 11:59 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	9,214	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	287,541	194.01
194.02	07952	ADULT DAY CARE	0	112,292	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	194.03
194.04	07954	IDLE SPACE	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	11,319	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,155,774	22,959,347	200.00

RECLASSIFICATIONS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-6

Date/Time Prepared:
2/27/2020 11:59 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS ADC AND ALU DIETARY EXPENSE					
1.00	DIETARY-SCC	10.01	0	97,552		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	97,552		
	C - RECLASS ASSISTED LIVING BUILDING DEP					
1.00	NEW CAP REL COSTS-ALU BLDG	1.01	0	60,329		1.00
	TOTALS		0	60,329		
	D - RECLASS PT/MOB SPACE DEPRECIATION					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	5,220		1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	28,844		2.00
	TOTALS		0	34,064		
	E - RECLASS NURSING HOME ADMIN AND GEN					
1.00	SKILLED NURSING FACILITY	44.00	0	9,173		1.00
2.00	OTHER LONG TERM CARE	46.00	0	95,399		2.00
	TOTALS		0	104,572		
	G - RECLASS PHYSICIAN HOSPITAL MED DIRCT					
1.00	ADULTS & PEDIATRICS	30.00	10,088	1,009		1.00
	TOTALS		10,088	1,009		
	H - RECLASS NEW HOSPITAL DEPRECIATION					
1.00	NEW CAP REL COSTS-2007 HOSPITAL	1.02	0	1,291,365		1.00
	TOTALS		0	1,291,365		
	J - RECLASS NEW HOSPITAL MME DEPRECIATN					
1.00	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	0	901,116		1.00
	TOTALS		0	901,116		
	K - RECLASS INTEREST EXPENSE - NEW HOSP					
1.00	NEW CAP REL COSTS-2007 HOSPITAL	1.02	0	1,916,984		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	0	289,531		2.00
	TOTALS		0	2,206,515		
	M - RECLASS PHYSICIAN IP ROUND TIME					
1.00	ADULTS & PEDIATRICS	30.00	3,258	489		1.00
2.00		0.00	0	0		2.00
	TOTALS		3,258	489		
	P - RECLASS PHYSICIAN BENEFITS					
1.00	RURAL HEALTH CLINIC	88.00	0	99,868		1.00
2.00	RURAL HEALTH CLINIC II	88.01	0	29,789		2.00
	TOTALS		0	129,657		
	U - RECLASS COMMUNITY FITNESS CTR USE					
1.00	COMMUNITY FITNESS CENTER	194.05	9,671	1,648		1.00
2.00	OCCUPATIONAL THERAPY	67.00	24,884	4,146		2.00
	TOTALS		34,555	5,794		
	X - RECLASS SURGEON FEES					
1.00	OPERATING ROOM	50.00	0	38,353		1.00
	TOTALS		0	38,353		
	Y - RECLASS PROPERTY INSURANCE EXP					
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	55,320		1.00
	TOTALS		0	55,320		
	AA - RECLASS CLINIC MGR TIME TO HOSP/NH					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	19,979	0		1.00
2.00	RURAL HEALTH CLINIC II	88.01	4,874	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	120	0		3.00
	TOTALS		24,973	0		
	BB - RECLASS SR CARE ADMINISTRATOR TIME					
1.00	ASSISTED LIVING UNITS	194.01	12,856	0		1.00
2.00	ADULT DAY CARE	194.02	2,723	0		2.00
	TOTALS		15,579	0		
	FF - RECLASS EXPENSES TO MATCH REVENUES					
1.00	SNF PHYSICAL THERAPY - SCC THERAPY	76.02	5,055	0		1.00
	TOTALS		5,055	0		
	HH - RECLASS HOSP MED DIRECTOR TIME					
1.00	ADULTS & PEDIATRICS	30.00	84,799	11,356		1.00
2.00	CARDIAC REHAB	66.01	33,920	4,543		2.00
	TOTALS		118,719	15,899		
	JJ - RECLASS CAP LEASE INTEREST EXPENSE					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	20,221		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	807		2.00
	TOTALS		0	21,028		

RECLASSIFICATIONS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-6

Date/Time Prepared:
2/27/2020 11:59 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	KK - RECLASS ELIZABETH CLINIC DEPR					1.00
	RURAL HEALTH CLINIC II	88.01	0	25,118		
	TOTALS		0	25,118		
1.00	MM - RECLASS CLINIC MD SALARY					1.00
	OTHER ADMINISTRATIVE AND GENERAL	5.04	87,274	0		
	ADULTS & PEDIATRICS	30.00	1,396	0		
3.00	RURAL HEALTH CLINIC	88.00	1,257	0	3.00	
	TOTALS		89,927	0		
1.00	NN - ENT MD TIME IN OR					1.00
	OPERATING ROOM	50.00	0	5,923		
	TOTALS		0	5,923		
1.00	PP - RECLASS HOSPITAL BILLING EXPENSES					1.00
	HOSPITAL BILLING	5.03	0	263,692		
	TOTALS		0	263,692		
1.00	QQ - RECLASS CARDIAC REHAB EXP					1.00
	CARDIAC REHAB	66.01	69,016	9,889		
	TOTALS		69,016	9,889		
1.00	SS - RECLASS PHYSICIAN SURGERY TIME					1.00
	OPERATING ROOM	50.00	5,076	1,592		
	TOTALS		5,076	1,592		
1.00	TT - RECLASS SLEEP LAB EXPENSES					1.00
	SLEEP LAB	76.00	0	4,023		
	TOTALS		0	4,023		
500.00	Grand Total: Increases		376,246	5,273,299	500.00	

RECLASSIFICATIONS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-6

Date/Time Prepared:
2/27/2020 11:59 am

		Decreases				wkst. A-7 Ref.	
		Cost Center	Line #	Salary	Other		
		6.00	7.00	8.00	9.00	10.00	
A - RECLASS ADC AND ALU DIETARY EXPENSE							
1.00	ADULT DAY CARE		194.02	0	12,492	0	1.00
2.00	ASSISTED LIVING UNITS		194.01	0	85,060	0	2.00
	TOTALS			0	97,552		
C - RECLASS ASSISTED LIVING BUILDING DEP							
1.00	NEW CAP REL COSTS-BLDG & FIXT		1.00	0	60,329	9	1.00
	TOTALS			0	60,329		
D - RECLASS PT/MOB SPACE DEPRECIATION							
1.00	PHYSICIANS' PRIVATE OFFICES		192.00	0	5,220	9	1.00
2.00	PHYSICIANS' PRIVATE OFFICES		192.00	0	28,844	9	2.00
	TOTALS			0	34,064		
E - RECLASS NURSING HOME ADMIN AND GEN							
1.00	OTHER ADMINISTRATIVE AND GENERAL		5.04	0	104,572	0	1.00
2.00			0.00	0	0	0	2.00
	TOTALS			0	104,572		
G - RECLASS PHYSICIAN HOSPITAL MED DIRCT							
1.00	RURAL HEALTH CLINIC		88.00	10,088	1,009	0	1.00
	TOTALS			10,088	1,009		
H - RECLASS NEW HOSPITAL DEPRECIATION							
1.00	NEW CAP REL COSTS-BLDG & FIXT		1.00	0	1,291,365	9	1.00
	TOTALS			0	1,291,365		
J - RECLASS NEW HOSPITAL MME DEPRECIATN							
1.00	NEW CAP REL COSTS-MVBLE EQUIP		2.00	0	901,116	9	1.00
	TOTALS			0	901,116		
K - RECLASS INTEREST EXPENSE - NEW HOSP							
1.00	INTEREST EXPENSE		113.00	0	2,206,515	11	1.00
2.00			0.00	0	0	11	2.00
	TOTALS			0	2,206,515		
M - RECLASS PHYSICIAN IP ROUND TIME							
1.00	RURAL HEALTH CLINIC		88.00	2,794	419	0	1.00
2.00	RURAL HEALTH CLINIC II		88.01	464	70	0	2.00
	TOTALS			3,258	489		
P - RECLASS PHYSICIAN BENEFITS							
1.00	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	129,657	0	1.00
2.00			0.00	0	0	0	2.00
	TOTALS			0	129,657		
U - RECLASS COMMUNITY FITNESS CTR USE							
1.00	PHYSICAL THERAPY		66.00	34,555	5,794	0	1.00
2.00			0.00	0	0	0	2.00
	TOTALS			34,555	5,794		
X - RECLASS SURGEON FEES							
1.00	CLINIC		90.00	0	38,353	0	1.00
	TOTALS			0	38,353		
Y - RECLASS PROPERTY INSURANCE EXP							
1.00	OTHER ADMINISTRATIVE AND GENERAL		5.04	0	55,320	12	1.00
	TOTALS			0	55,320		
AA - RECLASS CLINIC MGR TIME TO HOSP/NH							
1.00	RURAL HEALTH CLINIC		88.00	24,973	0	0	1.00
2.00			0.00	0	0	0	2.00
3.00			0.00	0	0	0	3.00
	TOTALS			24,973	0		
BB - RECLASS SR CARE ADMINISTRATOR TIME							
1.00	OTHER LONG TERM CARE		46.00	15,579	0	0	1.00
2.00			0.00	0	0	0	2.00
	TOTALS			15,579	0		
FF - RECLASS EXPENSES TO MATCH REVENUES							
1.00	OTHER LONG TERM CARE		46.00	5,055	0	0	1.00
	TOTALS			5,055	0		
HH - RECLASS HOSP MED DIRECTOR TIME							
1.00	RURAL HEALTH CLINIC		88.00	118,719	15,899	0	1.00
2.00			0.00	0	0	0	2.00
	TOTALS			118,719	15,899		
JJ - RECLASS CAP LEASE INTEREST EXPENSE							
1.00	INTEREST EXPENSE		113.00	0	21,028	0	1.00
2.00			0.00	0	0	0	2.00
	TOTALS			0	21,028		

RECLASSIFICATIONS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-6

Date/Time Prepared:
2/27/2020 11:59 am

Decreases						
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
KK - RECLASS ELIZABETH CLINIC DEPR						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	25,118	9	1.00
	TOTALS		0	25,118		
MM - RECLASS CLINIC MD SALARY						
1.00	RURAL HEALTH CLINIC II	88.01	89,927	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		89,927	0		
NN - ENT MD TIME IN OR						
1.00	CLINIC	90.00	0	5,923	0	1.00
	TOTALS		0	5,923		
PP - RECLASS HOSPITAL BILLING EXPENSES						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	263,692	0	1.00
	TOTALS		0	263,692		
QQ - RECLASS CARDIAC REHAB EXP						
1.00	RESPIRATORY THERAPY	65.00	69,016	9,889	0	1.00
	TOTALS		69,016	9,889		
SS - RECLASS PHYSICIAN SURGERY TIME						
1.00	RURAL HEALTH CLINIC	88.00	5,076	1,592	0	1.00
	TOTALS		5,076	1,592		
TT - RECLASS SLEEP LAB EXPENSES						
1.00	CLINIC	90.00	0	4,023	0	1.00
	TOTALS		0	4,023		
500.00	Grand Total: Decreases		376,246	5,273,299		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part I
Date/Time Prepared:
2/27/2020 11:59 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	448,597	0	0	0	0	1.00
2.00	Land Improvements	3,786,229	147,390	0	147,390	0	2.00
3.00	Buildings and Fixtures	38,465,754	279,359	0	279,359	41,257	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	8,672,369	345,434	0	345,434	24,050	6.00
7.00	HIT designated Assets	2,639,630	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	54,012,579	772,183	0	772,183	65,307	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	54,012,579	772,183	0	772,183	65,307	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	448,597	0				1.00
2.00	Land Improvements	3,933,619	0				2.00
3.00	Buildings and Fixtures	38,703,856	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	8,993,753	0				6.00
7.00	HIT designated Assets	2,639,630	0				7.00
8.00	Subtotal (sum of lines 1-7)	54,719,455	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	54,719,455	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part II
Date/Time Prepared:
2/27/2020 11:59 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	NEW CAP REL COSTS-BLDG & FIXT	1,389,665	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-ALU BLDG	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	0	0	0	0	0	1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0	0	0	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	920,389	0	0	0	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	2,310,054	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,389,665				1.00
1.01	NEW CAP REL COSTS-ALU BLDG	0	0				1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	0	0				1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0				1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	920,389				2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	0				2.01
3.00	Total (sum of lines 1-2)	0	2,310,054				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part III
Date/Time Prepared:
2/27/2020 11:59 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	NEW CAP REL COSTS-BLDG & FIXT	4,560,343	0	4,560,343	0.084029	4,648	1.00
1.01	NEW CAP REL COSTS-ALU BLDG	2,623,068	0	2,623,068	0.048333	2,674	1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	35,328,474	0	35,328,474	0.650966	36,012	1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0	0	0.000000	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,047,530	0	2,047,530	0.037728	2,087	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	9,711,441	0	9,711,441	0.178944	9,899	2.01
3.00	Total (sum of lines 1-2)	54,270,856	0	54,270,856	1.000000	55,320	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Relat ed 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	NEW CAP REL COSTS-BLDG & FIXT	0	0	4,648	46,917	0	1.00
1.01	NEW CAP REL COSTS-ALU BLDG	0	0	2,674	60,329	0	1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	0	0	36,012	1,291,365	0	1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0	0	0	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2,087	19,273	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	0	9,899	564,678	0	2.01
3.00	Total (sum of lines 1-2)	0	0	55,320	1,982,562	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed 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	NEW CAP REL COSTS-BLDG & FIXT	0	4,648	0	0	51,565	1.00
1.01	NEW CAP REL COSTS-ALU BLDG	0	2,674	0	0	63,003	1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	1,905,824	36,012	0	0	3,233,201	1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0	0	0	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	2,087	0	0	21,360	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	286,028	9,899	0	0	860,605	2.01
3.00	Total (sum of lines 1-2)	2,191,852	55,320	0	0	4,229,734	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8

Date/Time Prepared:
2/27/2020 11:59 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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP REL COSTS-ALU BLDG (chapter 2)			0NEW CAP REL COSTS-ALU BLDG	1.01	0	1.01
1.02	Investment income - NEW CAP REL COSTS-2007 HOSPITAL (chapter 2)	B	-23,195	NEW CAP REL COSTS-2007 HOSPITAL	1.02	11	1.02
1.03	Investment income - NEW CAP REL COSTS-2007 MOB (chapter 2)			0NEW CAP REL COSTS-2007 MOB	1.03	0	1.03
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			0NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - NEW CAP REL COSTS-MVBLE EQUIP NEW HO (chapter 2)	B	-3,503	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	11	2.01
3.00	Investment income - other (chapter 2)	B	-245	RADIOLOGY-DIAGNOSTIC	54.00	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)	B	-22,885	OPERATION OF PLANT	7.00	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	-918,628			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-88,529	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-4,489	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8

Date/Time Prepared:
2/27/2020 11:59 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 #		
				3.00	4.00		
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-ALU BLDG			0 NEW CAP REL COSTS-ALU BLDG	1.01	0	26.01
26.02	Depreciation - NEW CAP REL COSTS-2007 HOSPITAL			0 NEW CAP REL COSTS-2007 HOSPITAL	1.02	0	26.02
26.03	Depreciation - NEW CAP REL COSTS-2007 MOB			0 NEW CAP REL COSTS-2007 MOB	1.03	0	26.03
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0 NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP NEW HO			0 NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	0	27.01
28.00	Non-physician Anesthetist			0 NONPHYSICIAN 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		0 OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0 ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0 SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-336,438	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	9	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01	INTEREST INCOME	B	-10	RURAL HEALTH CLINIC	88.00	0	33.01
33.05	PROVIDER RHC REVENUE	B	-10,800	RURAL HEALTH CLINIC	88.00	0	33.05
33.06	PART B BILLING COSTS	A	-32,737	HOSPITAL BILLING	5.03	0	33.06
33.07	SCHOOL ATHLETIC TRAINING REVENUE	B	-3,644	PHYSICAL THERAPY	66.00	0	33.07
33.08	HOSPITAL BED ASSESS (UP TO PAID AMT)	A	-279,350	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.08
33.09	MARKETING EXPENSES - NONALLOW	A	-88,203	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.09
34.00	LOBBYING EXPENSE ON DUES PAID	A	-12,787	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	34.00
35.00	COMMUNITY GRANTS / DONATIONS / PROM	A	-4,505	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	35.00
36.00	NH BED ASSESSMENT	A	-148,445	OTHER LONG TERM CARE	46.00	0	36.00
37.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	37.00
38.00	MISC REVENUE - SCHOOL NURSE		0		0.00	0	38.00
40.00	SENIOR CARE CAMPUS CAFETERIA	B	-54,343	DIETARY-SCC	10.01	0	40.00
41.00	OFFSET INTERNAL ALLOCATION FOR ADC/A	B	-95,768	DIETARY-SCC	10.01	0	41.00
42.00	RHC PROVIDER OR TIME	A	-12,455	RURAL HEALTH CLINIC	88.00	0	42.00
43.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.00
43.01	PHARMACY CONTRACT PROG EXPENSE	A	-22,450	DRUGS CHARGED TO PATIENTS	73.00	0	43.01
43.02	GOLF OUTING EXPENSES	A	-4,400	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	43.02
43.03	LAPSE CY PORT OF ADV REFUND 2006	A	12,035	NEW CAP REL COSTS-2007 HOSPITAL	1.02	11	43.03
43.04	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.04
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,155,774				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: 14-1302

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8-2

Date/Time Prepared:
2/27/2020 11:59 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	1,471,433	150,380	1,321,053	0	0	1.00
2.00	60.00	LABORATORY	10,546	0	10,546	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	399,788	399,788	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	3,213	3,213	0	0	0	4.00
5.00	50.00	OPERATING ROOM	49,352	49,352	0	0	0	5.00
6.00	90.00	CLINIC	315,895	315,895	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			2,250,227	918,628	1,331,599		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	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	90.00	CLINIC	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	150,380		1.00
2.00	60.00	LABORATORY	0	0	0	0		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	399,788		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	3,213		4.00
5.00	50.00	OPERATING ROOM	0	0	0	49,352		5.00
6.00	90.00	CLINIC	0	0	0	315,895		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	918,628		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1302		Period: From 10/01/2018 To 09/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/27/2020 11:59 am	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					5	1.00
2.00	Line 1 multiplied by 15 hours per week					75	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					14	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					5.55	7.00
8.00	Optional travel expense rate per mile					0.56	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	83.25	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	20	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	394	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)					6,619	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)					6,619	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)					6,619	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)					6,619	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)					557	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)					557	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)					78	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					635	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)					1,590	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)					1,590	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)					221	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					635	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: 14-1302		Period: From 10/01/2018 To 09/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/27/2020 11:59 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)						6,619	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						635	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)						7,254	63.00
64.00	Total cost of outside supplier services (from your records)						7,179	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						557	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						78	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						635	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						78	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						1,590	101.01
101.02	Line 34 = sum of lines 27 and 31						1,668	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						1,590	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						221	102.01
102.02	Line 35 = sum of lines 31 and 32						1,811	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1302		Period: From 10/01/2018 To 09/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/27/2020 11:59 am	
				Speech Pathology		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					41	1.00
2.00	Line 1 multiplied by 15 hours per week					615	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					124	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					5.55	7.00
8.00	Optional travel expense rate per mile					0.56	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	745.99	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.40	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)	38.20	38.20	0.00			11.00
12.00	Number of travel hours (provider site)	0	94	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	5,612	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)					56,994	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)					56,994	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)					56,994	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)					56,994	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)					4,737	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)					4,737	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)					688	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					5,425	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)					7,182	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)					7,182	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)					3,143	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					5,425	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: 14-1302		Period: From 10/01/2018 To 09/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/27/2020 11:59 am		
				Speech Pathology		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)	76.40	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)						56,994	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						5,425	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)						62,419	63.00
64.00	Total cost of outside supplier services (from your records)						58,506	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						4,737	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						688	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						5,425	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						688	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						7,182	101.01
101.02	Line 34 = sum of lines 27 and 31						7,870	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						7,182	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						3,143	102.01
102.02	Line 35 = sum of lines 31 and 32						10,325	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:

From 10/01/2018
To 09/30/2019

Worksheet B

Part I

Date/Time Prepared:
2/27/2020 11:59 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW ALU BLDG	NEW 2007 HOSPITAL	NEW 2007 MOB	
			0	1.00	1.01	1.02	1.03	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	51,565	51,565				1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG	63,003	0	63,003			1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL	3,233,201	0	0	3,233,201		1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB	0	0	0	0	0	1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	21,360					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	860,605					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,461,348	0	0	0	0	4.00
5.01	00570	ADMITTING	283,879	0	0	46,730		5.01
5.02	00550	INFORMATION TECHNOLOGY	580,231	585	0	23,211		5.02
5.03	00590	HOSPITAL BILLING	230,955	0	0	0		5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	1,166,278	7,666	18,942	280,442		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0		6.00
7.00	00700	OPERATION OF PLANT	618,007	0	0	217,477		7.00
7.01	00701	OPERATION OF PLANT-SCC	294,619	1,965	0	0		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	42,454	0	0	21,976		8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	30,758	196	0	0		8.01
9.00	00900	HOUSEKEEPING	179,909	0	0	16,667		9.00
9.01	00901	HOUSEKEEPING-SCC	95,747	374	0	0		9.01
10.00	01000	DIETARY	275,252	0	0	197,908		10.00
10.01	01001	DIETARY-SCC	428,474	1,452	0	0		10.01
11.00	01100	CAFETERIA	0	0	0	0		11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0		11.01
13.00	01300	NURSING ADMINISTRATION	256,535	651	0	7,902		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	73,175	0	0	42,100		14.00
15.00	01500	PHARMACY	0	0	0	47,718		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	199,740	0	0	42,409		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	980,855	0	0	546,316		30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
42.00	04200	SUBPROVIDER	0	0	0	0		42.00
44.00	04400	SKILLED NURSING FACILITY	9,173	1,705	0	0		44.00
46.00	04600	OTHER LONG TERM CARE	1,837,425	17,732	0	0		46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	679,110	0	0	332,357		50.00
53.00	05300	ANESTHESIOLOGY	250,533	0	0	3,333		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	709,947	0	0	224,144		54.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	708,730	0	0	66,422		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0		60.01
64.00	06400	INTRAVENOUS THERAPY	23,461	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	22,459	0	0	11,605		65.00
66.00	06600	PHYSICAL THERAPY	1,118,721	0	0	266,985		66.00
66.01	06601	CARDIAC REHAB	117,368	0	0	18,519		66.01
67.00	06700	OCCUPATIONAL THERAPY	106,183	0	0	22,964		67.00
68.00	06800	SPEECH PATHOLOGY	58,708	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	101,781	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	342,635	0	0	0		73.00
76.00	03020	SLEEP LAB	55,029	0	0	21,606		76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0		76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	5,055	0	0	0		76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,530,112	0	0	353,901		88.00
88.01	08801	RURAL HEALTH CLINIC II	471,630	0	0	0		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
90.00	09000	CLINIC	41,777	0	0	40,125		90.00
91.00	09100	EMERGENCY	1,921,194	0	0	342,049		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0		93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0		110.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/27/2020 11:59 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW ALU BLDG	NEW 2007 HOSPITAL	NEW 2007 MOB	
			0	1.00	1.01	1.02	1.03	
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,538,981	32,326	18,942	3,194,866	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	18,334	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,214	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	287,541	0	40,762	0	0	194.01
194.02	07952	ADULT DAY CARE	112,292	0	3,299	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	19,239	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	11,319	0	0	20,001	0	194.05
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)	22,959,347	51,565	63,003	3,233,201	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/27/2020 11:59 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	INFORMATION TECHNOLOGY	
			NEW MVBLE EQUIP	NEW MVBLE EQUIP NEW HO				
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	21,360					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	860,605				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	2,461,348			4.00
5.01	00570	ADMITTING	0	0	82,337	412,946		5.01
5.02	00550	INFORMATION TECHNOLOGY	0	51,392	86,525	0	741,944	5.02
5.03	00590	HOSPITAL BILLING	0	0	0	0	0	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	392	122,891	209,430	0	44,815	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	27,625	25,037	0	24,897	7.00
7.01	00701	OPERATION OF PLANT-SCC	288	0	22,199	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	920	0	0	0	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	0	3,571	0	0	8.01
9.00	00900	HOUSEKEEPING	0	533	43,393	0	0	9.00
9.01	00901	HOUSEKEEPING-SCC	0	0	22,886	0	0	9.01
10.00	01000	DIETARY	0	50,800	58,421	0	14,938	10.00
10.01	01001	DIETARY-SCC	33	0	68,292	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	0	174	74,522	0	4,979	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	20,663	0	0	14.00
15.00	01500	PHARMACY	0	4,595	0	0	9,959	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	319	53,541	0	19,918	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	54,299	230,635	49,714	79,672	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	11,349	0	452,556	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	189,575	64,440	49,558	74,692	50.00
53.00	05300	ANESTHESIOLOGY	0	9,689	0	10,053	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	197,353	94,292	95,961	44,815	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	18	30,776	86,661	47,505	24,897	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	11,632	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,730	0	4,426	0	65.00
66.00	06600	PHYSICAL THERAPY	85	13,729	300,857	55,711	134,450	66.00
66.01	06601	CARDIAC REHAB	0	3,684	30,422	4,076	4,979	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	27,322	6,336	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,135	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	14,275	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	26,262	0	73.00
76.00	03020	SLEEP LAB	0	6,354	9,224	352	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	1,494	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	40	26,608	125,352	0	129,467	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	24,492	44,179	0	44,815	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	8,665	0	0	34,856	90.00
91.00	09100	EMERGENCY	99	30,573	113,019	34,950	49,795	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2018
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	INFORMATION TECHNOLOGY	
			NEW MVBLE EQUIP	NEW MVBLE EQUIP NEW HO				
			2.00	2.01	4.00	5.01	5.02	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,304	856,776	2,351,270	412,946	741,944	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	265	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	8,015	1,242	79,308	0	0	194.01
194.02	07952	ADULT DAY CARE	1,028	153	27,912	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	13	2,169	2,858	0	0	194.05
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)	21,360	860,605	2,461,348	412,946	741,944	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2018
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Cost Center Description			HOSPITAL BILLING	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
			5.03	5A.03	5.04	6.00	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING	230,955					5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	0	1,850,856	1,850,856			5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0		6.00
7.00	00700	OPERATION OF PLANT	0	913,043	97,988	0	1,011,031	7.00
7.01	00701	OPERATION OF PLANT-SCC	0	319,071	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	65,350	7,013	0	8,336	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	34,525	0	0	0	8.01
9.00	00900	HOUSEKEEPING	0	240,502	25,811	0	6,322	9.00
9.01	00901	HOUSEKEEPING-SCC	0	119,007	0	0	0	9.01
10.00	01000	DIETARY	0	597,319	64,104	0	75,072	10.00
10.01	01001	DIETARY-SCC	0	498,251	0	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	0	344,763	37,000	0	2,997	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	135,938	14,589	0	15,970	14.00
15.00	01500	PHARMACY	0	62,272	6,683	0	18,101	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	315,927	33,905	0	16,087	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	25,060	1,966,551	211,050	0	207,229	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	10,878	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	2,319,062	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	24,981	1,414,713	151,827	0	126,072	50.00
53.00	05300	ANESTHESIOLOGY	5,068	278,676	29,908	0	1,264	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	48,371	1,414,883	151,845	0	85,023	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	23,947	988,956	106,135	0	25,196	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	5,863	40,956	4,395	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,231	42,451	4,556	0	4,402	65.00
66.00	06600	PHYSICAL THERAPY	28,083	1,918,621	205,906	0	109,470	66.00
66.01	06601	CARDIAC REHAB	2,055	181,103	19,436	0	7,025	66.01
67.00	06700	OCCUPATIONAL THERAPY	3,194	165,999	17,815	0	8,711	67.00
68.00	06800	SPEECH PATHOLOGY	1,076	61,919	6,645	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,196	123,252	13,227	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,238	382,135	41,011	0	0	73.00
76.00	03020	SLEEP LAB	178	92,743	9,953	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	6,549	703	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	17,308	2,182,788	234,257	0	134,244	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,311	590,427	63,365	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	177	125,600	13,479	0	15,220	90.00
91.00	09100	EMERGENCY	17,618	2,509,297	269,298	0	129,748	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	230,955	22,314,383	1,841,904	0	996,489	118.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
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Cost Center Description			HOSPITAL BILLING	Subtotal	OTHER ADMINISTRATIV E AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
			5.03	5A.03	5.04	6.00	7.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,599	1,996	0	6,955	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	9,214	989	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	416,868	0	0	0	194.01
194.02	07952	ADULT DAY CARE	0	144,684	0	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	19,239	2,065	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	36,360	3,902	0	7,587	194.05
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)	230,955	22,959,347	1,850,856	0	1,011,031	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			OPERATION OF PLANT-SCC	LAUNDRY & LINEN SERVICE	LAUNDRY & LINEN SERVICE-SCC	HOUSEKEEPING	HOUSEKEEPING- SCC	
			7.01	8.00	8.01	9.00	9.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING						5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-SCC	319,071					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	80,699				8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	1,006	0	35,531			8.01
9.00	00900	HOUSEKEEPING	0	0	0	272,635		9.00
9.01	00901	HOUSEKEEPING-SCC	1,914	0	0	0	120,921	9.01
10.00	01000	DIETARY	0	0	0	22,504	0	10.00
10.01	01001	DIETARY-SCC	7,436	0	0	0	4,132	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	3,334	0	0	898	1,853	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	4,787	0	14.00
15.00	01500	PHARMACY	0	0	0	5,426	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	4,822	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	0	80,699	0	62,122	0	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	8,728	0	0	0	4,849	44.00
46.00	04600	OTHER LONG TERM CARE	90,791	0	35,531	0	50,443	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	37,793	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	379	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	25,488	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	7,553	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,320	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,961	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	1,228	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	948	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	41,471	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	4,212	0	90.00
91.00	09100	EMERGENCY	0	0	0	38,895	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	113,209	80,699	35,531	271,807	61,277	118.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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Cost Center Description			OPERATION OF PLANT-SCC	LAUNDRY & LINEN SERVICE	LAUNDRY & LINEN SERVICE-SCC	HOUSEKEEPING	HOUSEKEEPING- SCC	
			7.01	8.00	8.01	9.00	9.01	
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
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	99,316	0	0	0	55,178	194.01
194.02	07952	ADULT DAY CARE	8,038	0	0	0	4,466	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	98,508	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	828	0	194.05
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)	319,071	80,699	35,531	272,635	120,921	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			DIETARY	DIETARY-SCC	CAFETERIA	CAFETERIA-SCC	NURSING ADMINISTRATION	
			10.00	10.01	11.00	11.01	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING						5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-SCC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC						8.01
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING-SCC						9.01
10.00	01000	DIETARY	758,999					10.00
10.01	01001	DIETARY-SCC	0	509,819				10.01
11.00	01100	CAFETERIA	0	0	0			11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0		11.01
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	390,845	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	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	758,999	0	0	0	312,749	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	318,619	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	39,048	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	39,048	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	758,999	318,619	0	0	390,845	118.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			DIETARY	DIETARY-SCC	CAFETERIA	CAFETERIA-SCC	NURSING ADMINISTRATIO N	
			10.00	10.01	11.00	11.01	13.00	
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
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	31,436	0	0	0	194.01
194.02	07952	ADULT DAY CARE	0	159,764	0	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	0	0	194.05
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)	758,999	509,819	0	0	390,845	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/27/2020 11:59 am

Cost Center Description			CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
			14.00	15.00	16.00	19.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING						5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-SCC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC						8.01
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING-SCC						9.01
10.00	01000	DIETARY						10.00
10.01	01001	DIETARY-SCC						10.01
11.00	01100	CAFETERIA						11.00
11.01	01101	CAFETERIA-SCC						11.01
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	171,284					14.00
15.00	01500	PHARMACY	0	92,482				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	721	0	371,462			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,301	0	40,304	0	3,652,004	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	24,455	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	2,814,446	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	89,569	0	40,177	0	1,899,199	50.00
53.00	05300	ANESTHESIOLOGY	1,626	0	8,150	0	320,003	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	77,815	0	1,755,054	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	38,513	0	1,166,353	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	4,499	0	9,430	0	59,280	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	3,589	0	56,318	65.00
66.00	06600	PHYSICAL THERAPY	22,356	0	45,166	0	2,313,480	66.00
66.01	06601	CARDIAC REHAB	4,849	0	3,304	0	216,945	66.01
67.00	06700	OCCUPATIONAL THERAPY	547	0	5,137	0	199,157	67.00
68.00	06800	SPEECH PATHOLOGY	2	0	1,731	0	70,297	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	427	0	11,573	0	148,479	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70	92,482	21,291	0	536,989	73.00
76.00	03020	SLEEP LAB	3,797	0	286	0	106,779	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	7,252	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	15,348	0	27,837	0	2,635,945	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,168	0	8,541	0	667,501	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	284	0	158,795	90.00
91.00	09100	EMERGENCY	10,004	0	28,334	0	3,024,624	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	171,284	92,482	371,462	0	21,833,355	118.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
			14.00	15.00	16.00	19.00	24.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	27,550	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	10,203	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	0	0	0	602,798	194.01
194.02	07952	ADULT DAY CARE	0	0	0	0	316,952	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	0	119,812	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	0	48,677	194.05
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)	171,284	92,482	371,462	0	22,959,347	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/27/2020 11:59 am

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG		1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL		1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB		1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00570	ADMITTING		5.01
5.02	00550	INFORMATION TECHNOLOGY		5.02
5.03	00590	HOSPITAL BILLING		5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL		5.04
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
7.01	00701	OPERATION OF PLANT-SCC		7.01
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC		8.01
9.00	00900	HOUSEKEEPING		9.00
9.01	00901	HOUSEKEEPING-SCC		9.01
10.00	01000	DIETARY		10.00
10.01	01001	DIETARY-SCC		10.01
11.00	01100	CAFETERIA		11.00
11.01	01101	CAFETERIA-SCC		11.01
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICE & 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	0 3,652,004	30.00
41.00	04100	SUBPROVIDER - IRF	0 0	41.00
42.00	04200	SUBPROVIDER	0 0	42.00
44.00	04400	SKILLED NURSING FACILITY	0 24,455	44.00
46.00	04600	OTHER LONG TERM CARE	0 2,814,446	46.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0 1,899,199	50.00
53.00	05300	ANESTHESIOLOGY	0 320,003	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0 1,755,054	54.00
57.00	05700	CT SCAN	0 0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0 0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0 0	59.00
60.00	06000	LABORATORY	0 1,166,353	60.00
60.01	06001	BLOOD LABORATORY	0 0	60.01
64.00	06400	INTRAVENOUS THERAPY	0 59,280	64.00
65.00	06500	RESPIRATORY THERAPY	0 56,318	65.00
66.00	06600	PHYSICAL THERAPY	0 2,313,480	66.00
66.01	06601	CARDIAC REHAB	0 216,945	66.01
67.00	06700	OCCUPATIONAL THERAPY	0 199,157	67.00
68.00	06800	SPEECH PATHOLOGY	0 70,297	68.00
69.00	06900	ELECTROCARDIOLOGY	0 0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0 148,479	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0 0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0 536,989	73.00
76.00	03020	SLEEP LAB	0 106,779	76.00
76.01	03950	PAIN CLINIC / SERVICE	0 0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0 7,252	76.02
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0 2,635,945	88.00
88.01	08801	RURAL HEALTH CLINIC II	0 667,501	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0 0	89.00
90.00	09000	CLINIC	0 158,795	90.00
91.00	09100	EMERGENCY	0 3,024,624	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0 0	92.00
93.00	04040	FAMILY PRACTICE	0 0	93.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0 0	99.10
SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION	0 0	109.00
110.00	11000	INTESTINAL ACQUISITION	0 0	110.00
111.00	11100	ISLET ACQUISITION	0 0	111.00
113.00	11300	INTEREST EXPENSE	0 0	113.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/27/2020 11:59 am

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	21,833,355		118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	27,550		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,203		192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0		192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0		194.00
194.01	07951	ASSISTED LIVING UNITS	0	602,798		194.01
194.02	07952	ADULT DAY CARE	0	316,952		194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0		194.03
194.04	07954	IDLE SPACE	0	119,812		194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	48,677		194.05
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	22,959,347		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/27/2020 11:59 am

Cost Center Description			CAPITAL RELATED COSTS					
			Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW ALU BLDG	NEW 2007 HOSPITAL		NEW 2007 MOB
			0	1.00	1.01	1.02	1.03	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00570	ADMITTING	0	0	0	46,730	0	5.01
5.02	00550	INFORMATION TECHNOLOGY	0	585	0	23,211	0	5.02
5.03	00590	HOSPITAL BILLING	0	0	0	0	0	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	0	7,666	18,942	280,442	0	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	217,477	0	7.00
7.01	00701	OPERATION OF PLANT-SCC	0	1,965	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	21,976	0	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	196	0	0	0	8.01
9.00	00900	HOUSEKEEPING	0	0	0	16,667	0	9.00
9.01	00901	HOUSEKEEPING-SCC	0	374	0	0	0	9.01
10.00	01000	DIETARY	0	0	0	197,908	0	10.00
10.01	01001	DIETARY-SCC	0	1,452	0	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	0	651	0	7,902	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	42,100	0	14.00
15.00	01500	PHARMACY	0	0	0	47,718	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	42,409	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	0	0	0	546,316	0	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	1,705	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	17,732	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	332,357	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,333	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,028	0	0	224,144	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	66,422	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,605	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	266,985	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	18,519	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	22,964	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	21,606	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	353,901	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	40,125	0	90.00
91.00	09100	EMERGENCY	0	0	0	342,049	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet B
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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW ALU BLDG	NEW 2007 HOSPITAL	NEW 2007 MOB	
				1.00	1.01	1.02	1.03	
113.00	11300	INTEREST EXPENSE	0					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,028	32,326	18,942	3,194,866	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	18,334	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	0	40,762	0	0	194.01
194.02	07952	ADULT DAY CARE	0	0	3,299	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	19,239	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	20,001	0	194.05
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)	21,028	51,565	63,003	3,233,201	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
			NEW MVBLE EQUIP	NEW MVBLE EQUIP NEW HO				
			2.00	2.01				
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0		4.00
5.01	00570	ADMITTING	0	0	46,730	0	46,730	5.01
5.02	00550	INFORMATION TECHNOLOGY	0	51,392	75,188	0	0	5.02
5.03	00590	HOSPITAL BILLING	0	0	0	0	0	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	392	122,891	430,333	0	0	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	27,625	245,102	0	0	7.00
7.01	00701	OPERATION OF PLANT-SCC	288	0	2,253	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	920	22,896	0	0	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	0	196	0	0	8.01
9.00	00900	HOUSEKEEPING	0	533	17,200	0	0	9.00
9.01	00901	HOUSEKEEPING-SCC	0	0	374	0	0	9.01
10.00	01000	DIETARY	0	50,800	248,708	0	0	10.00
10.01	01001	DIETARY-SCC	33	0	1,485	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	0	174	8,727	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	42,100	0	0	14.00
15.00	01500	PHARMACY	0	4,595	52,313	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	319	42,728	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	0	54,299	600,615	0	5,625	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	1,705	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	11,349	0	29,081	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	189,575	521,932	0	5,608	50.00
53.00	05300	ANESTHESIOLOGY	0	9,689	13,022	0	1,138	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	197,353	442,525	0	10,861	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	18	30,776	97,216	0	5,375	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	1,316	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,730	13,335	0	501	65.00
66.00	06600	PHYSICAL THERAPY	85	13,729	280,799	0	6,304	66.00
66.01	06601	CARDIAC REHAB	0	3,684	22,203	0	461	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	22,964	0	717	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	242	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,615	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,972	73.00
76.00	03020	SLEEP LAB	0	6,354	27,960	0	40	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	40	26,608	380,549	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	24,492	24,492	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	8,665	48,790	0	0	90.00
91.00	09100	EMERGENCY	99	30,573	372,721	0	3,955	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
			NEW MVBLE EQUIP	NEW MVBLE EQUIP NEW HO				
			2.00	2.01				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,304	856,776	4,136,242	0	46,730	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	265	18,599	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	8,015	1,242	50,019	0	0	194.01
194.02	07952	ADULT DAY CARE	1,028	153	4,480	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	19,239	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	13	2,169	22,183	0	0	194.05
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)	21,360	860,605	4,250,762	0	46,730	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
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Cost Center Description			INFORMATION TECHNOLOGY	HOSPITAL BILLING	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
			5.02	5.03	5.04	6.00	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY	75,188					5.02
5.03	00590	HOSPITAL BILLING	0	0				5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	4,542	0	434,875			5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0		6.00
7.00	00700	OPERATION OF PLANT	2,523	0	23,023	0	270,648	7.00
7.01	00701	OPERATION OF PLANT-SCC	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,648	0	2,232	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	0	0	0	0	8.01
9.00	00900	HOUSEKEEPING	0	0	6,064	0	1,692	9.00
9.01	00901	HOUSEKEEPING-SCC	0	0	0	0	0	9.01
10.00	01000	DIETARY	1,514	0	15,062	0	20,096	10.00
10.01	01001	DIETARY-SCC	0	0	0	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	505	0	8,694	0	802	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	3,428	0	4,275	14.00
15.00	01500	PHARMACY	1,009	0	1,570	0	4,845	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,018	0	7,966	0	4,306	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,074	0	49,589	0	55,477	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,569	0	35,673	0	33,749	50.00
53.00	05300	ANESTHESIOLOGY	0	0	7,027	0	338	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,542	0	35,678	0	22,760	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,523	0	24,938	0	6,745	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	1,033	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,070	0	1,178	65.00
66.00	06600	PHYSICAL THERAPY	13,624	0	48,380	0	29,304	66.00
66.01	06601	CARDIAC REHAB	505	0	4,567	0	1,881	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	4,186	0	2,332	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,561	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	3,108	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	9,636	0	0	73.00
76.00	03020	SLEEP LAB	0	0	2,339	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	165	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	13,120	0	55,041	0	35,936	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,542	0	14,888	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	3,532	0	3,167	0	4,074	90.00
91.00	09100	EMERGENCY	5,046	0	63,271	0	34,733	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	75,188	0	432,772	0	266,755	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet B
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Cost Center Description			INFORMATION TECHNOLOGY	HOSPITAL BILLING	OTHER ADMINISTRATIV E AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
			5.02	5.03	5.04	6.00	7.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	469	0	1,862	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	232	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	0	0	0	0	194.01
194.02	07952	ADULT DAY CARE	0	0	0	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	485	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	917	0	2,031	194.05
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)	75,188	0	434,875	0	270,648	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
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Cost Center Description			OPERATION OF PLANT-SCC	LAUNDRY & LINEN SERVICE	LAUNDRY & LINEN SERVICE-SCC	HOUSEKEEPING	HOUSEKEEPING- SCC	
			7.01	8.00	8.01	9.00	9.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING						5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-SCC	2,253					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	26,776				8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	7	0	203			8.01
9.00	00900	HOUSEKEEPING	0	0	0	24,956		9.00
9.01	00901	HOUSEKEEPING-SCC	14	0	0	0	388	9.01
10.00	01000	DIETARY	0	0	0	2,060	0	10.00
10.01	01001	DIETARY-SCC	53	0	0	0	13	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	24	0	0	82	6	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	438	0	14.00
15.00	01500	PHARMACY	0	0	0	497	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	441	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	0	26,776	0	5,687	0	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	62	0	0	0	16	44.00
46.00	04600	OTHER LONG TERM CARE	641	0	203	0	162	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	3,459	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	35	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,333	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	691	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	121	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,095	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	112	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	87	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,796	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	386	0	90.00
91.00	09100	EMERGENCY	0	0	0	3,560	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	801	26,776	203	24,880	197	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2018
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Cost Center Description			OPERATION OF PLANT-SCC	LAUNDRY & LINEN SERVICE	LAUNDRY & LINEN SERVICE-SCC	HOUSEKEEPING	HOUSEKEEPING- SCC	
			7.01	8.00	8.01	9.00	9.01	
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
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	699	0	0	0	177	194.01
194.02	07952	ADULT DAY CARE	57	0	0	0	14	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	696	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	76	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,253	26,776	203	24,956	388	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet B
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Cost Center Description			DIETARY	DIETARY-SCC	CAFETERIA	CAFETERIA-SCC	NURSING ADMINISTRATION	
			10.00	10.01	11.00	11.01	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING						5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-SCC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC						8.01
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING-SCC						9.01
10.00	01000	DIETARY	287,440					10.00
10.01	01001	DIETARY-SCC	0	1,551				10.01
11.00	01100	CAFETERIA	0	0	0			11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0		11.01
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	18,840	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	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	287,440	0	0	0	15,076	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	969	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	1,882	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	1,882	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	287,440	969	0	0	18,840	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
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To 09/30/2019Worksheet B
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Cost Center Description			DIETARY	DIETARY-SCC	CAFETERIA	CAFETERIA-SCC	NURSING ADMINISTRATIO N	
			10.00	10.01	11.00	11.01	13.00	
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
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	96	0	0	0	194.01
194.02	07952	ADULT DAY CARE	0	486	0	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	0	0	194.05
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)	287,440	1,551	0	0	18,840	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
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Cost Center Description			CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
			14.00	15.00	16.00	19.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING						5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-SCC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC						8.01
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING-SCC						9.01
10.00	01000	DIETARY						10.00
10.01	01001	DIETARY-SCC						10.01
11.00	01100	CAFETERIA						11.00
11.01	01101	CAFETERIA-SCC						11.01
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	50,241					14.00
15.00	01500	PHARMACY	0	60,234				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	212	0	57,671			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,608	0	6,259		1,064,226	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		0	41.00
42.00	04200	SUBPROVIDER	0	0	0		0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		1,783	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0		31,056	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	26,274	0	6,239		642,385	50.00
53.00	05300	ANESTHESIOLOGY	477	0	1,266		23,303	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	12,071		530,770	54.00
57.00	05700	CT SCAN	0	0	0		0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		0	59.00
60.00	06000	LABORATORY	0	0	5,981		143,469	60.00
60.01	06001	BLOOD LABORATORY	0	0	0		0	60.01
64.00	06400	INTRAVENOUS THERAPY	1,320	0	1,464		5,133	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	557		16,762	65.00
66.00	06600	PHYSICAL THERAPY	6,557	0	7,014		393,077	66.00
66.01	06601	CARDIAC REHAB	1,422	0	513		31,664	66.01
67.00	06700	OCCUPATIONAL THERAPY	160	0	798		31,244	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	269		2,072	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	125	0	1,797		6,645	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20	60,234	3,306		76,168	73.00
76.00	03020	SLEEP LAB	1,114	0	44		31,497	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0		0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0		165	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,502	0	4,323		497,267	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,516	0	1,326		46,764	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0	89.00
90.00	09000	CLINIC	0	0	44		59,993	90.00
91.00	09100	EMERGENCY	2,934	0	4,400		492,502	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0		0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0		0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0		0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0		0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,241	60,234	57,671	0	4,127,945	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
			14.00	15.00	16.00	19.00	24.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		20,930	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		232	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0		0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0		0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	0	0		50,991	194.01
194.02	07952	ADULT DAY CARE	0	0	0		5,037	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0		0	194.03
194.04	07954	IDLE SPACE	0	0	0		20,420	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0		25,207	194.05
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)	50,241	60,234	57,671	0	4,250,762	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG		1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL		1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB		1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00570	ADMITTING		5.01
5.02	00550	INFORMATION TECHNOLOGY		5.02
5.03	00590	HOSPITAL BILLING		5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL		5.04
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
7.01	00701	OPERATION OF PLANT-SCC		7.01
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC		8.01
9.00	00900	HOUSEKEEPING		9.00
9.01	00901	HOUSEKEEPING-SCC		9.01
10.00	01000	DIETARY		10.00
10.01	01001	DIETARY-SCC		10.01
11.00	01100	CAFETERIA		11.00
11.01	01101	CAFETERIA-SCC		11.01
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICE & 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	0 1,064,226	30.00
41.00	04100	SUBPROVIDER - IRF	0 0	41.00
42.00	04200	SUBPROVIDER	0 0	42.00
44.00	04400	SKILLED NURSING FACILITY	0 1,783	44.00
46.00	04600	OTHER LONG TERM CARE	0 31,056	46.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0 642,385	50.00
53.00	05300	ANESTHESIOLOGY	0 23,303	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0 530,770	54.00
57.00	05700	CT SCAN	0 0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0 0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0 0	59.00
60.00	06000	LABORATORY	0 143,469	60.00
60.01	06001	BLOOD LABORATORY	0 0	60.01
64.00	06400	INTRAVENOUS THERAPY	0 5,133	64.00
65.00	06500	RESPIRATORY THERAPY	0 16,762	65.00
66.00	06600	PHYSICAL THERAPY	0 393,077	66.00
66.01	06601	CARDIAC REHAB	0 31,664	66.01
67.00	06700	OCCUPATIONAL THERAPY	0 31,244	67.00
68.00	06800	SPEECH PATHOLOGY	0 2,072	68.00
69.00	06900	ELECTROCARDIOLOGY	0 0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0 6,645	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0 0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0 76,168	73.00
76.00	03020	SLEEP LAB	0 31,497	76.00
76.01	03950	PAIN CLINIC / SERVICE	0 0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0 165	76.02
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0 497,267	88.00
88.01	08801	RURAL HEALTH CLINIC II	0 46,764	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0 0	89.00
90.00	09000	CLINIC	0 59,993	90.00
91.00	09100	EMERGENCY	0 492,502	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0 0	92.00
93.00	04040	FAMILY PRACTICE	0 0	93.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0 0	99.10
SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION	0 0	109.00
110.00	11000	INTESTINAL ACQUISITION	0 0	110.00
111.00	11100	ISLET ACQUISITION	0 0	111.00
113.00	11300	INTEREST EXPENSE	0 0	113.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/27/2020 11:59 am

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,127,945		118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	20,930		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	232		192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0		192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0		194.00
194.01	07951	ASSISTED LIVING UNITS	0	50,991		194.01
194.02	07952	ADULT DAY CARE	0	5,037		194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0		194.03
194.04	07954	IDLE SPACE	0	20,420		194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	25,207		194.05
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	4,250,762		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/27/2020 11:59 am

Cost Center Description			CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW ALU BLDG (SQUARE FEET)	NEW 2007 HOSPITAL (SQUARE FEET)	NEW 2007 MOB (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	
			1.00	1.01	1.02	1.03	2.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	50,914					1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG	0	29,602				1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL	0	0	52,376			1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB	0	0	0	0		1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					84,501	2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO					0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00570	ADMITTING	0	0	757	0	0	5.01
5.02	00550	INFORMATION TECHNOLOGY	578	0	376	0	0	5.02
5.03	00590	HOSPITAL BILLING	0	0	0	0	0	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	7,569	8,900	4,543	0	1,551	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	3,523	0	0	7.00
7.01	00701	OPERATION OF PLANT-SCC	1,940	0	0	0	1,138	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	356	0	0	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	194	0	0	0	0	8.01
9.00	00900	HOUSEKEEPING	0	0	270	0	0	9.00
9.01	00901	HOUSEKEEPING-SCC	369	0	0	0	0	9.01
10.00	01000	DIETARY	0	0	3,206	0	0	10.00
10.01	01001	DIETARY-SCC	1,434	0	0	0	132	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	643	0	128	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	682	0	0	14.00
15.00	01500	PHARMACY	0	0	773	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	687	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	0	0	8,850	0	0	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	1,683	0	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	17,508	0	0	0	44,889	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	5,384	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	54	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,631	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	1,076	0	72	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	188	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	4,325	0	336	66.00
66.01	06601	CARDIAC REHAB	0	0	300	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	372	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	350	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	5,733	0	160	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	650	0	0	90.00
91.00	09100	EMERGENCY	0	0	5,541	0	393	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/27/2020 11:59 am

Cost Center Description			CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW ALU BLDG (SQUARE FEET)	NEW 2007 HOSPITAL (SQUARE FEET)	NEW 2007 MOB (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	
			1.00	1.01	1.02	1.03	2.00	
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,918	8,900	51,755	0	48,671	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	297	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	19,152	0	0	31,709	194.01
194.02	07952	ADULT DAY CARE	0	1,550	0	0	4,068	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	18,996	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	324	0	53	194.05
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)	51,565	63,003	3,233,201	0	21,360	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.012786	2.128336	61.730583	0.000000	0.252778	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
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: 14-1302

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/27/2020 11:59 am

Cost Center Description			CAPITAL RELATED COSTS NEW MVBLE EQUIP NEW HO (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	INFORMATION TECHNOLOGY (NO. OF COMPUTERS)	HOSPITAL BILLING (GROSS CHARGES HOSP BILLING)	
			2.01	4.00	5.01	5.02	5.03	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	882,593					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,328,113				4.00
5.01	00570	ADMITTING	0	278,593	22,782,574			5.01
5.02	00550	INFORMATION TECHNOLOGY	52,705	292,761	0	149		5.02
5.03	00590	HOSPITAL BILLING	0	0	0	0	25,277,449	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	126,031	708,617	0	9	0	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	28,331	84,713	0	5	0	7.00
7.01	00701	OPERATION OF PLANT-SCC	0	75,110	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	943	0	0	0	0	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	12,082	0	0	0	8.01
9.00	00900	HOUSEKEEPING	547	146,823	0	0	0	9.00
9.01	00901	HOUSEKEEPING-SCC	0	77,435	0	0	0	9.01
10.00	01000	DIETARY	52,098	197,671	0	3	0	10.00
10.01	01001	DIETARY-SCC	0	231,069	0	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	178	252,150	0	1	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	69,914	0	0	0	14.00
15.00	01500	PHARMACY	4,712	0	0	2	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	327	181,160	0	4	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	55,686	780,365	2,742,704	16	2,742,704	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	1,531,256	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	194,419	218,036	2,734,072	15	2,734,072	50.00
53.00	05300	ANESTHESIOLOGY	9,937	0	554,633	0	554,633	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	202,396	319,043	5,294,675	9	5,294,675	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	31,562	293,223	2,620,848	5	2,620,848	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	641,731	0	641,731	64.00
65.00	06500	RESPIRATORY THERAPY	1,774	0	244,206	0	244,206	65.00
66.00	06600	PHYSICAL THERAPY	14,080	1,017,967	3,073,540	27	3,073,540	66.00
66.01	06601	CARDIAC REHAB	3,778	102,936	224,857	1	224,857	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	92,446	349,558	0	349,558	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	117,794	0	117,794	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	787,522	0	787,522	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,448,832	0	1,448,832	73.00
76.00	03020	SLEEP LAB	6,516	31,210	19,442	0	19,442	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	5,055	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	27,288	424,135	0	26	1,894,305	88.00
88.01	08801	RURAL HEALTH CLINIC II	25,118	149,482	0	9	581,231	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	8,886	0	0	7	19,339	90.00
91.00	09100	EMERGENCY	31,354	382,405	1,928,160	10	1,928,160	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/27/2020 11:59 am

Cost Center Description			CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	INFORMATION TECHNOLOGY (NO. OF COMPUTERS)	HOSPITAL BILLING (GROSS CHARGES HOSP BILLING)	
			NEW MVBLE EQUIP NEW HO (DOLLAR VALUE)					
			2.01	4.00	5.01	5.02	5.03	
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	878,666	7,955,657	22,782,574	149	25,277,449	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	272	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	1,274	268,344	0	0	0	194.01
194.02	07952	ADULT DAY CARE	157	94,441	0	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	2,224	9,671	0	0	0	194.05
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)	860,605	2,461,348	412,946	741,944	230,955	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.975087	0.295547	0.018126	4,979.489933	0.009137	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		0	46,730	75,188	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000000	0.002051	504.617450	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: 14-1302

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:

2/27/2020 11:59 am

Cost Center Description		Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FT)	OPERATION OF PLANT-SCC (SQUARE FT SCC)	
		5A.04	5.04	6.00	7.00	7.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG					1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL					1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB					1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00570	ADMITTING					5.01
5.02	00550	INFORMATION TECHNOLOGY					5.02
5.03	00590	HOSPITAL BILLING					5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	-1,850,856	17,246,145			5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0		6.00
7.00	00700	OPERATION OF PLANT	0	913,043	0	43,177	7.00
7.01	00701	OPERATION OF PLANT-SCC	-319,071	0	0	61,529	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	65,350	0	356	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	-34,525	0	0	194	8.01
9.00	00900	HOUSEKEEPING	0	240,502	0	270	9.00
9.01	00901	HOUSEKEEPING-SCC	-119,007	0	0	369	9.01
10.00	01000	DIETARY	0	597,319	0	3,206	10.00
10.01	01001	DIETARY-SCC	-498,251	0	0	1,434	10.01
11.00	01100	CAFETERIA	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	0	344,763	0	128	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	135,938	0	682	14.00
15.00	01500	PHARMACY	0	62,272	0	773	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	315,927	0	687	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,966,551	0	8,850	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	-10,878	0	0	1,683	44.00
46.00	04600	OTHER LONG TERM CARE	-2,319,062	0	0	17,508	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,414,713	0	5,384	50.00
53.00	05300	ANESTHESIOLOGY	0	278,676	0	54	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,414,883	0	3,631	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	988,956	0	1,076	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	40,956	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	42,451	0	188	65.00
66.00	06600	PHYSICAL THERAPY	0	1,918,621	0	4,675	66.00
66.01	06601	CARDIAC REHAB	0	181,103	0	300	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	165,999	0	372	67.00
68.00	06800	SPEECH PATHOLOGY	0	61,919	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	123,252	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	382,135	0	0	73.00
76.00	03020	SLEEP LAB	0	92,743	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	6,549	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,182,788	0	5,733	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	590,427	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	125,600	0	650	90.00
91.00	09100	EMERGENCY	0	2,509,297	0	5,541	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,151,650	17,162,733	0	42,556	21,831

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/27/2020 11:59 am

Cost Center Description		Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FT)	OPERATION OF PLANT-SCC (SQUARE FT SCC)	
		5A.04	5.04	6.00	7.00	7.01	
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,599	0	297	0190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	9,214	0	0	0192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0194.00
194.01	07951	ASSISTED LIVING UNITS	-416,868	0	0	0	19,152194.01
194.02	07952	ADULT DAY CARE	-144,684	0	0	0	1,550194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0194.03
194.04	07954	IDLE SPACE	0	19,239	0	0	18,996194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	36,360	0	324	0194.05
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		1,850,856	0	1,011,031	319,071202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.107320	0.000000	23.415962	5.185701203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		434,875	0	270,648	2,253204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.025216	0.000000	6.268337	0.036617205.00
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: 14-1302

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			LAUNDRY & LINEN SERVICE (PATIENT DAYS)	LAUNDRY & LINEN SERVICE-SCC (PATIENT DAYS SCC)	HOUSEKEEPING (SQUARE FT)	HOUSEKEEPING-SCC (SQUARE FT SCC)	DIETARY (PATIENT DAYS)	
			8.00	8.01	9.00	9.01	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING						5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-SCC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE	2,498					8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	17,149				8.01
9.00	00900	HOUSEKEEPING	0	0	38,840			9.00
9.01	00901	HOUSEKEEPING-SCC	0	0	0	41,970		9.01
10.00	01000	DIETARY	0	0	3,206	0	2,498	10.00
10.01	01001	DIETARY-SCC	0	0	0	1,434	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	0	0	128	643	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	682	0	0	14.00
15.00	01500	PHARMACY	0	0	773	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	687	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	2,498	0	8,850	0	2,498	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	1,683	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	17,149	0	17,508	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	5,384	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	54	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,631	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	1,076	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	188	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,704	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	175	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	135	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	5,908	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	600	0	0	90.00
91.00	09100	EMERGENCY	0	0	5,541	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			LAUNDRY & LINEN SERVICE (PATIENT DAYS)	LAUNDRY & LINEN SERVICE-SCC (PATIENT DAYS SCC)	HOUSEKEEPING (SQUARE FT)	HOUSEKEEPING- SCC (SQUARE FT SCC)	DIETARY (PATIENT DAYS)	
			8.00	8.01	9.00	9.01	10.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,498	17,149	38,722	21,268	2,498	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
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	0	0	19,152	0	194.01
194.02	07952	ADULT DAY CARE	0	0	0	1,550	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	118	0	0	194.05
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)	80,699	35,531	272,635	120,921	758,999	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	32.305444	2.071899	7.019439	2.881129	303.842674	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	26,776	203	24,956	388	287,440	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	10.718975	0.011837	0.642533	0.009245	115.068054	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: 14-1302

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			DIETARY-SCC (PATIENT DAYS SCC)	CAFETERIA (FTE)	CAFETERIA-SCC (FTE'S -SCC)	NURSING ADMINISTRATIO N (HOURS OF SERVICE)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	
			10.01	11.00	11.01	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING						5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-SCC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC						8.01
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING-SCC						9.01
10.00	01000	DIETARY						10.00
10.01	01001	DIETARY-SCC	27,440					10.01
11.00	01100	CAFETERIA	0	0				11.00
11.01	01101	CAFETERIA-SCC	0	0	0			11.01
13.00	01300	NURSING ADMINISTRATION	0	0	0	2,152		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	893,105	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	3,762	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	0	0	1,722	64,142	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	17,149	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	215	467,032	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	8,478	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	23,461	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	116,567	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	25,284	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	2,852	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	8	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	2,224	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	363	73.00
76.00	03020	SLEEP LAB	0	0	0	0	19,796	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	80,025	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	26,948	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	215	52,163	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			DIETARY-SCC (PATIENT DAYS SCC)	CAFETERIA (FTE)	CAFETERIA-SCC (FTE'S -SCC)	NURSING ADMINISTRATIO N (HOURS OF SERVICE)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	
			10.01	11.00	11.01	13.00	14.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,149	0	0	2,152	893,105	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
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	1,692	0	0	0	0	194.01
194.02	07952	ADULT DAY CARE	8,599	0	0	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	0	0	194.05
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)	509,819	0	0	390,845	171,284	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.579410	0.000000	0.000000	181.619424	0.191785	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,551	0	0	18,840	50,241	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.056523	0.000000	0.000000	8.754647	0.056254	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: 14-1302

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			PHARMACY (GROSS CHARGES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES HOSP BILLING)	NONPHYSICIAN ANESTHETISTS (TIME SPENT)	
			15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG				1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL				1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB				1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00570	ADMITTING				5.01
5.02	00550	INFORMATION TECHNOLOGY				5.02
5.03	00590	HOSPITAL BILLING				5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL				5.04
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT-SCC				7.01
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC				8.01
9.00	00900	HOUSEKEEPING				9.00
9.01	00901	HOUSEKEEPING-SCC				9.01
10.00	01000	DIETARY				10.00
10.01	01001	DIETARY-SCC				10.01
11.00	01100	CAFETERIA				11.00
11.01	01101	CAFETERIA-SCC				11.01
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY				14.00
15.00	01500	PHARMACY	1,448,832			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	25,277,449		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,742,704	0	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,734,072	0	50.00
53.00	05300	ANESTHESIOLOGY	0	554,633	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,294,675	0	54.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	2,620,848	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	641,731	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	244,206	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,073,540	0	66.00
66.01	06601	CARDIAC REHAB	0	224,857	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	349,558	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	117,794	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	787,522	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,448,832	1,448,832	0	73.00
76.00	03020	SLEEP LAB	0	19,442	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,894,305	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	581,231	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	19,339	0	90.00
91.00	09100	EMERGENCY	0	1,928,160	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	111.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		PHARMACY (GROSS CHARGES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES HOSP BILLING)	NONPHYSICIAN ANESTHETISTS (TIME SPENT)		
		15.00	16.00	19.00		
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,448,832	25,277,449	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	0	0	194.01
194.02	07952	ADULT DAY CARE	0	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	194.05
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)	92,482	371,462	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.063832	0.014695	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	60,234	57,671	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.041574	0.002282	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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
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			Title XVIII	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Total Costs
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,652,004		3,652,004	30.00
41.00	04100	SUBPROVIDER - IRF	0		0	41.00
42.00	04200	SUBPROVIDER	0		0	42.00
44.00	04400	SKILLED NURSING FACILITY	24,455		24,455	44.00
46.00	04600	OTHER LONG TERM CARE	2,814,446		2,814,446	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,899,199		1,899,199	50.00
53.00	05300	ANESTHESIOLOGY	320,003		320,003	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,755,054		1,755,054	54.00
57.00	05700	CT SCAN	0		0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	59.00
60.00	06000	LABORATORY	1,166,353		1,166,353	60.00
60.01	06001	BLOOD LABORATORY	0		0	60.01
64.00	06400	INTRAVENOUS THERAPY	59,280		59,280	64.00
65.00	06500	RESPIRATORY THERAPY	56,318	0	56,318	65.00
66.00	06600	PHYSICAL THERAPY	2,313,480	0	2,313,480	66.00
66.01	06601	CARDIAC REHAB	216,945	0	216,945	66.01
67.00	06700	OCCUPATIONAL THERAPY	199,157	0	199,157	67.00
68.00	06800	SPEECH PATHOLOGY	70,297	0	70,297	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	148,479		148,479	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	536,989		536,989	73.00
76.00	03020	SLEEP LAB	106,779		106,779	76.00
76.01	03950	PAIN CLINIC / SERVICE	0		0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	7,252		7,252	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,635,945		2,635,945	88.00
88.01	08801	RURAL HEALTH CLINIC II	667,501		667,501	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	89.00
90.00	09000	CLINIC	158,795		158,795	90.00
91.00	09100	EMERGENCY	3,024,624		3,024,624	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	136,552		136,552	92.00
93.00	04040	FAMILY PRACTICE	0		0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0	110.00
111.00	11100	ISLET ACQUISITION	0		0	111.00
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)	21,969,907	0	21,969,907	200.00
201.00		Less Observation Beds	136,552		136,552	201.00
202.00		Total (see instructions)	21,833,355	0	21,833,355	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
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			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	2,635,286		2,635,286		30.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
46.00	04600	OTHER LONG TERM CARE	4,145,002		4,145,002		46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	643,788	2,090,258	2,734,046	0.694648	0.000000
53.00	05300	ANESTHESIOLOGY	19,703	534,930	554,633	0.576964	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	139,134	5,155,541	5,294,675	0.331475	0.000000
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000
60.00	06000	LABORATORY	160,278	2,460,570	2,620,848	0.445029	0.000000
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000
64.00	06400	INTRAVENOUS THERAPY	28,427	613,304	641,731	0.092375	0.000000
65.00	06500	RESPIRATORY THERAPY	223,052	21,154	244,206	0.230617	0.000000
66.00	06600	PHYSICAL THERAPY	621,334	2,452,206	3,073,540	0.752709	0.000000
66.01	06601	CARDIAC REHAB	0	224,857	224,857	0.964813	0.000000
67.00	06700	OCCUPATIONAL THERAPY	263,386	86,172	349,558	0.569739	0.000000
68.00	06800	SPEECH PATHOLOGY	49,486	68,308	117,794	0.596779	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	441,041	346,481	787,522	0.188539	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	655,830	793,002	1,448,832	0.370636	0.000000
76.00	03020	SLEEP LAB	0	19,442	19,442	5.492182	0.000000
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0.000000	0.000000
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0.000000	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,894,305	1,894,305		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	581,231	581,231		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	310	19,029	19,339	8.211128	0.000000
91.00	09100	EMERGENCY	9,697	1,918,463	1,928,160	1.568658	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	107,418	107,418	1.271221	0.000000
93.00	04040	FAMILY PRACTICE	0	0	0	0.000000	0.000000
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	10,035,754	19,386,671	29,422,425		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	10,035,754	19,386,671	29,422,425		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
41.00	04100	SUBPROVIDER - IRF				41.00
42.00	04200	SUBPROVIDER				42.00
44.00	04400	SKILLED NURSING FACILITY				44.00
46.00	04600	OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.694648			50.00
53.00	05300	ANESTHESIOLOGY	0.576964			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.331475			54.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.445029			60.00
60.01	06001	BLOOD LABORATORY	0.000000			60.01
64.00	06400	INTRAVENOUS THERAPY	0.092375			64.00
65.00	06500	RESPIRATORY THERAPY	0.230617			65.00
66.00	06600	PHYSICAL THERAPY	0.752709			66.00
66.01	06601	CARDIAC REHAB	0.964813			66.01
67.00	06700	OCCUPATIONAL THERAPY	0.569739			67.00
68.00	06800	SPEECH PATHOLOGY	0.596779			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.188539			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.370636			73.00
76.00	03020	SLEEP LAB	5.492182			76.00
76.01	03950	PAIN CLINIC / SERVICE	0.000000			76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0.000000			76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	8.211128			90.00
91.00	09100	EMERGENCY	1.568658			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.271221			92.00
93.00	04040	FAMILY PRACTICE	0.000000			93.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION				109.00
110.00	11000	INTESTINAL ACQUISITION				110.00
111.00	11100	ISLET ACQUISITION				111.00
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: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/27/2020 11:59 am

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,652,004		3,652,004	0	3,652,004	30.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	24,455		24,455	0	24,455	44.00
46.00	04600	OTHER LONG TERM CARE	2,814,446		2,814,446	0	2,814,446	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,899,199		1,899,199	0	1,899,199	50.00
53.00	05300	ANESTHESIOLOGY	320,003		320,003	0	320,003	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,755,054		1,755,054	0	1,755,054	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	1,166,353		1,166,353	0	1,166,353	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	59,280		59,280	0	59,280	64.00
65.00	06500	RESPIRATORY THERAPY	56,318	0	56,318	0	56,318	65.00
66.00	06600	PHYSICAL THERAPY	2,313,480	0	2,313,480	0	2,313,480	66.00
66.01	06601	CARDIAC REHAB	216,945	0	216,945	0	216,945	66.01
67.00	06700	OCCUPATIONAL THERAPY	199,157	0	199,157	0	199,157	67.00
68.00	06800	SPEECH PATHOLOGY	70,297	0	70,297	0	70,297	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	148,479		148,479	0	148,479	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	536,989		536,989	0	536,989	73.00
76.00	03020	SLEEP LAB	106,779		106,779	0	106,779	76.00
76.01	03950	PAIN CLINIC / SERVICE	0		0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	7,252		7,252	0	7,252	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,635,945		2,635,945	0	2,635,945	88.00
88.01	08801	RURAL HEALTH CLINIC II	667,501		667,501	0	667,501	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	158,795		158,795	0	158,795	90.00
91.00	09100	EMERGENCY	3,024,624		3,024,624	0	3,024,624	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	136,552		136,552	0	136,552	92.00
93.00	04040	FAMILY PRACTICE	0		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0		0		0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0		0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	11100	ISLET ACQUISITION	0		0		0	111.00
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	21,969,907	0	21,969,907	0	21,969,907	200.00
201.00		Less Observation Beds	136,552		136,552		136,552	201.00
202.00		Total (see instructions)	21,833,355	0	21,833,355	0	21,833,355	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/27/2020 11:59 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	2,635,286		2,635,286		30.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
46.00	04600	OTHER LONG TERM CARE	4,145,002		4,145,002		46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	643,788	2,090,258	2,734,046	0.694648	50.00
53.00	05300	ANESTHESIOLOGY	19,703	534,930	554,633	0.576964	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	139,134	5,155,541	5,294,675	0.331475	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	160,278	2,460,570	2,620,848	0.445029	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	28,427	613,304	641,731	0.092375	64.00
65.00	06500	RESPIRATORY THERAPY	223,052	21,154	244,206	0.230617	65.00
66.00	06600	PHYSICAL THERAPY	621,334	2,452,206	3,073,540	0.752709	66.00
66.01	06601	CARDIAC REHAB	0	224,857	224,857	0.964813	66.01
67.00	06700	OCCUPATIONAL THERAPY	263,386	86,172	349,558	0.569739	67.00
68.00	06800	SPEECH PATHOLOGY	49,486	68,308	117,794	0.596779	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	441,041	346,481	787,522	0.188539	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	655,830	793,002	1,448,832	0.370636	73.00
76.00	03020	SLEEP LAB	0	19,442	19,442	5.492182	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0.000000	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0.000000	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,894,305	1,894,305	1.391510	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	581,231	581,231	1.148426	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
90.00	09000	CLINIC	310	19,029	19,339	8.211128	90.00
91.00	09100	EMERGENCY	9,697	1,918,463	1,928,160	1.568658	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	107,418	107,418	1.271221	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	10,035,754	19,386,671	29,422,425		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	10,035,754	19,386,671	29,422,425		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/27/2020 11:59 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
41.00	04100	SUBPROVIDER - IRF				41.00
42.00	04200	SUBPROVIDER				42.00
44.00	04400	SKILLED NURSING FACILITY				44.00
46.00	04600	OTHER LONG TERM CARE				46.00
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
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
60.01	06001	BLOOD LABORATORY	0.000000			60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
66.01	06601	CARDIAC REHAB	0.000000			66.01
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03020	SLEEP LAB	0.000000			76.00
76.01	03950	PAIN CLINIC / SERVICE	0.000000			76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0.000000			76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000			88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
93.00	04040	FAMILY PRACTICE	0.000000			93.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION				109.00
110.00	11000	INTESTINAL ACQUISITION				110.00
111.00	11100	ISLET ACQUISITION				111.00
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: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part II
Date/Time Prepared:
2/27/2020 11:59 am

				Title XVIII		Hospital	Cost	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	642,385	2,734,046	0.234958	321,018	75,426	50.00
53.00	05300	ANESTHESIOLOGY	23,303	554,633	0.042015	9,851	414	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	530,770	5,294,675	0.100246	53,121	5,325	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	143,469	2,620,848	0.054741	75,267	4,120	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	5,133	641,731	0.007999	23,000	184	64.00
65.00	06500	RESPIRATORY THERAPY	16,762	244,206	0.068639	44,315	3,042	65.00
66.00	06600	PHYSICAL THERAPY	393,077	3,073,540	0.127891	49,323	6,308	66.00
66.01	06601	CARDIAC REHAB	31,664	224,857	0.140818	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	31,244	349,558	0.089381	13,663	1,221	67.00
68.00	06800	SPEECH PATHOLOGY	2,072	117,794	0.017590	2,222	39	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,645	787,522	0.008438	241,018	2,034	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,168	1,448,832	0.052572	109,803	5,773	73.00
76.00	03020	SLEEP LAB	31,497	19,442	1.620049	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0.000000	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	165	0	0.000000	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	497,267	1,894,305	0.262506	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	46,764	581,231	0.080457	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	59,993	19,339	3.102177	307	952	90.00
91.00	09100	EMERGENCY	492,502	1,928,160	0.255426	5,308	1,356	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	39,792	107,418	0.370441	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0.000000	0	0	93.00
200.00		Total (lines 50 through 199)	3,070,672	22,642,137		948,216	106,194	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/27/2020 11:59 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	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
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
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/27/2020 11:59 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	2,734,046	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	554,633	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,294,675	0.000000		54.00
57.00	05700	CT SCAN	0	0	0	0	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000		59.00
60.00	06000	LABORATORY	0	0	0	2,620,848	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000		60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	641,731	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	244,206	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,073,540	0.000000		66.00
66.01	06601	CARDIAC REHAB	0	0	0	224,857	0.000000		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	349,558	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	117,794	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	787,522	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,448,832	0.000000		73.00
76.00	03020	SLEEP LAB	0	0	0	19,442	0.000000		76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0.000000		76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0.000000		76.02
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,894,305	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	581,231	0.000000		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000		89.00
90.00	09000	CLINIC	0	0	0	19,339	0.000000		90.00
91.00	09100	EMERGENCY	0	0	0	1,928,160	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	107,418	0.000000		92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0.000000		93.00
200.00		Total (lines 50 through 199)	0	0	0	22,642,137			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/27/2020 11:59 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	321,018	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	0.000000	9,851	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	53,121	0	0	0 54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0 59.00
60.00	06000	LABORATORY	0.000000	75,267	0	0	0 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0 60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000	23,000	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	44,315	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	49,323	0	0	0 66.00
66.01	06601	CARDIAC REHAB	0.000000	0	0	0	0 66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	13,663	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	2,222	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	241,018	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	109,803	0	0	0 73.00
76.00	03020	SLEEP LAB	0.000000	0	0	0	0 76.00
76.01	03950	PAIN CLINIC / SERVICE	0.000000	0	0	0	0 76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0.000000	0	0	0	0 76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0 88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0 88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0 89.00
90.00	09000	CLINIC	0.000000	307	0	0	0 90.00
91.00	09100	EMERGENCY	0.000000	5,308	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0 92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	0	0	0 93.00
200.00		Total (lines 50 through 199)		948,216	0	0	0 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part V
Date/Time Prepared:
2/27/2020 11:59 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	0.694648	0	876,496	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.576964	0	178,438	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.331475	0	1,685,396	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.445029	0	869,822	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.092375	0	39,800	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.230617	0	6,812	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.752709	0	1,063,700	0	0	66.00
66.01	06601	CARDIAC REHAB	0.964813	0	145,480	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.569739	0	47,090	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.596779	0	36,329	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.188539	0	207,141	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.370636	0	347,927	3,602	0	73.00
76.00	03020	SLEEP LAB	5.492182	0	6,081	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0.000000	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0.000000	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	8.211128	0	9,871	0	0	90.00
91.00	09100	EMERGENCY	1.568658	0	1,021,485	2,527	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.271221	0	62,736	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	0	0	0	93.00
200.00		Subtotal (see instructions)		0	6,604,604	6,129	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	6,604,604	6,129	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part V
Date/Time Prepared:
2/27/2020 11:59 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	608,856	0		50.00
53.00	05300	ANESTHESIOLOGY	102,952	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	558,667	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	387,096	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
64.00	06400	INTRAVENOUS THERAPY	3,677	0		64.00
65.00	06500	RESPIRATORY THERAPY	1,571	0		65.00
66.00	06600	PHYSICAL THERAPY	800,657	0		66.00
66.01	06601	CARDIAC REHAB	140,361	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	26,829	0		67.00
68.00	06800	SPEECH PATHOLOGY	21,680	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	39,054	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	128,954	1,335		73.00
76.00	03020	SLEEP LAB	33,398	0		76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0		76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0		76.02
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	81,052	0		90.00
91.00	09100	EMERGENCY	1,602,361	3,964		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	79,751	0		92.00
93.00	04040	FAMILY PRACTICE	0	0		93.00
200.00		Subtotal (see instructions)	4,616,916	5,299		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	4,616,916	5,299		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1302

Period:

Worksheet D

Component CCN:14-Z302

From 10/01/2018
To 09/30/2019Part V
Date/Time Prepared:
2/27/2020 11:59 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	0.694648	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.576964	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.331475	0	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.445029	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.092375	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.230617	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.752709	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0.964813	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.569739	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.596779	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.188539	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.370636	0	0	0	0	73.00
76.00	03020	SLEEP LAB	5.492182	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0.000000	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0.000000	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	8.211128	0	0	0	0	90.00
91.00	09100	EMERGENCY	1.568658	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.271221	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000		0	0	0	93.00
200.00		Subtotal (see instructions)		0	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	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1302

Period:

Worksheet D

Component CCN:14-Z302

From 10/01/2018
To 09/30/2019Part V
Date/Time Prepared:
2/27/2020 11:59 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
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
66.01	06601	CARDIAC REHAB	0	0		66.01
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	SLEEP LAB	0	0		76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0		76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0		76.02
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	FAMILY PRACTICE	0	0		93.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN:14-1302 Component CCN:14-6140		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 11:59 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	0	93.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1302 Component CCN: 14-6140		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 11:59 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	2,734,046	0.000000	50.00
53.00	05300	ANESTHESIOLOGY		0	0	0	554,633	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	5,294,675	0.000000	54.00
57.00	05700	CT SCAN		0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	2,620,848	0.000000	60.00
60.01	06001	BLOOD LABORATORY		0	0	0	0	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY		0	0	0	641,731	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	244,206	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	3,073,540	0.000000	66.00
66.01	06601	CARDIAC REHAB		0	0	0	224,857	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	349,558	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	117,794	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	787,522	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	1,448,832	0.000000	73.00
76.00	03020	SLEEP LAB		0	0	0	19,442	0.000000	76.00
76.01	03950	PAIN CLINIC / SERVICE		0	0	0	0	0.000000	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY		0	0	0	0	0.000000	76.02
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	1,894,305	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II		0	0	0	581,231	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	0	0.000000	89.00
90.00	09000	CLINIC		0	0	0	19,339	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	1,928,160	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	107,418	0.000000	92.00
93.00	04040	FAMILY PRACTICE		0	0	0	0	0.000000	93.00
200.00		Total (lines 50 through 199)		0	0	0	22,642,137		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN:14-1302 Component CCN:14-6140		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/27/2020 11:59 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	0	0	0	0	54.00
57.00	05700	CT SCAN		0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY		0.000000	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY		0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB		0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY		0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	0	0	0	0	73.00
76.00	03020	SLEEP LAB		0.000000	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE		0.000000	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY		0.000000	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II		0.000000	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		0.000000	0	0	0	0	89.00
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
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
93.00	04040	FAMILY PRACTICE		0.000000	0	0	0	0	93.00
200.00		Total (lines 50 through 199)			0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1302	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/27/2020 11:59 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)		2,498	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		556	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		469	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		378	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)		1,376	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		59	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)		129	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		311	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)		378	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)		1,039	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			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		140.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		140.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,652,004	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)		8,260	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)		18,060	25.00
26.00	Total swing-bed cost (see instructions)		2,779,328	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		872,676	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		872,676	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,569.56	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		488,133	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		488,133	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019

Worksheet D-1

Date/Time Prepared:
2/27/2020 11:59 am

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						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)					435,349	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					923,482	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)					593,294	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					1,630,773	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					2,224,067	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)					87	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,569.56	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					136,552	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1302		Period: From 10/01/2018 To 09/30/2019		Worksheet D-1 Date/Time Prepared: 2/27/2020 11:59 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	1,064,226	3,652,004	0.291409	136,552	39,792	90.00
91.00	Nursing School cost	0	3,652,004	0.000000	136,552	0	91.00
92.00	Allied health cost	0	3,652,004	0.000000	136,552	0	92.00
93.00	All other Medical Education	0	3,652,004	0.000000	136,552	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1302 Component CCN: 14-6140	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/27/2020 11:59 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		0	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		0	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		0	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			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		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		24,455	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		24,455	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		24,455	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)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-1302 Component CCN: 14-6140	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/27/2020 11:59 am
				Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT						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)						48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						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)						50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges						54.00
55.00 Target amount per discharge						55.00
56.00 Target amount (line 54 x line 55)						56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00 Bonus payment (see instructions)						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						59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						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)						61.00
62.00 Relief payment (see instructions)						62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						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)						64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						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)						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)						68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						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)					24,455	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					0.00	71.00
72.00 Program routine service cost (line 9 x line 71)					0	72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					0	74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00 Program capital-related costs (line 9 x line 76)					0	77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00 Inpatient routine service cost per diem limitation					0.00	81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00 Reasonable inpatient routine service costs (see instructions)					0	83.00
84.00 Program inpatient ancillary services (see instructions)					0	84.00
85.00 Utilization review - physician compensation (see instructions)					0	85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					0	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-1302 Component CCN: 14-6140		Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/27/2020 11:59 am	
			Title XVIII		Skilled Nursing Facility	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1302	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/27/2020 11:59 am	
Cost Center Description			Title XVIII	Hospital	Cost	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		393,206		30.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.694648	321,018	222,995	50.00
53.00	05300	ANESTHESIOLOGY	0.576964	9,851	5,684	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.331475	53,121	17,608	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.445029	75,267	33,496	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.092375	23,000	2,125	64.00
65.00	06500	RESPIRATORY THERAPY	0.230617	44,315	10,220	65.00
66.00	06600	PHYSICAL THERAPY	0.752709	49,323	37,126	66.00
66.01	06601	CARDIAC REHAB	0.964813	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.569739	13,663	7,784	67.00
68.00	06800	SPEECH PATHOLOGY	0.596779	2,222	1,326	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.188539	241,018	45,441	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.370636	109,803	40,697	73.00
76.00	03020	SLEEP LAB	5.492182	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0.000000	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0.000000	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	8.211128	307	2,521	90.00
91.00	09100	EMERGENCY	1.568658	5,308	8,326	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.271221	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		948,216	435,349	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)		948,216		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1302	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3
			Component CCN: 14-Z302		Date/Time Prepared: 2/27/2020 11:59 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
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.694648	0	50.00
53.00	05300	ANESTHESIOLOGY	0.576964	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.331475	33,248	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.445029	84,330	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.092375	4,850	64.00
65.00	06500	RESPIRATORY THERAPY	0.230617	44,341	65.00
66.00	06600	PHYSICAL THERAPY	0.752709	406,816	66.00
66.01	06601	CARDIAC REHAB	0.964813	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.569739	176,659	67.00
68.00	06800	SPEECH PATHOLOGY	0.596779	40,858	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.188539	17,438	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.370636	288,205	73.00
76.00	03020	SLEEP LAB	5.492182	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0.000000	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0.000000	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	8.211128	0	90.00
91.00	09100	EMERGENCY	1.568658	4,147	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.271221	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,100,892	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		1,100,892	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1302 Component CCN: 14-6140	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/27/2020 11:59 am	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.694648	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.576964	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.331475	0	0	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.445029	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0.092375	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.230617	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.752709	0	0	66.00
66.01	06601 CARDIAC REHAB	0.964813	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.569739	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.596779	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.188539	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.370636	0	0	73.00
76.00	03020 SLEEP LAB	5.492182	0	0	76.00
76.01	03950 PAIN CLINIC / SERVICE	0.000000	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0.000000	0	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLINIC	8.211128	0	0	90.00
91.00	09100 EMERGENCY	1.568658	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.271221	0	0	92.00
93.00	04040 FAMILY PRACTICE	0.000000	0	0	93.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1302	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part B Date/Time Prepared: 2/27/2020 11:59 am
		Title XVIII	Hospital	Cost
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		4,622,215	1.00
2.00	Medical and other services reimbursed under OPPI (see instructions)		0	2.00
3.00	OPPI 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)		4,622,215	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)		4,668,437	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)		21,999	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,121,567	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)		3,524,871	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		3,524,871	30.00
31.00	Primary payer payments		598	31.00
32.00	Subtotal (line 30 minus line 31)		3,524,273	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)		26,775	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		17,404	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		7,183	36.00
37.00	Subtotal (see instructions)		3,541,677	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)		3,541,677	40.00
40.01	Sequestration adjustment (see instructions)		70,834	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		3,413,848	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		56,995	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1302 Component CCN: 14-6140	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part B Date/Time Prepared: 2/27/2020 11:59 am
		Title XVIII	Skilled Nursing Facility	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
4.01	Outlier reconciliation amount (see instructions)			4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			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)			18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			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)		0	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)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	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)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		0	37.00
38.00	MSP-LCC reconciliation amount from PS&R			38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		0	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		0	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		0	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)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet E-1
Part I
Date/Time Prepared:
2/27/2020 11:59 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		695,465		3,413,848	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	05/02/2019	46,798		0	3.01
3.02		09/12/2019	31,755		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)		78,553		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)		774,018		3,413,848	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		48,102		56,995	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		822,120		3,470,843	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: 14-1302

Period:

Worksheet E-1

Component CCN: 14-Z302

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/27/2020 11:59 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		3,137,807		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	05/02/2019	165,811		0	3.50
3.51		09/12/2019	89,629		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)		-255,440		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,882,367		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		144,951		0	6.02
7.00	Total Medicare program liability (see instructions)		2,737,416		0	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: 14-1302 Component CCN: 14-6140		Period: From 10/01/2018 To 09/30/2019		Worksheet E-1 Part I Date/Time Prepared: 2/27/2020 11:59 am	
		Title XVIII		Skilled Nursing Facility		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		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)		0		0	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		0		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: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet E-1
Part II
Date/Time Prepared:
2/27/2020 11:59 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:14-1302

Period:

Worksheet E-2

Component CCN:14-Z302

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 11:59 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)		2,246,308	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)		613,154	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		1,417	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)		2,859,462	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		2,859,462	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)		2,859,462	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		66,180	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)		2,793,282	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)		2,793,282	0	19.00
19.01	Sequestration adjustment (see instructions)		55,866	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
20.00	Interim payments		2,882,367	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)		-144,951	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: 14-1302	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part V Date/Time Prepared: 2/27/2020 11:59 am
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		923,482	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)		923,482	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		932,717	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)		932,717	19.00
20.00	Deductibles (exclude professional component)		101,724	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		830,993	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		830,993	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		12,162	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		7,905	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		4,807	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		838,898	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)		838,898	30.00
30.01	Sequestration adjustment (see instructions)		16,778	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		774,018	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)		48,102	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-1302 Component CCN:14-6140	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part VI Date/Time Prepared: 2/27/2020 11:59 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		0	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		0	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		0	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		0	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Demonstration payment adjustment amount before sequestration		0	14.99
15.00	Subtotal (see instructions)		0	15.00
15.01	Sequestration adjustment (see instructions)		0	15.01
15.02	Demonstration payment adjustment amount after sequestration		0	15.02
16.00	Interim payments		0	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)		0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

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

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019

Worksheet G

Date/Time Prepared:
2/27/2020 11:59 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	2,401,326	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,558,200	0	0	0	4.00
5.00	Other receivable	14,347	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,672,889	0	0	0	6.00
7.00	Inventory	378,343	0	0	0	7.00
8.00	Prepaid expenses	141,854	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)	7,821,181	0	0	0	11.00
FIXED ASSETS						
12.00	Land	448,597	0	0	0	12.00
13.00	Land improvements	3,933,618	0	0	0	13.00
14.00	Accumulated depreciation	-2,533,425	0	0	0	14.00
15.00	Buildings	38,703,856	0	0	0	15.00
16.00	Accumulated depreciation	-20,232,423	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	8,993,752	0	0	0	23.00
24.00	Accumulated depreciation	-7,006,846	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	2,639,630	0	0	0	27.00
28.00	Accumulated depreciation	-2,032,428	0	0	0	28.00
29.00	Minor equipment-nondepreciable	142,453	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	23,056,784	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	2,563,978	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	1,551,506	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,115,484	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	34,993,449	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	874,108	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,320,782	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	599,987	0	0	0	40.00
41.00	Deferred income	309,159	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	270,000	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,374,036	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	35,869,845	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	35,869,845	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	39,243,881	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-4,250,432	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-4,250,432	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	34,993,449	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019

Worksheet G-1

Date/Time Prepared:
2/27/2020 11:59 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		-4,856,593		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		626,316				2.00
3.00	Total (sum of line 1 and line 2)		-4,230,277		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)		-4,230,277		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	CHANGE IN NET DEFICIT	20,155		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)		20,155		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-4,250,432		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	CHANGE IN NET DEFICIT		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: 14-1302

Period:
From 10/01/2018
To 09/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
2/27/2020 11:59 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,635,286		2,635,286	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	4,145,002		4,145,002	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	6,780,288		6,780,288	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				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)	6,780,288		6,780,288	17.00
18.00	Ancillary services	3,255,466		3,255,466	18.00
19.00	Outpatient services	0	16,911,135	16,911,135	19.00
20.00	RURAL HEALTH CLINIC	0	1,894,305	1,894,305	20.00
20.01	RURAL HEALTH CLINIC II	0	581,231	581,231	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	0	3,597,219	3,597,219	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	10,035,754	22,983,890	33,019,644	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		25,115,121		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	PROVISION FOR BAD DEBTS	738,124			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)		738,124		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		25,853,245		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1302

Period:
From 10/01/2018
To 09/30/2019

Worksheet G-3

Date/Time Prepared:
2/27/2020 11:59 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	33,019,644	1.00
2.00	Less contractual allowances and discounts on patients' accounts	9,356,140	2.00
3.00	Net patient revenues (line 1 minus line 2)	23,663,504	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	25,853,245	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,189,741	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	105,301	6.00
7.00	Income from investments	114,709	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	243,624	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	230,103	17.00
18.00	Revenue from sale of medical records and abstracts	4,489	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	22,885	22.00
23.00	Governmental appropriations	0	23.00
24.00	AQUATICS REVENUE	28,251	24.00
24.01	ASSISTED LIVING UNITS	757,528	24.01
24.02	ADULT DAY CARE PROGRAM	160,477	24.02
24.03	FITNESS CENTER REVENUE	135,859	24.03
24.04	GRANT REVENUE	324,605	24.04
24.05	MISCELLANEOUS REVENUE	18,927	24.05
24.06	GAIN ON FORGIVENESS OF DEBT	672,886	24.06
25.00	Total other income (sum of lines 6-24)	2,819,644	25.00
26.00	Total (line 5 plus line 25)	629,903	26.00
27.00	LOSS ON SALE OF EQUIPMENT	3,587	27.00
27.01	OTHER EXPENSES (SPECIFY)	0	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	3,587	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	626,316	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1302

Period:

Worksheet M-1

Component CCN: 14-8511

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 11:59 am

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	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	925,537	0	925,537	-59,056	866,481
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	82,788	0	82,788	3,142	85,930
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	267,750	0	267,750	0	267,750
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	25,052	25,052	-24,973	79
10.00	Subtotal (sum of lines 1 through 9)	1,276,075	25,052	1,301,127	-80,887	1,220,240
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	33,385	33,385	0	33,385
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	33,385	33,385	0	33,385
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,276,075	58,437	1,334,512	-80,887	1,253,625
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	1,443	1,443
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	1,443	1,443
FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	807	807
30.00	Administrative Costs	151,323	146,179	297,502	0	297,502
31.00	Total Facility Overhead (sum of lines 29 and 30)	151,323	146,179	297,502	807	298,309
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,427,398	204,616	1,632,014	-78,637	1,553,377

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1302

Period:

Worksheet M-1

Component CCN: 14-8511

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 11:59 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	-23,255	843,226	1.00
2.00 Physician Assistant	0	0	2.00
3.00 Nurse Practitioner	0	85,930	3.00
4.00 Visiting Nurse	0	0	4.00
5.00 Other Nurse	0	267,750	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	79	9.00
10.00 Subtotal (sum of lines 1 through 9)	-23,255	1,196,985	10.00
11.00 Physician Services Under Agreement	0	0	11.00
12.00 Physician Supervision Under Agreement	0	0	12.00
13.00 Other Costs Under Agreement	0	0	13.00
14.00 Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00 Medical Supplies	0	33,385	15.00
16.00 Transportation (Health Care Staff)	0	0	16.00
17.00 Depreciation-Medical Equipment	0	0	17.00
18.00 Professional Liability Insurance	0	0	18.00
19.00 Other Health Care Costs	0	0	19.00
20.00 Allowable GME Costs	0	0	20.00
21.00 Subtotal (sum of lines 15 through 20)	0	33,385	21.00
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-23,255	1,230,370	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	1,443	25.02
26.00 All other nonreimbursable costs	0	0	26.00
27.00 Nonallowable GME costs	0	0	27.00
28.00 Total Nonreimbursable Costs (sum of lines 23 through 27)	0	1,443	28.00
FACILITY OVERHEAD			
29.00 Facility Costs	-10	797	29.00
30.00 Administrative Costs	0	297,502	30.00
31.00 Total Facility Overhead (sum of lines 29 and 30)	-10	298,299	31.00
32.00 Total facility costs (sum of lines 22, 28 and 31)	-23,265	1,530,112	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1302

Period:

Worksheet M-1

Component CCN: 14-8557

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 11:59 am

		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	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	285,173	0	285,173	-60,672	224,501
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	19,799	0	19,799	0	19,799
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	114,556	0	114,556	0	114,556
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	16,227	16,227	4,874	21,101
10.00	Subtotal (sum of lines 1 through 9)	419,528	16,227	435,755	-55,798	379,957
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	4,828	4,828	0	4,828
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	4,828	4,828	0	4,828
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	419,528	21,055	440,583	-55,798	384,785
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	5,124	5,124	25,118	30,242
30.00	Administrative Costs	33,593	23,010	56,603	0	56,603
31.00	Total Facility Overhead (sum of lines 29 and 30)	33,593	28,134	61,727	25,118	86,845
32.00	Total facility costs (sum of lines 22, 28 and 31)	453,121	49,189	502,310	-30,680	471,630

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1302

Period:

Worksheet M-1

Component CCN: 14-8557

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 11:59 am

RHC II

Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00 Physician	0	224,501	1.00
2.00 Physician Assistant	0	0	2.00
3.00 Nurse Practitioner	0	19,799	3.00
4.00 Visiting Nurse	0	0	4.00
5.00 Other Nurse	0	114,556	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	21,101	9.00
10.00 Subtotal (sum of lines 1 through 9)	0	379,957	10.00
11.00 Physician Services Under Agreement	0	0	11.00
12.00 Physician Supervision Under Agreement	0	0	12.00
13.00 Other Costs Under Agreement	0	0	13.00
14.00 Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00 Medical Supplies	0	4,828	15.00
16.00 Transportation (Health Care Staff)	0	0	16.00
17.00 Depreciation-Medical Equipment	0	0	17.00
18.00 Professional Liability Insurance	0	0	18.00
19.00 Other Health Care Costs	0	0	19.00
20.00 Allowable GME Costs	0	0	20.00
21.00 Subtotal (sum of lines 15 through 20)	0	4,828	21.00
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	384,785	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	30,242	29.00
30.00 Administrative Costs	0	56,603	30.00
31.00 Total Facility Overhead (sum of lines 29 and 30)	0	86,845	31.00
32.00 Total facility costs (sum of lines 22, 28 and 31)	0	471,630	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1302

Period:

Worksheet M-2

Component CCN: 14-8511

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 11:59 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	2.34	8,321	4,200	9,828	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.59	1,015	2,100	1,239	3.00
4.00	Subtotal (sum of lines 1 through 3)	2.93	9,336		11,067	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.93	9,336		11,067	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				1,230,370	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				1,443	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				1,231,813	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.998829	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				298,299	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,105,833	15.00
16.00	Total overhead (sum of lines 14 and 15)				1,404,132	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				1,404,132	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				1,402,488	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				2,632,858	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1302

Period:

Worksheet M-2

Component CCN: 14-8557

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/27/2020 11:59 am

				RHC II		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.65	2,576	4,200	2,730		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.20	328	2,100	420		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.85	2,904		3,150	3,150	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.85	2,904			3,150	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					384,785	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)					384,785	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)					86,845	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					195,871	15.00
16.00	Total overhead (sum of lines 14 and 15)					282,716	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					282,716	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					282,716	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					667,501	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1302 Component CCN: 14-8511	Period: From 10/01/2018 To 09/30/2019	Worksheet M-3 Date/Time Prepared: 2/27/2020 11:59 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)			2,632,858	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			73,873	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,558,985	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			11,067	4.00	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00	
6.00	Total adjusted visits (line 4 plus line 5)			11,067	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			231.23	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			83.45	83.45	8.00
9.00	Rate for Program covered visits (see instructions)			231.23	231.23	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			2,313	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			534,835	0	11.00
12.00	Program covered visits for mental health services (from contractor records)			0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)			0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)			0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)					15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *			0	534,835	16.00
16.01	Total program charges (see instructions)(from contractor's records)				453,294	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				12,017	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				14,178	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.)				377,866	16.04
16.05	Total program cost (see instructions)			0	392,044	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				48,324	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				78,591	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				392,044	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				25,054	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				417,098	22.00
23.00	Allowable bad debts (see instructions)				0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				0	24.00
25.00	SEQUESTRATION				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)				417,098	26.00
26.01	Sequestration adjustment (see instructions)				8,342	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				447,127	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)				-38,371	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: 14-1302 Component CCN: 14-8557	Period: From 10/01/2018 To 09/30/2019	Worksheet M-3 Date/Time Prepared: 2/27/2020 11:59 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)			667,501	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			12,410	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			655,091	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,150	4.00	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00	
6.00	Total adjusted visits (line 4 plus line 5)			3,150	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			207.97	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)			83.45	83.45	8.00
9.00	Rate for Program covered visits (see instructions)			207.97	207.97	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			618	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			128,525	0	11.00
12.00	Program covered visits for mental health services (from contractor records)			0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)			0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)			0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)					15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *			0	128,525	16.00
16.01	Total program charges (see instructions)(from contractor's records)				112,825	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				2,458	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				2,800	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.)				91,837	16.04
16.05	Total program cost (see instructions)			0	94,637	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				10,929	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				19,887	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				94,637	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				2,791	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				97,428	22.00
23.00	Allowable bad debts (see instructions)				0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)				0	25.50
25.99	Demonstration payment adjustment amount before sequestration				0	25.99
26.00	Net reimbursable amount (see instructions)				97,428	26.00
26.01	Sequestration adjustment (see instructions)				1,949	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				83,865	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)				11,614	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: 14-1302 Component CCN: 14-8511	Period: From 10/01/2018 To 09/30/2019	Worksheet M-4 Date/Time Prepared: 2/27/2020 11:59 am	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1,196,985	1,196,985	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000496	0.000866	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		594	1,037	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		21,424	11,467	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		22,018	12,504	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,230,370	1,230,370	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,402,488	1,402,488	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.017895	0.010163	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		25,098	14,253	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		47,116	26,757	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		173	302	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		272.35	88.60	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		51	126	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		13,890	11,164	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)			73,873	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)			25,054	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN:14-1302 Component CCN:14-8557	Period: From 10/01/2018 To 09/30/2019	Worksheet M-4 Date/Time Prepared: 2/27/2020 11:59 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)		379,957	379,957	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000315	0.000391	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		120	149	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		5,074	1,811	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		5,194	1,960	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		384,785	384,785	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		282,716	282,716	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.013498	0.005094	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		3,816	1,440	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		9,010	3,400	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		37	46	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		243.51	73.91	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		6	18	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		1,461	1,330	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)			12,410	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			2,791	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1302 Component CCN: 14-8511	Period: From 10/01/2018 To 09/30/2019	Worksheet M-5 Date/Time Prepared: 2/27/2020 11:59 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		436,066	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		05/02/2019	7,300	3.01	
3.02		09/12/2019	3,761	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)		11,061	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		447,127	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		0	6.01	
6.02	SETTLEMENT TO PROGRAM		38,371	6.02	
7.00	Total Medicare program liability (see instructions)		408,756	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:14-1302 Component CCN:14-8557	Period: From 10/01/2018 To 09/30/2019	Worksheet M-5 Date/Time Prepared: 2/27/2020 11:59 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		83,865	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			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)		83,865		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		11,614		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		95,479		7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00