

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

OMB NO. 0938-0050

EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND PROVIDER CCN:14-1313	Period: From 10/01/2018 To 09/30/2019	Worksheet S Parts I-III Date/Time Prepared: 2/19/2020 6:01 pm
SETTLEMENT SUMMARY		

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 2/19/2020	Time: 6:01 pm
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☐ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.
	(3) Settled with Audit	9. ☐ Final Report for this Provider CCN	
	(4) Reopened		
	(5) Amended		

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MASON DISTRICT HOSPITAL (14-1313) for the cost reporting period beginning 10/01/2018 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) DOUGLAS KOSIER

Officer or Administrator of Provider(s)

CEO

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
	1.00	2.00	3.00	4.00	5.00		
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-96,257	-177,147	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0				0	3.00
5.00	Swing bed - SNF	0	-103,781	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	HAVANA MEDICAL ASSOCIATES RHC I	0		28,156		0	10.00
10.01	MASON CITY MEDICAL ASSOCIATES II	0		1,453		0	10.01
10.02	MANITO MEDICAL CLINIC RHC III	0		25,357		0	10.02
200.00	Total	0	-200,038	-122,181	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 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 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.

Health Financial Systems		MASON DISTRICT HOSPITAL		In Lieu of Form CMS-2552-10						
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN:14-1313		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/19/2020 6:01 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street:615 NORTH PROMENADE STREET		PO Box:				1.00			
2.00	City: HAVANA		State: IL		Zip Code:62644-0530		County: MASON 2.00			
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		MASON DISTRICT HOSPITAL	141313	99914	1	07/01/2001	N	O	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		MASON DISTRICT HOSPITAL	142313	99914		07/01/2001	N	O	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA		MASON DISTRICT HHA	147202	99914		01/09/1982	N	P	N
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		HAVANA MEDICAL ASSOCIATES RHC	143457	99914		02/01/2001	O	O	O
15.01	Hospital-Based Health Clinic - RHC		MASON CITY MEDICAL ASSOCIATES	143462	99914		03/03/2003	O	O	O
15.02	Hospital-Based Health Clinic - RHC		MANITO MEDICAL ASSOCIATES	148592	99914		04/19/2018	O	O	O
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					10/01/2018	09/30/2019		20.00	
21.00	Type of Control (see instructions)					11			21.00	
						1.00	2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		23.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part I
Date/Time Prepared:
2/19/2020 6:01 pm

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid days	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 Status	Date of Geographic Reclassification	
					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)					with	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					submit	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					or "N"		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part I
Date/Time Prepared:
2/19/2020 6:01 pm

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N			60.00
		Y/N	IME	Direct GME	
		1.00	2.00	3.00	4.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count
		1.00	2.00	3.00	4.00
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00
61.20	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
					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
62.01	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
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" N for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)				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

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From 10/01/2018
To 09/30/2019Worksheet S-2
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
					1.00	2.00	3.00
<u>Inpatient Psychiatric Facility PPS</u>							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00	
<u>Inpatient Rehabilitation Facility PPS</u>							
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	
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	

Health Financial Systems		MASON DISTRICT HOSPITAL		In Lieu of Form CMS-2552-10	
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			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N	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.			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	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	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	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			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	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			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.			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.			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.			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	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	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.			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.			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
			Physical	Occupational	
			1.00	2.00	
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	109.00
			N	N	
			N	N	
			N	N	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:14-1313	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part I Date/Time Prepared: 2/19/2020 6:01 pm	
			1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00		
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N	111.00		
			1.00	2.00	3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	1 N	115.00		
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N	116.00		
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y	117.00		
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1	118.00		
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	91,415	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	120.00		
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N	121.00		
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N	122.00		
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N	125.00		
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.		126.00		
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.		127.00		
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.		128.00		
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.		129.00		
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.		130.00		
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.		131.00		
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.		132.00		
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.		133.00		
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.		134.00		
All Providers					
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		

Health Financial Systems		MASON DISTRICT HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:14-1313		Period: From 10/01/2018 To 09/30/2019	
				Worksheet S-2 Part I Date/Time Prepared: 2/19/2020 6:01 pm	
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name:	Contractor's Name:		Contractor's Number:	
142.00	Street:	PO Box:			
143.00	City:	State:		Zip Code:	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?				Y
				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.				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
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
				1.00	
165.00	Multicampus 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
		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.				N
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)				0
168.01	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
				Beginning	Ending
				1.00	2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				170.00
				1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)				0

Health Financial Systems		MASON DISTRICT HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN:14-1313	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part II Date/Time Prepared: 2/19/2020 6:01 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		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 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 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.				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
			1.00	2.00	3.00
					4.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	01/06/2020	Y	01/06/2020
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

Health Financial Systems		MASON DISTRICT HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN:14-1313		Period: From 10/01/2018 To 09/30/2019	
		Worksheet S-2 Part II Date/Time Prepared: 2/19/2020 6:01 pm			
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N	N		20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N			22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N			23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N			24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N			25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N			26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N			27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N			30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N			31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N			32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N			33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y			34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y			35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?	N			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N			37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N			40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAVID	MCCLUNG		41.00
42.00	Enter the employer/company name of the cost report preparer	RSM US LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	6414942144	DAVID.MCCLUNG@RSMUS.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part II
Date/Time Prepared:
2/19/2020 6:01 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/19/2020 6:01 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	10,443.45	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	10,443.45	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	10,443.45	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 HAVANA MEDICAL ASSOCIATES RHC	88.00				0	26.00
26.01 MASON CITY MEDICAL ASSOCIATES	88.01				0	26.01
26.02 MANITO MEDICAL CLINIC RHC	88.02				0	26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/19/2020 6:01 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	312	2	454			1.00
2.00 HMO and other (see instructions)	86	13				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	552	0	583			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	144			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	864	2	1,181			7.00
8.00 INTENSIVE CARE UNIT	0	0	0			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	864	2	1,181	0.00	172.61	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	5,954	0	8,196	0.00	11.16	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)			0			24.10
25.00 CMHC - CMHC						25.00
26.00 HAVANA MEDICAL ASSOCIATES RHC	5,230	4,399	16,522	0.00	43.01	26.00
26.01 MASON CITY MEDICAL ASSOCIATES	253	711	1,818	0.00	4.24	26.01
26.02 MANITO MEDICAL CLINIC RHC	278	1,684	3,522	0.00	3.22	26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	234.24	27.00
28.00 Observation Bed Days		0	131			28.00
29.00 Ambulance Trips	615					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:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/19/2020 6:01 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	101	2	140	1.00
2.00 HMO and other (see instructions)			19	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	101	2	140	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 HAVANA MEDICAL ASSOCIATES RHC	0.00					26.00
26.01 MASON CITY MEDICAL ASSOCIATES	0.00					26.01
26.02 MANITO MEDICAL CLINIC RHC	0.00					26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

Health Financial Systems		MASON DISTRICT HOSPITAL			In Lieu of Form CMS-2552-10		
HOME HEALTH AGENCY STATISTICAL DATA				Provider CCN:14-1313 Component CCN:14-7202		Period: From 10/01/2018 To 09/30/2019	
				Home Health Agency I		Worksheet S-4 Date/Time Prepared: 2/19/2020 6:01 pm	
						PPS	
				1.00			
0.00 County				MASON		0.00	
				Title V	Title XVIII	Title XIX	Other
				1.00	2.00	3.00	4.00
						Total	5.00
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	1,252	0	835	2,087	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	186.00	0.00	124.00	310.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		1.00	0.00	1.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			2.02	0.00	2.02	5.00
6.00	Direct Nursing Service			7.13	0.00	7.13	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.00	0.00	1.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			3			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			37900			20.00
20.01				44100			20.01
20.02				99914			20.02
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	2,841	817	55	17	3,730	21.00
22.00	Skilled Nursing Visit Charges	805,069	232,028	15,214	4,862	1,057,173	22.00
23.00	Physical Therapy Visits	796	256	4	8	1,064	23.00
24.00	Physical Therapy Visit Charges	251,008	80,830	1,264	2,528	335,630	24.00
25.00	Occupational Therapy Visits	321	146	0	8	475	25.00
26.00	Occupational Therapy Visit Charges	101,172	46,136	0	2,528	149,836	26.00
27.00	Speech Pathology Visits	24	4	0	0	28	27.00
28.00	Speech Pathology Visit Charges	7,473	1,066	0	0	8,539	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	465	191	0	1	657	31.00
32.00	Home Health Aide Visit Charges	73,470	30,178	0	158	103,806	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,447	1,414	59	34	5,954	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,238,192	390,238	16,478	10,076	1,654,984	35.00
36.00	Total Number of Episodes (standard/non outlier)	251		22	4	277	36.00
37.00	Total Number of Outlier Episodes		48		0	48	37.00
38.00	Total Non-Routine Medical Supply Charges	18,600	8,159	320	0	27,079	38.00

Health Financial Systems		MASON DISTRICT HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN:14-1313 Component CCN:14-3457		Period: From 10/01/2018 To 09/30/2019 Worksheet S-8 Date/Time Prepared: 2/19/2020 6:01 pm	
		RHC I		Cost	
		1.00			
1.00	Clinic Address and Identification				
	Street	615 N PROMENADE ST 1.00			
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	HAVANA		IL 62644	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)				
5.00	Migrant Health Center (Section 329(d), PHS Act)				
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				
7.00	Appalachian Regional Commission				
8.00	Look-Alikes				
9.00	OTHER (SPECIFY)				
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	yes or N		0	10.00
		Sunday	Monday	Tuesday	
		from	to	from	to
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	CLINIC	08:00		17:00	08:00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N			12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	30.8? N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number				
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				
		County			
		4.00			
2.00	City, State, ZIP Code, County	MASON			
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
Facility hours of operations (1)					
11.00	CLINIC	17:00	08:00	17:00	08:00
		17:00		08:00	17:00

Health Financial Systems		MASON DISTRICT HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN:14-1313	Period: From 10/01/2018	Worksheet S-8	
		Component CCN:14-3457	To 09/30/2019	Date/Time Prepared: 2/19/2020 6:01 pm	
		RHC I		Cost	
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
Facility hours of operations (1)					
11.00	CLINIC	08:00	17:00		11.00

Health Financial Systems		MASON DISTRICT HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN:14-1313 Component CCN:14-3462		Period: From 10/01/2018 To 09/30/2019 Worksheet S-8 Date/Time Prepared: 2/19/2020 6:01 pm	
		RHC II		Cost	
		1.00			
1.00	Clinic Address and Identification	122 EAST ELM STREET			
	Street				
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	MASON CITY		IL	62664-0530
				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)				
5.00	Migrant Health Center (Section 329(d), PHS Act)				
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				
7.00	Appalachian Regional Commission				
8.00	Look-Alikes				
9.00	OTHER (SPECIFY)				
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	yes or N		0	10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
	Facility hours of operations (1)				
11.00	CLINIC	08:00		16:00	08:00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N			12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	30.8? N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number				
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				
		County			
		4.00			
2.00	City, State, ZIP Code, County	MASON			
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
	Facility hours of operations (1)				
11.00	CLINIC	16:00	08:00	16:00	08:00
				16:00	

Health Financial Systems		MASON DISTRICT HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN:14-1313	Period: From 10/01/2018	Worksheet S-8	
		Component CCN:14-3462	To 09/30/2019	Date/Time Prepared: 2/19/2020 6:01 pm	
		RHC II		Cost	
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
Facility hours of operations (1)					
11.00	CLINIC	08:00	16:00		11.00

Health Financial Systems		MASON DISTRICT HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN:14-1313 Component CCN:14-8592		Period: From 10/01/2018 To 09/30/2019 Worksheet S-8 Date/Time Prepared: 2/19/2020 6:01 pm	
		RHC III		Cost	
		1.00			
1.00	Clinic Address and Identification				
	Street	1301 S. EAST AVENUE			
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	MANITO		IL	61546
				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)				
5.00	Migrant Health Center (Section 329(d), PHS Act)				
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				
7.00	Appalachian Regional Commission				
8.00	Look-Alikes				
9.00	OTHER (SPECIFY)				
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	yes or N		0	10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
	Facility hours of operations (1)				
11.00	CLINIC	08:00		16:00	08:00
				1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?	30.8? N		0	12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number				
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				
		County			
		4.00			
2.00	City, State, ZIP Code, County	MASON			
		Tuesday		Wednesday	Thursday
		to	from	to	from
		6.00	7.00	8.00	9.00
	Facility hours of operations (1)				
11.00	CLINIC	16:00	08:00	16:00	08:00
				16:00	

Health Financial Systems		MASON DISTRICT HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN:14-1313	Period: From 10/01/2018	Worksheet S-8	
		Component CCN:14-8592	To 09/30/2019	Date/Time Prepared: 2/19/2020 6:01 pm	
		RHC III		Cost	
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
Facility hours of operations (1)					
11.00	CLINIC	08:00	16:00		11.00

Health Financial Systems		MASON DISTRICT HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN:14-1313	Period: From 10/01/2018 To 09/30/2019	Worksheet S-10 Date/Time Prepared: 2/19/2020 6:01 pm	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.575773	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			328,601	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?			N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			115,109	5.00
6.00	Medicaid charges			2,969,920	6.00
7.00	Medicaid cost (line 1 times line 6)			1,710,000	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)			1,266,290	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP			6,753	9.00
10.00	Stand-alone CHIP charges			21,560	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			12,414	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			5,661	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			1,286,763	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12, 17, 18 and 16)			1,271,951	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)	31,124	171,605	202,729	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	17,920	171,605	189,525	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)	17,920	171,605	189,525	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)			1,378,841	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			198,865	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			305,946	27.01
28.00	Non-Medicare bad debt expense (see instructions)			1,072,895	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			724,825	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			914,350	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			2,186,301	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN:14-1313

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

Worksheet A

Date/Time Prepared:
2/19/2020 6:01 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	456,749	456,749	1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	0	0	44,799	44,799	1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	0	0	410,306	410,306	1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL	0	0	9,691	9,691	1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,175,501	1,175,501	-695,126	480,375	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,954,861	2,954,861	0	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	770,944	1,691,578	2,462,522	0	5.01
5.02	00591	A&G HOSPITAL ONLY	325,143	178,228	503,371	0	5.02
6.00	00600	MAINTENANCE & REPAIRS	233,563	280,411	513,974	0	6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	0	0	0	6.01
7.00	00700	OPERATION OF PLANT	0	235,990	235,990	0	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	22,478	22,478	0	7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI	0	7,617	7,617	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	27,610	17,661	45,271	0	8.00
9.00	00900	HOUSEKEEPING	234,306	77,057	311,363	0	9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0	9.01
10.00	01000	DIETARY	226,772	184,421	411,193	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	185,336	23,424	208,760	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	80,962	13,148	94,110	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	125,237	86,312	211,549	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	300,735	300,735	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	918,267	534,000	1,452,267	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	178,677	40,890	219,567	0	50.00
53.00	05300	ANESTHESIOLOGY	0	141	141	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	583,523	279,386	862,909	-90,063	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	64,841	62,344	127,185	3,220	54.01
56.00	05600	RADIOISOTOPE	23,522	74,707	98,229	395	56.00
58.00	05800	MRI	0	119,626	119,626	1,326	58.00
60.00	06000	LABORATORY	682,574	753,731	1,436,305	69,697	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	56,438	56,438	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	26,325	26,325	0	64.00
66.00	06600	PHYSICAL THERAPY	542,575	140,173	682,748	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	181,000	28,789	209,789	0	67.00
68.00	06800	SPEECH PATHOLOGY	31,804	3,375	35,179	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	429,388	116,619	546,007	15,425	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	422,767	422,767	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	303,723	352,977	656,700	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	199,733	122,142	321,875	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	4,859	14,165	19,024	0	76.01
76.02	03950	DIABETIC EDUCATION	40,446	9,494	49,940	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	3,768,302	736,158	4,504,460	-90,115	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	358,641	83,385	442,026	0	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	631,435	161,609	793,044	0	88.02
91.00	09100	EMERGENCY	422,545	1,704,333	2,126,878	656,388	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	976,910	106,073	1,082,983	-656,388	95.00
101.00	10100	HOME HEALTH AGENCY	604,641	147,902	752,543	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		226,419	226,419	-226,419	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,157,279	13,573,390	26,730,669	-90,115	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	44,254	7,753	52,007	90,115	192.00
194.00	07950	HOSPICE	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	13,201,533	13,581,143	26,782,676	0	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN:14-1313

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

Worksheet A

Date/Time Prepared:
2/19/2020 6:01 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-59,893	396,856	1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	0	44,799	1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	-53,014	357,292	1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL	0	9,691	1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	480,375	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-954,508	2,000,353	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	-52,082	2,410,440	5.01
5.02	00591	A&G HOSPITAL ONLY	-315	503,056	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	513,974	6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	0	6.01
7.00	00700	OPERATION OF PLANT	-444	235,546	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	22,478	7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI	0	7,617	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	45,271	8.00
9.00	00900	HOUSEKEEPING	0	311,363	9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	9.01
10.00	01000	DIETARY	-134,574	276,619	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	208,760	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	94,110	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,028	208,521	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-31,147	269,588	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-337,920	1,114,347	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	219,567	50.00
53.00	05300	ANESTHESIOLOGY	0	141	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,400	770,446	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	130,405	54.01
56.00	05600	RADIOISOTOPE	0	98,624	56.00
58.00	05800	MRI	0	120,952	58.00
60.00	06000	LABORATORY	0	1,506,002	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	56,438	62.00
64.00	06400	INTRAVENOUS THERAPY	0	26,325	64.00
66.00	06600	PHYSICAL THERAPY	0	682,748	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	209,789	67.00
68.00	06800	SPEECH PATHOLOGY	-16,330	18,849	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	03160	CARDIOPULMONARY	-37,633	523,799	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	422,767	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	656,700	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	321,875	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	19,024	76.01
76.02	03950	DIABETIC EDUCATION	0	49,940	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0	4,414,345	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0	442,026	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	-300	792,744	88.02
91.00	09100	EMERGENCY	-263,554	2,519,712	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	426,595	95.00
101.00	10100	HOME HEALTH AGENCY	-180	752,363	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,947,322	24,693,232	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	142,122	192.00
194.00	07950	HOSPICE	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,947,322	24,835,354	200.00

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	61,623	1.00
2.00	NEW CAP REL COSTS-NEW MED SURG	1.02	0	164,796	2.00
	TOTALS		0	226,419	
B - EMS SALARY TO ER					
1.00	EMERGENCY	91.00	656,388	0	1.00
	TOTALS		656,388	0	
C - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	395,126	1.00
2.00	NEW CAP REL COSTS-CLINIC BUILDING	1.01	0	44,799	2.00
3.00	NEW CAP REL COSTS-NEW MED SURG	1.02	0	245,510	3.00
4.00	NEW CAP REL COSTS - WEST CAMPUS BUIL	1.03	0	9,691	4.00
	TOTALS		0	695,126	
D - RHC PHYSICIAN					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	90,115	0	1.00
	TOTALS		90,115	0	
E - OP REGISTRATION					
1.00	LABORATORY	60.00	51,736	17,961	1.00
2.00	CARDIOPULMONARY	69.01	11,450	3,975	2.00
3.00	RADIOLOGY-ULTRASOUND	54.01	2,390	830	3.00
4.00	RADIOISOTOPE	56.00	293	102	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	3,753	1,303	5.00
6.00	MRI	58.00	984	342	6.00
	TOTALS		70,606	24,513	
500.00	Grand Total: Increases		817,109	946,058	500.00

Decreases							
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
6.00	7.00	8.00	9.00	10.00			
A - INTEREST RECLASS							
1.00 INTEREST EXPENSE	113.00	0	226,419	11			1.00
2.00	0.00	0	0	11			2.00
TOTALS		0	226,419				
B - EMS SALARY TO ER							
1.00 AMBULANCE SERVICES	95.00	656,388	0	0			1.00
TOTALS		656,388	0				
C - DEPRECIATION							
1.00 CAP REL COSTS-MVBLE EQUIP	2.00	0	695,126	9			1.00
2.00	0.00	0	0	9			2.00
3.00	0.00	0	0	9			3.00
4.00	0.00	0	0	9			4.00
TOTALS		0	695,126				
D - RHC PHYSICIAN							
1.00 HAVANA MEDICAL ASSOCIATES RHC	88.00	90,115	0	0			1.00
TOTALS		90,115	0				
E - OP REGISTRATION							
1.00 RADIOLOGY-DIAGNOSTIC	54.00	70,606	24,513	0			1.00
2.00	0.00	0	0	0			2.00
3.00	0.00	0	0	0			3.00
4.00	0.00	0	0	0			4.00
5.00	0.00	0	0	0			5.00
6.00	0.00	0	0	0			6.00
TOTALS		70,606	24,513				
500.00 Grand Total: Decreases		817,109	946,058				500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part I
Date/Time Prepared:
2/19/2020 6:01 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	163,928	0	0	0	0	1.00	
2.00	Land Improvements	603,633	0	0	0	0	2.00	
3.00	Buildings and Fixtures	16,628,119	1,361,328	0	1,361,328	0	3.00	
4.00	Building Improvements	366,777	0	0	0	101,546	4.00	
5.00	Fixed Equipment	3,578,865	18,702	0	18,702	0	5.00	
6.00	Movable Equipment	9,955,085	735,014	0	735,014	0	6.00	
7.00	HIT designated Assets	810,377	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	32,106,784	2,115,044	0	2,115,044	101,546	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	32,106,784	2,115,044	0	2,115,044	101,546	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	163,928	0					1.00
2.00	Land Improvements	603,633	0					2.00
3.00	Buildings and Fixtures	17,989,447	0					3.00
4.00	Building Improvements	265,231	0					4.00
5.00	Fixed Equipment	3,597,567	0					5.00
6.00	Movable Equipment	10,690,099	0					6.00
7.00	HIT designated Assets	810,377	0					7.00
8.00	Subtotal (sum of lines 1-7)	34,120,282	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	34,120,282	0	10.00				

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part II
Date/Time Prepared:
2/19/2020 6:01 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	0	0	0	1.02
1.03	NEW CAP REL COSTS - WEST CAMPUS BUIL	0	0	0	0	0	1.03
2.00	CAP REL COSTS-MVBLE EQUIP	1,175,501	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,175,501	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related	of cols. 9				
		Costs (see	through 14)				
		instructions)					
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0				1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0				1.02
1.03	NEW CAP REL COSTS - WEST CAMPUS BUIL	0	0				1.03
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,175,501				2.00
3.00	Total (sum of lines 1-2)	0	1,175,501				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part III
Date/Time Prepared:
2/19/2020 6:01 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	22,619,806	0	22,619,806	0.662943	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	0.000000	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	0	0.000000	0	1.02
1.03	NEW CAP REL COSTS - WEST CAMPUS BUIL	0	0	0	0.000000	0	1.03
2.00	CAP REL COSTS-MVBLE EQUIP	11,500,476	0	11,500,476	0.337057	0	2.00
3.00	Total (sum of lines 1-2)	34,120,282	0	34,120,282	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	336,343	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	44,799	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	0	244,308	0	1.02
1.03	NEW CAP REL COSTS - WEST CAMPUS BUIL	0	0	0	9,691	0	1.03
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	480,375	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,115,516	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	42,249	0	0	18,264	396,856	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	0	44,799	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	112,984	0	0	0	357,292	1.02
1.03	NEW CAP REL COSTS - WEST CAMPUS BUIL	0	0	0	0	9,691	1.03
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	480,375	2.00
3.00	Total (sum of lines 1-2)	155,233	0	0	18,264	1,289,013	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN:14-1313

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

Worksheet A-8

Date/Time Prepared:
2/19/2020 6:01 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.	
				Cost Center				
		1.00	2.00	3.00		4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT		1.00	0	1.00
1.01	Investment income - NEW CAP REL COSTS-CLINIC BUILDING (chapter 2)			0NEW CAP REL COSTS-CLINIC BUILDING		1.01	0	1.01
1.02	Investment income - NEW CAP REL COSTS-NEW MED SURG (chapter 2)			0NEW CAP REL COSTS-NEW MED SURG		1.02	0	1.02
1.03	Investment income - NEW CAP REL COSTS - WEST CAMPUS BUIL (chapter 2)			0NEW CAP REL COSTS - WEST CAMPUS BUIL		1.03	0	1.03
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP		2.00	0	2.00
3.00	Investment income - other (chapter 2)			0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00	Television and radio service (chapter 21)			0		0.00	0	8.00
9.00	Parking lot (chapter 21)			0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-631,058				0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)			0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1		0			0	12.00
13.00	Laundry and linen service			0		0.00	0	13.00
14.00	Cafeteria-employees and guests			0		0.00	0	14.00
15.00	Rental of quarters to employees and others			0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00	Sale of drugs to other than patients			0		0.00	0	17.00
18.00	Sale of medical records and abstracts			0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00	Vending machines			0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***		65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY		66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***		114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0CAP REL COSTS-BLDG & FIXT		1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-CLINIC BUILDING			0NEW CAP REL COSTS-CLINIC BUILDING		1.01	0	26.01
26.02	Depreciation - NEW CAP REL COSTS-NEW MED SURG			0NEW CAP REL COSTS-NEW MED SURG		1.02	0	26.02
26.03	Depreciation - NEW CAP REL COSTS - WEST CAMPUS BUIL			0NEW CAP REL COSTS - WEST CAMPUS BUIL		1.03	0	26.03

ADJUSTMENTS TO EXPENSES

Provider CCN:14-1313

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

Worksheet A-8

Date/Time Prepared:
2/19/2020 6:01 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0	0.00	0	32.00
33.00	MEDICAL RECORD FEES -OTHER OP	B	-3,028MEDICAL RECORDS & LIBRARY	16.00	0	33.00
33.01	CAFETERIA SALES -OTHER OP	B	-134,574DIETARY	10.00	0	33.01
33.02	DIETARY CONSULT -OTHER OP	B	0DIETARY	10.00	0	33.02
33.03	SALE OF NON-PAT SUPP-OTHER OP	B	1,371ADMINISTRATIVE AND GENERAL	5.01	0	33.03
33.04	ON-CALL CRNA SERVICES	A	-31,147NONPHYSICIAN ANESTHETISTS	19.00	0	33.04
33.05	PROF BUILDING RENT -OTHER OP	B	-55,783CAP REL COSTS-BLDG & FIXT	1.00	9	33.05
33.06	MISCELLANEOUS -OTHER OP	B	-918ADMINISTRATIVE AND GENERAL	5.01	0	33.06
33.07	RENTAL INCOME	B	-3,000CAP REL COSTS-BLDG & FIXT	1.00	9	33.07
33.08	COMMUNITY ED FEES -OTHER OP	B	-5,185ADMINISTRATIVE AND GENERAL	5.01	0	33.08
33.09	LAB OUTREACH REV -OTHER OP	B	0LABORATORY	60.00	0	33.09
33.10	INTEREST INCOME -NON OPER	B	-19,374CAP REL COSTS-BLDG & FIXT	1.00	11	33.10
33.11	INTEREST INCOME -NON OPER	B	-51,812NEW CAP REL COSTS-NEW MED SURG	1.02	11	33.11
33.12	FITNESS EXPENSE	A	-10,449CARDIOPULMONARY	69.01	0	33.12
33.13	FITNESS CENTER REV	B	0CARDIOPULMONARY	69.01	0	33.13
33.14	HOME HEALTH REV	B	-180HOME HEALTH AGENCY	101.00	0	33.14
33.15	TELEPHONE OFFSET - OPERATIONS	A	-444OPERATION OF PLANT	7.00	0	33.15
33.16	TELEPHONE OFFSET - SALARIES	A	-110ADMINISTRATIVE AND GENERAL	5.01	0	33.16
33.17	TELEPHONE OFFSET - BENEFITS	A	-18EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.17
33.18	MEDICAR - EXPENSES	A	-17,098ADMINISTRATIVE AND GENERAL	5.01	0	33.18
33.19	MEDICAR - BENEFITS	A	-2,039EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.19
33.20	LOBBYING DUES	A	-8,539ADMINISTRATIVE AND GENERAL	5.01	0	33.20
33.21	ADVERTISING	A	-21,603ADMINISTRATIVE AND GENERAL	5.01	0	33.21
33.22	ADVERTISING	A	-315A&G HOSPITAL ONLY	5.02	0	33.22
33.25	ADVERTISING	A	-300MANITO MEDICAL CLINIC RHC	88.02	0	33.25
33.27	SPEECH THERAPY IN SCHOOLS	B	0SPEECH PATHOLOGY	68.00	0	33.27
33.34	SPEECH THERAPY IN SCHOOLS	B	-16,330SPEECH PATHOLOGY	68.00	0	33.34
33.35	TELEVISIONS	A	-1,202NEW CAP REL COSTS-NEW MED SURG	1.02	9	33.35
33.36	SELF INSURANCE	A	-589,182EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.36
33.37	UNFUNDED POST-EMPLOYMENT BENEFIT	A	-26,867EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.37
33.38	NON-ALLOW DONATION EXP	A	0ADMINISTRATIVE AND GENERAL	5.01	0	33.38
33.39	BOND AMORTIZATION COST FY14	A	18,264CAP REL COSTS-BLDG & FIXT	1.00	14	33.39
33.40	IMRF CONTRIBUTION	A	-336,402EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.40
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,947,322			50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN:14-1313

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

Worksheet A-8-2

Date/Time Prepared:
2/19/2020 6:01 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,570,412	263,554	1,306,858	0	0	1.00
2.00	60.00	LABORATORY	48,000	0	48,000	0	0	2.00
3.00	69.01	CARDIOPULMONARY	27,184	27,184	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	2,400	2,400	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	337,920	337,920	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,985,916	631,058	1,354,858	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	69.01	CARDIOPULMONARY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	263,554		1.00
2.00	60.00	LABORATORY	0	0	0	0		2.00
3.00	69.01	CARDIOPULMONARY	0	0	0	27,184		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	2,400		4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	337,920		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	631,058		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/19/2020 6:01 pm

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	NEW CAP REL COSTS - WEST CAMPUS BUIL	
			0	1.00	1.01	1.02	1.03	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	396,856	396,856				1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	44,799	0	44,799			1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	357,292	0	0	357,292		1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL	9,691	0	0	0	9,691	1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP	480,375					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,000,353	0	0	0	0	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	2,410,440	87,963	2,377	0	0	5.01
5.02	00591	A&G HOSPITAL ONLY	503,056	4,505	2,194	2,933	0	5.02
6.00	00600	MAINTENANCE & REPAIRS	513,974	0	0	0	0	6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	0	0	0	0	6.01
7.00	00700	OPERATION OF PLANT	235,546	39,303	375	7,821	0	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	22,478	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI	7,617	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	45,271	11,832	0	2,906	0	8.00
9.00	00900	HOUSEKEEPING	311,363	2,624	0	1,717	0	9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0	0	9.01
10.00	01000	DIETARY	276,619	19,234	0	0	0	10.00
11.00	01100	CAFETERIA	0	8,176	0	1,982	0	11.00
13.00	01300	NURSING ADMINISTRATION	208,760	6,007	0	4,254	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	94,110	10,929	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	208,521	5,400	455	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	269,588	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,114,347	5,848	0	278,531	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	219,567	47,342	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	141	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	770,446	36,906	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	130,405	1,843	0	0	0	54.01
56.00	05600	RADIOISOTOPE	98,624	4,005	0	0	0	56.00
58.00	05800	MRI	120,952	0	0	0	0	58.00
60.00	06000	LABORATORY	1,506,002	21,692	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	56,438	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	26,325	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	682,748	7,812	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	209,789	1,638	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	18,849	1,183	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	523,799	37,118	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	422,767	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	656,700	0	0	49,407	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	321,875	0	1,907	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	19,024	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	49,940	4,498	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	4,414,345	0	33,610	0	0	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	442,026	0	0	0	0	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	792,744	0	0	0	0	88.02
91.00	09100	EMERGENCY	2,519,712	30,998	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	426,595	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	752,363	0	3,881	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,693,232	396,856	44,799	349,551	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	7,741	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	142,122	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	0	0	9,691	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/19/2020 6:01 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
		BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	NEW CAP REL COSTS - WEST CAMPUS BUIL	
		1.00	1.01	1.02	1.03	
202.00 TOTAL (sum lines 118 through 201)	24,835,354	396,856	44,799	357,292	9,691	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/19/2020 6:01 pm

Cost Center Description		CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE AND GENERAL	Subtotal	
		MVBLE EQUIP					
		2.00	4.00	4A	5.01	5A.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING					1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG					1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL					1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP	480,375				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,000,353			4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	62,736	120,762	2,684,278	2,684,278	5.01
5.02	00591	A&G HOSPITAL ONLY	0	51,073	563,761	68,317	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	36,688	550,662	66,729	6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	0	0	0	6.01
7.00	00700	OPERATION OF PLANT	1,352	0	284,397	34,463	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	22,478	2,724	7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI	0	0	7,617	923	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	2,552	4,337	66,898	8,107	8.00
9.00	00900	HOUSEKEEPING	0	36,805	352,509	42,717	9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0	9.01
10.00	01000	DIETARY	729	35,621	332,203	40,256	10.00
11.00	01100	CAFETERIA	0	0	10,158	1,231	11.00
13.00	01300	NURSING ADMINISTRATION	0	29,112	248,133	30,069	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	12,717	117,756	14,270	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	327	19,672	234,375	28,402	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	269,588	32,669	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	23,374	144,240	1,566,340	189,809	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	30,775	28,066	325,750	39,474	50.00
53.00	05300	ANESTHESIOLOGY	0	0	141	17	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	110,341	81,158	998,851	121,041	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	10,561	142,809	17,306	54.01
56.00	05600	RADIOISOTOPE	0	0	102,629	12,437	56.00
58.00	05800	MRI	0	155	121,107	14,676	58.00
60.00	06000	LABORATORY	40,126	115,345	1,683,165	203,966	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	56,438	6,839	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	26,325	3,190	64.00
66.00	06600	PHYSICAL THERAPY	63,979	85,227	839,766	101,763	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	28,431	239,858	29,066	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,996	25,028	3,033	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	0	560,917	67,972	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	422,767	51,231	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,539	47,709	755,355	91,534	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	31,374	355,156	43,038	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	763	19,787	2,398	76.01
76.02	03950	DIABETIC EDUCATION	0	6,353	60,791	7,367	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	39,775	577,760	5,065,490	613,843	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	1,753	56,335	500,114	60,604	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0	99,185	891,929	108,084	88.02
91.00	09100	EMERGENCY	9,913	169,478	2,730,101	330,834	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	83,974	50,347	560,916	67,972	95.00
101.00	10100	HOME HEALTH AGENCY	7,130	94,976	858,350	104,015	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	480,375	1,979,246	24,654,693	2,662,386	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	7,741	938	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	21,107	163,229	19,780	192.00
194.00	07950	HOSPICE	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	9,691	1,174	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	194.04
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	480,375	2,000,353	24,835,354	2,684,278	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/19/2020 6:01 pm

Cost Center Description			A&G HOSPITAL ONLY	MAINTENANCE & REPAIRS	MAINTENANCE & REPAIRS - WEST CAMPUS	OPERATION OF PLANT	OPERATION OF PLANT-CLINIC	
			5.02	6.00	6.01	7.00	7.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY	632,078					5.02
6.00	00600	MAINTENANCE & REPAIRS	23,219	640,610				6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	0	0			6.01
7.00	00700	OPERATION OF PLANT	11,992	51,493	0	382,345		7.00
7.01	00701	OPERATION OF PLANT-CLINIC	948	0	0	0	26,150	7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI	321	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	2,821	15,260	0	13,276	0	8.00
9.00	00900	HOUSEKEEPING	14,864	3,767	0	3,277	0	9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0	0	9.01
10.00	01000	DIETARY	14,007	23,187	0	20,172	0	10.00
11.00	01100	CAFETERIA	428	10,542	0	9,171	0	11.00
13.00	01300	NURSING ADMINISTRATION	10,463	8,713	0	7,581	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,965	13,175	0	11,462	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,883	8,220	0	5,664	331	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	11,367	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	66,045	103,434	0	89,988	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,735	57,070	0	49,651	0	50.00
53.00	05300	ANESTHESIOLOGY	6	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,117	44,490	0	38,706	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	6,022	2,222	0	1,933	0	54.01
56.00	05600	RADIOISOTOPE	4,327	4,827	0	4,200	0	56.00
58.00	05800	MRI	5,107	0	0	0	0	58.00
60.00	06000	LABORATORY	70,971	26,149	0	22,750	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,380	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	1,110	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	35,409	9,417	0	8,193	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,114	1,975	0	1,718	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,055	1,426	0	1,241	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	23,651	44,746	0	38,929	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,826	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,850	17,097	0	14,875	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	14,975	7,159	0	0	1,386	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	834	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	2,563	5,422	0	4,717	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0	126,199	0	0	24,433	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0	0	0	0	0	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	37,608	0	0	0	0	88.02
91.00	09100	EMERGENCY	115,118	37,367	0	32,510	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	23,651	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	14,574	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	631,752	637,931	0	380,014	26,150	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	326	2,679	0	2,331	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	632,078	640,610	0	382,345	26,150	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
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Cost Center Description			OPERATION OF PLANT - WEST CAMPUS BUI	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	HOUSEKEEPING - WEST CAMPUS BUILDING	DIETARY	
			7.02	8.00	9.00	9.01	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS						6.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI	8,861					7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	106,362				8.00
9.00	00900	HOUSEKEEPING	0	0	417,134			9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0		9.01
10.00	01000	DIETARY	0	0	16,966	0	446,791	10.00
11.00	01100	CAFETERIA	0	0	7,713	0	359,360	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	6,375	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	9,640	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	6,014	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	44,190	75,683	0	72,025	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	15,859	41,758	0	556	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,349	32,553	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	1,626	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	3,532	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	287	19,133	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	4,274	6,891	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,445	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,044	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	1,465	32,740	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	12,510	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	5,238	0	14,152	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	0	3,967	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0	716	92,340	0	0	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0	68	0	0	0	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	0	24,800	27,342	0	698	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	239	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	76	10,664	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	106,323	415,174	0	446,791	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1,960	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	39	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	8,861	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,861	106,362	417,134	0	446,791	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet B
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS						6.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING						9.01
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	398,603					11.00
13.00	01300	NURSING ADMINISTRATION	5,020	316,354				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,881	0	178,149			14.00
15.00	01500	PHARMACY	0	0	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,314	0	0	0	300,203	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	49,134	195,887	0	0	17,728	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,410	32,484	0	0	7,932	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	4,611	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,065	0	2,568	0	47,414	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	2,829	0	335	0	5,755	54.01
56.00	05600	RADIOISOTOPE	917	0	8,853	0	3,546	56.00
58.00	05800	MRI	102	0	499	0	9,190	58.00
60.00	06000	LABORATORY	40,648	0	76,868	0	56,379	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	10,107	0	606	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	3,211	0	3,423	64.00
66.00	06600	PHYSICAL THERAPY	20,337	0	0	0	15,619	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,556	0	0	0	6,200	67.00
68.00	06800	SPEECH PATHOLOGY	1,096	0	0	0	675	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	19,954	0	0	0	12,623	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	75,708	0	4,482	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,404	0	0	0	6,807	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	9,582	23,982	0	0	6,558	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	280	0	0	0	275	76.01
76.02	03950	DIABETIC EDUCATION	1,096	0	0	0	163	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	108,971	0	0	0	28,480	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0	0	0	0	2,527	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0	0	0	0	5,096	88.02
91.00	09100	EMERGENCY	74,007	64,001	0	0	19,847	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	17,788	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	16,479	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	398,603	316,354	178,149	0	300,203	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	398,603	316,354	178,149	0	300,203	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
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Cost Center Description		NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING				1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG				1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL				1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00590	ADMINISTRATIVE AND GENERAL				5.01
5.02	00591	A&G HOSPITAL ONLY				5.02
6.00	00600	MAINTENANCE & REPAIRS				6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS				6.01
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT-CLINIC				7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI				7.02
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING				9.01
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	313,624			19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,470,263	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	592,679	0	50.00
53.00	05300	ANESTHESIOLOGY	313,624	318,399	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,369,154	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	180,837	0	54.01
56.00	05600	RADIOISOTOPE	0	145,268	0	56.00
58.00	05800	MRI	0	150,681	0	58.00
60.00	06000	LABORATORY	0	2,200,316	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	76,370	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	37,259	0	64.00
66.00	06600	PHYSICAL THERAPY	0	1,041,669	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	295,932	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	34,598	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	802,997	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	572,014	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	939,432	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	481,226	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	23,574	0	76.01
76.02	03950	DIABETIC EDUCATION	0	86,086	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0	6,060,472	0	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0	563,313	0	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0	1,042,717	0	88.02
91.00	09100	EMERGENCY	0	3,456,625	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	670,566	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,004,158	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	313,624	24,616,605	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,975	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	183,048	0	192.00
194.00	07950	HOSPICE	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	19,726	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	194.04
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	313,624	24,835,354	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	NEW CAP REL COSTS - WEST CAMPUS BUIL	
				1.00	1.01	1.02	1.03	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	0	87,963	2,377	0	0	5.01
5.02	00591	A&G HOSPITAL ONLY	0	4,505	2,194	2,933	0	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	0	0	0	0	6.01
7.00	00700	OPERATION OF PLANT	0	39,303	375	7,821	0	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI	0	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	11,832	0	2,906	0	8.00
9.00	00900	HOUSEKEEPING	0	2,624	0	1,717	0	9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0	0	9.01
10.00	01000	DIETARY	0	19,234	0	0	0	10.00
11.00	01100	CAFETERIA	0	8,176	0	1,982	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	6,007	0	4,254	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,929	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,400	455	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	5,848	0	278,531	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	47,342	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	36,906	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	1,843	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	4,005	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	21,692	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	7,812	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,638	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,183	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	37,118	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	49,407	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	1,907	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	4,498	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0	0	33,610	0	0	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0	0	0	0	0	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	0	30,998	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	3,881	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	396,856	44,799	349,551	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	7,741	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	0	0	9,691	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	396,856	44,799	357,292	9,691	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		CAPITAL RELATED COSTS	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE AND GENERAL	A&G HOSPITAL ONLY	
		MOVABLE EQUIP					
		2.00	2A	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING					1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG					1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL					1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	62,736	153,076	0	153,076	5.01
5.02	00591	A&G HOSPITAL ONLY	0	9,632	0	3,896	13,528
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	3,806	497
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	0	0	0	0
7.00	00700	OPERATION OF PLANT	1,352	48,851	0	1,965	257
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	0	155	20
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI	0	0	0	53	7
8.00	00800	LAUNDRY & LINEN SERVICE	2,552	17,290	0	462	60
9.00	00900	HOUSEKEEPING	0	4,341	0	2,436	318
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0	0
10.00	01000	DIETARY	729	19,963	0	2,296	300
11.00	01100	CAFETERIA	0	10,158	0	70	9
13.00	01300	NURSING ADMINISTRATION	0	10,261	0	1,715	224
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,929	0	814	106
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	327	6,182	0	1,620	212
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	1,863	243
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	23,374	307,753	0	10,825	1,414
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	30,775	78,117	0	2,251	294
53.00	05300	ANESTHESIOLOGY	0	0	0	1	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	110,341	147,247	0	6,903	902
54.01	05401	RADIOLOGY-ULTRASOUND	0	1,843	0	987	129
56.00	05600	RADIOISOTOPE	0	4,005	0	709	93
58.00	05800	MRI	0	0	0	837	109
60.00	06000	LABORATORY	40,126	61,818	0	11,632	1,519
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	390	51
64.00	06400	INTRAVENOUS THERAPY	0	0	0	182	24
66.00	06600	PHYSICAL THERAPY	63,979	71,791	0	5,804	758
67.00	06700	OCCUPATIONAL THERAPY	0	1,638	0	1,658	216
68.00	06800	SPEECH PATHOLOGY	0	1,183	0	173	23
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
69.01	03160	CARDIOPULMONARY	0	37,118	0	3,876	506
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,922	382
73.00	07300	DRUGS CHARGED TO PATIENTS	1,539	50,946	0	5,220	682
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,907	0	2,454	321
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	137	18
76.02	03950	DIABETIC EDUCATION	0	4,498	0	420	55
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	39,775	73,385	0	35,000	0
88.01	08801	MASON CITY MEDICAL ASSOCIATES	1,753	1,753	0	3,456	0
88.02	08802	MANITO MEDICAL CLINIC RHC	0	0	0	6,164	805
91.00	09100	EMERGENCY	9,913	40,911	0	18,868	2,461
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	83,974	83,974	0	3,876	506
101.00	10100	HOME HEALTH AGENCY	7,130	11,011	0	5,932	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	480,375	1,271,581	0	151,828	13,521
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,741	0	53	7
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,128	0
194.00	07950	HOSPICE	0	0	0	0	0
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0
194.02	07952	MEALS ON WHEELS	0	0	0	0	0
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	9,691	0	67	0
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	480,375	1,289,013	0	153,076	13,528

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/19/2020 6:01 pm

Cost Center Description			MAINTENANCE & REPAIRS	MAINTENANCE & REPAIRS - WEST CAMPUS	OPERATION OF PLANT	OPERATION OF PLANT-CLINIC	OPERATION OF PLANT - WEST CAMPUS BUI	
			6.00	6.01	7.00	7.01	7.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS	4,303					6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	0				6.01
7.00	00700	OPERATION OF PLANT	346	0	51,419			7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	0	175		7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI	0	0	0	0	60	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	102	0	1,785	0	0	8.00
9.00	00900	HOUSEKEEPING	25	0	441	0	0	9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0	0	9.01
10.00	01000	DIETARY	156	0	2,713	0	0	10.00
11.00	01100	CAFETERIA	71	0	1,233	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	59	0	1,019	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	88	0	1,541	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	55	0	762	2	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	695	0	12,105	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	383	0	6,677	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	299	0	5,205	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	15	0	260	0	0	54.01
56.00	05600	RADIOISOTOPE	32	0	565	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	176	0	3,059	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	63	0	1,102	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	13	0	231	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	10	0	167	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	301	0	5,235	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	115	0	2,000	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	48	0	0	9	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	36	0	634	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	848	0	0	164	0	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0	0	0	0	0	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	251	0	4,372	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	98	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,285	0	51,106	175	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18	0	313	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	0	0	60	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,303	0	51,419	175	60	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/19/2020 6:01 pm

Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	HOUSEKEEPING - WEST CAMPUS BUILDING	DIETARY	CAFETERIA	
			8.00	9.00	9.01	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS						6.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI						7.02
8.00	00800	LAUNDRY & LINEN SERVICE	19,699					8.00
9.00	00900	HOUSEKEEPING	0	7,561				9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0			9.01
10.00	01000	DIETARY	0	308	0	25,736		10.00
11.00	01100	CAFETERIA	0	140	0	20,700	32,381	11.00
13.00	01300	NURSING ADMINISTRATION	0	116	0	0	408	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	175	0	0	559	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	109	0	0	594	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,185	1,372	0	4,149	3,991	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,937	757	0	32	683	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,657	590	0	0	2,199	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	29	0	0	230	54.01
56.00	05600	RADIOISOTOPE	0	64	0	0	75	56.00
58.00	05800	MRI	0	0	0	0	8	58.00
60.00	06000	LABORATORY	53	347	0	0	3,302	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	792	125	0	0	1,652	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	26	0	0	451	67.00
68.00	06800	SPEECH PATHOLOGY	0	19	0	0	89	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	271	593	0	0	1,621	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	227	0	0	764	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	95	0	815	778	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	23	76.01
76.02	03950	DIABETIC EDUCATION	0	72	0	0	89	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	133	1,672	0	0	8,853	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	13	0	0	0	0	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	4,593	496	0	40	6,012	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	44	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	14	193	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,692	7,525	0	25,736	32,381	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	36	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	19,699	7,561	0	25,736	32,381	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			13.00	14.00	15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS						6.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING						9.01
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	13,802					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,212				14.00
15.00	01500	PHARMACY	0	0	0			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	9,536		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	2,106	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,547	0	0	563		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,417	0	0	252		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	146		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	205	0	1,506		54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	27	0	183		54.01
56.00	05600	RADIOISOTOPE	0	706	0	113		56.00
58.00	05800	MRI	0	40	0	292		58.00
60.00	06000	LABORATORY	0	6,132	0	1,794		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	806	0	19		62.00
64.00	06400	INTRAVENOUS THERAPY	0	256	0	109		64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	496		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	197		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	21		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
69.01	03160	CARDIOPULMONARY	0	0	0	401		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,040	0	142		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	216		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,046	0	0	208		76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	9		76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	5		76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0	0	0	904		88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0	0	0	80		88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0	0	0	162		88.02
91.00	09100	EMERGENCY	2,792	0	0	630		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	565		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	523		101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,802	14,212	0	9,536	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	HOSPICE	0	0	0	0		194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0		194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0		194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	0	0		194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0		194.04
200.00		Cross Foot Adjustments					2,106	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	13,802	14,212	0	9,536	2,106	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/19/2020 6:01 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING			1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG			1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL			1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00590	ADMINISTRATIVE AND GENERAL			5.01
5.02	00591	A&G HOSPITAL ONLY			5.02
6.00	00600	MAINTENANCE & REPAIRS			6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS			6.01
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT-CLINIC			7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI			7.02
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING			9.01
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	359,599	0	359,599
31.00	03100	INTENSIVE CARE UNIT	0	0	0
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	93,800	0	93,800
53.00	05300	ANESTHESIOLOGY	147	0	147
54.00	05400	RADIOLOGY-DIAGNOSTIC	167,713	0	167,713
54.01	05401	RADIOLOGY-ULTRASOUND	3,703	0	3,703
56.00	05600	RADIOISOTOPE	6,362	0	6,362
58.00	05800	MRI	1,286	0	1,286
60.00	06000	LABORATORY	89,832	0	89,832
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,266	0	1,266
64.00	06400	INTRAVENOUS THERAPY	571	0	571
66.00	06600	PHYSICAL THERAPY	82,583	0	82,583
67.00	06700	OCCUPATIONAL THERAPY	4,430	0	4,430
68.00	06800	SPEECH PATHOLOGY	1,685	0	1,685
69.00	06900	ELECTROCARDIOLOGY	0	0	0
69.01	03160	CARDIOPULMONARY	49,922	0	49,922
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,486	0	9,486
73.00	07300	DRUGS CHARGED TO PATIENTS	60,170	0	60,170
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	7,681	0	7,681
76.01	03952	TELEMEDICINE PSYCH SERVICES	187	0	187
76.02	03950	DIABETIC EDUCATION	5,809	0	5,809
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	120,959	0	120,959
88.01	08801	MASON CITY MEDICAL ASSOCIATES	5,302	0	5,302
88.02	08802	MANITO MEDICAL CLINIC RHC	7,131	0	7,131
91.00	09100	EMERGENCY	81,426	0	81,426
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	88,965	0	88,965
101.00	10100	HOME HEALTH AGENCY	17,771	0	17,771
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,267,786	0	1,267,786
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,168	0	8,168
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,135	0	1,135
194.00	07950	HOSPICE	0	0	0
194.01	07951	FAMILY MEDICAL CENTER	0	0	0
194.02	07952	MEALS ON WHEELS	0	0	0
194.03	07954	FITNESS CENTER - WEST CAMPUS	9,818	0	9,818
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0
200.00		Cross Foot Adjustments	2,106	0	2,106
201.00		Negative Cost Centers	0	0	0
202.00		TOTAL (sum lines 118 through 201)	1,289,013	0	1,289,013

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-1313

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

Worksheet B-1

Date/Time Prepared:
2/19/2020 6:01 pm

Cost Center Description			CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	NEW CAP REL COSTS - WEST CAMPUS BUIL (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	
			1.00	1.01	1.02	1.03	2.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	52,325					1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	0	18,398				1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	0	0	13,523			1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL	0	0	0	21,571		1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP					471,066	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	11,598	976	0	0	61,520	5.01
5.02	00591	A&G HOSPITAL ONLY	594	901	111	0	0	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	0	0	0	0	6.01
7.00	00700	OPERATION OF PLANT	5,182	154	296	0	1,326	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI	0	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	1,560	0	110	0	2,503	8.00
9.00	00900	HOUSEKEEPING	346	0	65	0	0	9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0	0	9.01
10.00	01000	DIETARY	2,536	0	0	0	715	10.00
11.00	01100	CAFETERIA	1,078	0	75	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	792	0	161	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,441	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	712	187	0	0	321	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	771	0	10,542	0	22,921	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,242	0	0	0	30,179	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,866	0	0	0	108,202	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	243	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	528	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,860	0	0	0	39,348	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,030	0	0	0	62,739	66.00
67.00	06700	OCCUPATIONAL THERAPY	216	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	156	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	4,894	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,870	0	1,509	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	783	0	0	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	593	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0	13,803	0	0	39,004	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0	0	0	0	1,719	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	4,087	0	0	0	9,721	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	82,347	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,594	0	0	6,992	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,325	18,398	13,230	0	471,066	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	293	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	0	21,571	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-1313

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

Worksheet B-1

Date/Time Prepared:
2/19/2020 6:01 pm

Cost Center Description		CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	NEW CAP REL COSTS - WEST CAMPUS BUIL (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	
		1.00	1.01	1.02	1.03	2.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	396,856	44,799	357,292	9,691	480,375	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	7.584443	2.434993	26.421060	0.449261	1.019762	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:14-1313

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALA RIE)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	A&G HOSPITAL ONLY (ACCUM. COST)	
		4.00	5A.01	5.01	5A.02	5.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING					1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG					1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL					1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,734,732				4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	768,795	-2,684,278	22,151,076		5.01
5.02	00591	A&G HOSPITAL ONLY	325,143	0	563,761	-632,078	5.02
6.00	00600	MAINTENANCE & REPAIRS	233,563	0	550,662	0	6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	0	0	0	6.01
7.00	00700	OPERATION OF PLANT	0	0	284,397	0	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	22,478	0	7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI	0	0	7,617	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	27,610	0	66,898	0	8.00
9.00	00900	HOUSEKEEPING	234,306	0	352,509	0	9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0	9.01
10.00	01000	DIETARY	226,772	0	332,203	0	10.00
11.00	01100	CAFETERIA	0	0	10,158	0	11.00
13.00	01300	NURSING ADMINISTRATION	185,336	0	248,133	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	80,962	0	117,756	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	125,237	0	234,375	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	269,588	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	918,267	0	1,566,340	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	178,677	0	325,750	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	141	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	516,670	0	998,851	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	67,231	0	142,809	0	54.01
56.00	05600	RADIOISOTOPE	0	0	102,629	0	56.00
58.00	05800	MRI	984	0	121,107	0	58.00
60.00	06000	LABORATORY	734,310	0	1,683,165	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	56,438	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	26,325	0	64.00
66.00	06600	PHYSICAL THERAPY	542,575	0	839,766	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	181,000	0	239,858	0	67.00
68.00	06800	SPEECH PATHOLOGY	31,804	0	25,028	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	0	560,917	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	422,767	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	303,723	0	755,355	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	199,733	0	355,156	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	4,859	0	19,787	0	76.01
76.02	03950	DIABETIC EDUCATION	40,446	0	60,791	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	3,678,188	0	5,065,490	-5,679,333	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	358,641	0	500,114	-560,718	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	631,435	0	891,929	0	88.02
91.00	09100	EMERGENCY	1,078,933	0	2,730,101	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	320,522	0	560,916	0	95.00
101.00	10100	HOME HEALTH AGENCY	604,641	0	858,350	-962,365	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,600,363	-2,684,278	21,970,415	-7,834,494	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	7,741	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	134,369	0	163,229	-183,009	192.00
194.00	07950	HOSPICE	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	9,691	-10,865	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,000,353		2,684,278	632,078	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-1313

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

Worksheet B-1

Date/Time Prepared:
2/19/2020 6:01 pm

Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALA RIE)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	A&G HOSPITAL ONLY (ACCUM. COST)	
		4.00	5A.01	5.01	5A.02	5.02	
203.00	Unit cost multiplier (Wkst. B, Part I)	0.157079		0.121180		0.037608	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0		153,076		13,528	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000		0.006911		0.000805	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-1313

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

Worksheet B-1

Date/Time Prepared:
2/19/2020 6:01 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	MAINTENANCE & REPAIRS - WEST CAMPUS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-CLINIC (SQUARE FEET)	OPERATION OF PLANT - WEST CAMPUS BUI (SQUARE FEET)	
		6.00	6.01	7.00	7.01	7.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING					1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG					1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL					1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	ADMINISTRATIVE AND GENERAL					5.01
5.02	00591	A&G HOSPITAL ONLY					5.02
6.00	00600	MAINTENANCE & REPAIRS	70,066				6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS	0	21,571			6.01
7.00	00700	OPERATION OF PLANT	5,632	0	48,067		7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	0	14,773	7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	1,669	0	1,669	0	8.00
9.00	00900	HOUSEKEEPING	412	0	412	0	9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	0	0	9.01
10.00	01000	DIETARY	2,536	0	2,536	0	10.00
11.00	01100	CAFETERIA	1,153	0	1,153	0	11.00
13.00	01300	NURSING ADMINISTRATION	953	0	953	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,441	0	1,441	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	899	0	712	187	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	11,313	0	11,313	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,242	0	6,242	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,866	0	4,866	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	243	0	243	0	54.01
56.00	05600	RADIOISOTOPE	528	0	528	0	56.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	2,860	0	2,860	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,030	0	1,030	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	216	0	216	0	67.00
68.00	06800	SPEECH PATHOLOGY	156	0	156	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	4,894	0	4,894	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,870	0	1,870	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	783	0	0	783	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	593	0	593	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	13,803	0	0	13,803	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0	0	0	0	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0	0	0	0	88.02
91.00	09100	EMERGENCY	4,087	0	4,087	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	1,594	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	69,773	0	47,774	14,773	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	293	0	293	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	21,571	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	640,610	0	382,345	26,150	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.142951	0.000000	7.954418	1.770121	0.410783

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-1313

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

Worksheet B-1

Date/Time Prepared:
2/19/2020 6:01 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	MAINTENANCE & REPAIRS - WEST CAMPUS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-CLINIC (SQUARE FEET)	OPERATION OF PLANT - WEST CAMPUS BUI (SQUARE FEET)	
			6.00	6.01	7.00	7.01	7.02	
204.00		Cost to be allocated (per Wkst. B, Part II)	4,303	0	51,419	175	60	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.061414	0.000000	1.069736	0.011846	0.002782	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-1313

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

Worksheet B-1

Date/Time Prepared:
2/19/2020 6:01 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	HOUSEKEEPING - WEST CAMPUS BUILDING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		8.00	9.00	9.01	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING					1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG					1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL					1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	ADMINISTRATIVE AND GENERAL					5.01
5.02	00591	A&G HOSPITAL ONLY					5.02
6.00	00600	MAINTENANCE & REPAIRS					6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS					6.01
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT-CLINIC					7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI					7.02
8.00	00800	LAUNDRY & LINEN SERVICE	62,660				8.00
9.00	00900	HOUSEKEEPING	0	62,353			9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING	0	0	21,571		9.01
10.00	01000	DIETARY	0	2,536	0	34,571	10.00
11.00	01100	CAFETERIA	0	1,153	0	27,806	11.00
13.00	01300	NURSING ADMINISTRATION	0	953	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,441	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	899	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	26,033	11,313	0	5,573	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,343	6,242	0	43	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,453	4,866	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	243	0	0	54.01
56.00	05600	RADIOISOTOPE	0	528	0	0	56.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	169	2,860	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	2,518	1,030	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	216	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	156	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	863	4,894	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,870	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	783	0	1,095	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	593	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	422	13,803	0	0	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	40	0	0	0	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0	0	0	0	88.02
91.00	09100	EMERGENCY	14,610	4,087	0	54	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	141	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	45	1,594	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	62,637	62,060	0	34,571	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	293	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	23	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	21,571	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	106,362	417,134	0	446,791	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.697447	6.689879	0.000000	12.923867	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-1313

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

Worksheet B-1

Date/Time Prepared:
2/19/2020 6:01 pm

Cost Center Description			LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	HOUSEKEEPING - WEST CAMPUS BUILDING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			8.00	9.00	9.01	10.00	11.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	19,699	7,561	0	25,736	32,381	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.314379	0.121261	0.000000	0.744439	2.070264	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-1313

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

Worksheet B-1

Date/Time Prepared:
2/19/2020 6:01 pm

Cost Center Description		NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQ UI SI)	PHARMACY (COSTED REQ UI SI)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		13.00	14.00	15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING					1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG					1.02
1.03	00103	NEW CAP REL COSTS - WEST CAMPUS BUIL					1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	ADMINISTRATIVE AND GENERAL					5.01
5.02	00591	A&G HOSPITAL ONLY					5.02
6.00	00600	MAINTENANCE & REPAIRS					6.00
6.01	00601	MAINTENANCE & REPAIRS - WEST CAMPUS					6.01
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT-CLINIC					7.01
7.02	00702	OPERATION OF PLANT - WEST CAMPUS BUI					7.02
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
9.01	00901	HOUSEKEEPING - WEST CAMPUS BUILDING					9.01
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	47,146				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	994,819			14.00
15.00	01500	PHARMACY	0	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	42,753,991	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	29,193	0	0	2,524,696	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,841	0	0	1,129,546	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	656,591	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,340	0	6,752,163	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	1,870	0	819,564	54.01
56.00	05600	RADIOISOTOPE	0	49,437	0	504,989	56.00
58.00	05800	MRI	0	2,788	0	1,308,745	58.00
60.00	06000	LABORATORY	0	429,247	0	8,031,197	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	56,438	0	86,246	62.00
64.00	06400	INTRAVENOUS THERAPY	0	17,932	0	487,522	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,224,268	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	882,899	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	96,191	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	1,797,616	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	422,767	0	638,299	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	969,365	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,574	0	0	933,861	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	39,204	76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	23,231	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0	0	0	4,055,895	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0	0	0	359,823	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0	0	0	725,691	88.02
91.00	09100	EMERGENCY	9,538	0	0	2,826,372	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	2,533,205	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	2,346,812	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	47,146	994,819	0	42,753,991	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	194.02
194.03	07954	FITNESS CENTER - WEST CAMPUS	0	0	0	0	194.03
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	316,354	178,149	0	300,203	313,624

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-1313

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

Worksheet B-1

Date/Time Prepared:
2/19/2020 6:01 pm

Cost Center Description		NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQ UI SI)	PHARMACY (COSTED REQ UI SI)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		13.00	14.00	15.00	16.00	19.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	6.710092	0.179077	0.000000	0.007022	3,136.240000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	13,802	14,212	0	9,536	2,106	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.292750	0.014286	0.000000	0.000223	21.060000	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:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/19/2020 6:01 pm

		Title XVIII		Hospital		Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	2,470,263		2,470,263	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	592,679		592,679	0	0	50.00
53.00	05300 ANESTHESIOLOGY	318,399		318,399	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,369,154		1,369,154	0	0	54.00
54.01	05401 RADIOLOGY-ULTRASOUND	180,837		180,837	0	0	54.01
56.00	05600 RADIOISOTOPE	145,268		145,268	0	0	56.00
58.00	05800 MRI	150,681		150,681	0	0	58.00
60.00	06000 LABORATORY	2,200,316		2,200,316	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	76,370		76,370	0	0	62.00
64.00	06400 INTRAVENOUS THERAPY	37,259		37,259	0	0	64.00
66.00	06600 PHYSICAL THERAPY	1,041,669	0	1,041,669	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	295,932	0	295,932	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	34,598	0	34,598	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	03160 CARDIOPULMONARY	802,997		802,997	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	572,014		572,014	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	939,432		939,432	0	0	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	481,226		481,226	0	0	76.00
76.01	03952 TELEMEDICINE PSYCH SERVICES	23,574		23,574	0	0	76.01
76.02	03950 DIABETIC EDUCATION	86,086		86,086	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 HAVANA MEDICAL ASSOCIATES RHC	6,060,472		6,060,472	0	0	88.00
88.01	08801 MASON CITY MEDICAL ASSOCIATES	563,313		563,313	0	0	88.01
88.02	08802 MANITO MEDICAL CLINIC RHC	1,042,717		1,042,717	0	0	88.02
91.00	09100 EMERGENCY	3,456,625		3,456,625	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	274,520		274,520			92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	670,566		670,566	0	0	95.00
101.00	10100 HOME HEALTH AGENCY	1,004,158		1,004,158			101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	24,891,125	0	24,891,125	0	0	200.00
201.00	Less Observation Beds	274,520		274,520			201.00
202.00	Total (see instructions)	24,616,605	0	24,616,605	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/19/2020 6:01 pm

			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	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,914,922		1,914,922		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	83,598	1,045,948	1,129,546	0.524706	50.00
53.00	05300	ANESTHESIOLOGY	57,056	599,535	656,591	0.484927	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	255,804	6,496,359	6,752,163	0.202773	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	45,199	774,365	819,564	0.220650	54.01
56.00	05600	RADIOISOTOPE	10,851	494,138	504,989	0.287666	56.00
58.00	05800	MRI	8,813	1,299,932	1,308,745	0.115134	58.00
60.00	06000	LABORATORY	501,934	7,529,263	8,031,197	0.273971	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	42,695	43,551	86,246	0.885490	62.00
64.00	06400	INTRAVENOUS THERAPY	32,099	455,423	487,522	0.076425	64.00
66.00	06600	PHYSICAL THERAPY	372,795	1,851,473	2,224,268	0.468320	66.00
67.00	06700	OCCUPATIONAL THERAPY	384,743	498,156	882,899	0.335182	67.00
68.00	06800	SPEECH PATHOLOGY	19,055	77,136	96,191	0.359680	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
69.01	03160	CARDIOPULMONARY	235,585	1,562,031	1,797,616	0.446701	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	284,211	354,088	638,299	0.896154	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	298,670	670,695	969,365	0.969121	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	933,861	933,861	0.515308	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	39,204	39,204	0.601316	76.01
76.02	03950	DIABETIC EDUCATION	0	23,231	23,231	3.705652	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0	4,055,895	4,055,895		88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0	359,823	359,823		88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0	725,691	725,691		88.02
91.00	09100	EMERGENCY	8,651	2,817,721	2,826,372	1.222990	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	609,774	609,774	0.450200	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	2,198	2,531,007	2,533,205	0.264711	95.00
101.00	10100	HOME HEALTH AGENCY	0	2,346,812	2,346,812		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	4,558,879	38,195,112	42,753,991		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	4,558,879	38,195,112	42,753,991		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/19/2020 6:01 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	05401 RADIOLOGY-ULTRASOUND	0.000000			54.01
56.00	05600 RADIOISOTOPE	0.000000			56.00
58.00	05800 MRI	0.000000			58.00
60.00	06000 LABORATORY	0.000000			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000			62.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
69.01	03160 CARDIOPULMONARY	0.000000			69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000			76.00
76.01	03952 TELEMEDICINE PSYCH SERVICES	0.000000			76.01
76.02	03950 DIABETIC EDUCATION	0.000000			76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 HAVANA MEDICAL ASSOCIATES RHC				88.00
88.01	08801 MASON CITY MEDICAL ASSOCIATES				88.01
88.02	08802 MANITO MEDICAL CLINIC RHC				88.02
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
101.00	10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/19/2020 6:01 pm

				Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	2,470,263		2,470,263	0	2,470,263	30.00	
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	592,679		592,679	0	592,679	50.00	
53.00	05300	ANESTHESIOLOGY	318,399		318,399	0	318,399	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,369,154		1,369,154	0	1,369,154	54.00	
54.01	05401	RADIOLOGY-ULTRASOUND	180,837		180,837	0	180,837	54.01	
56.00	05600	RADIOISOTOPE	145,268		145,268	0	145,268	56.00	
58.00	05800	MRI	150,681		150,681	0	150,681	58.00	
60.00	06000	LABORATORY	2,200,316		2,200,316	0	2,200,316	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	76,370		76,370	0	76,370	62.00	
64.00	06400	INTRAVENOUS THERAPY	37,259		37,259	0	37,259	64.00	
66.00	06600	PHYSICAL THERAPY	1,041,669	0	1,041,669	0	1,041,669	66.00	
67.00	06700	OCCUPATIONAL THERAPY	295,932	0	295,932	0	295,932	67.00	
68.00	06800	SPEECH PATHOLOGY	34,598	0	34,598	0	34,598	68.00	
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00	
69.01	03160	CARDIOPULMONARY	802,997		802,997	0	802,997	69.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	572,014		572,014	0	572,014	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	939,432		939,432	0	939,432	73.00	
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	481,226		481,226	0	481,226	76.00	
76.01	03952	TELEMEDICINE PSYCH SERVICES	23,574		23,574	0	23,574	76.01	
76.02	03950	DIABETIC EDUCATION	86,086		86,086	0	86,086	76.02	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	6,060,472		6,060,472	0	6,060,472	88.00	
88.01	08801	MASON CITY MEDICAL ASSOCIATES	563,313		563,313	0	563,313	88.01	
88.02	08802	MANITO MEDICAL CLINIC RHC	1,042,717		1,042,717	0	1,042,717	88.02	
91.00	09100	EMERGENCY	3,456,625		3,456,625	0	3,456,625	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	274,520		274,520		274,520	92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	670,566		670,566	0	670,566	95.00	
101.00	10100	HOME HEALTH AGENCY	1,004,158		1,004,158		1,004,158	101.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	24,891,125	0	24,891,125	0	24,891,125	200.00	
201.00		Less Observation Beds	274,520		274,520		274,520	201.00	
202.00		Total (see instructions)	24,616,605	0	24,616,605	0	24,616,605	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/19/2020 6:01 pm

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,914,922		1,914,922		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	83,598	1,045,948	1,129,546	0.524706	50.00
53.00	05300	ANESTHESIOLOGY	57,056	599,535	656,591	0.484927	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	255,804	6,496,359	6,752,163	0.202773	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	45,199	774,365	819,564	0.220650	54.01
56.00	05600	RADIOISOTOPE	10,851	494,138	504,989	0.287666	56.00
58.00	05800	MRI	8,813	1,299,932	1,308,745	0.115134	58.00
60.00	06000	LABORATORY	501,934	7,529,263	8,031,197	0.273971	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	42,695	43,551	86,246	0.885490	62.00
64.00	06400	INTRAVENOUS THERAPY	32,099	455,423	487,522	0.076425	64.00
66.00	06600	PHYSICAL THERAPY	372,795	1,851,473	2,224,268	0.468320	66.00
67.00	06700	OCCUPATIONAL THERAPY	384,743	498,156	882,899	0.335182	67.00
68.00	06800	SPEECH PATHOLOGY	19,055	77,136	96,191	0.359680	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
69.01	03160	CARDIOPULMONARY	235,585	1,562,031	1,797,616	0.446701	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	284,211	354,088	638,299	0.896154	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	298,670	670,695	969,365	0.969121	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	933,861	933,861	0.515308	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	39,204	39,204	0.601316	76.01
76.02	03950	DIABETIC EDUCATION	0	23,231	23,231	3.705652	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0	4,055,895	4,055,895	1.494238	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0	359,823	359,823	1.565528	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0	725,691	725,691	1.436861	88.02
91.00	09100	EMERGENCY	8,651	2,817,721	2,826,372	1.222990	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	609,774	609,774	0.450200	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	2,198	2,531,007	2,533,205	0.264711	95.00
101.00	10100	HOME HEALTH AGENCY	0	2,346,812	2,346,812		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	4,558,879	38,195,112	42,753,991		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	4,558,879	38,195,112	42,753,991		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/19/2020 6:01 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	05401 RADIOLOGY-ULTRASOUND	0.000000			54.01
56.00	05600 RADIOISOTOPE	0.000000			56.00
58.00	05800 MRI	0.000000			58.00
60.00	06000 LABORATORY	0.000000			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000			62.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
69.01	03160 CARDIOPULMONARY	0.000000			69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000			76.00
76.01	03952 TELEMEDICINE PSYCH SERVICES	0.000000			76.01
76.02	03950 DIABETIC EDUCATION	0.000000			76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 HAVANA MEDICAL ASSOCIATES RHC	0.000000			88.00
88.01	08801 MASON CITY MEDICAL ASSOCIATES	0.000000			88.01
88.02	08802 MANITO MEDICAL CLINIC RHC	0.000000			88.02
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
101.00	10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN:14-1313	Period: From 10/01/2018 To 09/30/2019	Worksheet D Part II Date/Time Prepared: 2/19/2020 6:01 pm
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	93,800	1,129,546	0.083042	71,484	5,936	50.00
53.00 05300 ANESTHESIOLOGY	147	656,591	0.000224	48,828	11	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	167,713	6,752,163	0.024838	123,990	3,080	54.00
54.01 05401 RADIOLOGY-ULTRASOUND	3,703	819,564	0.004518	24,228	109	54.01
56.00 05600 RADIOISOTOPE	6,362	504,989	0.012598	2,552	32	56.00
58.00 05800 MRI	1,286	1,308,745	0.000983	4,544	4	58.00
60.00 06000 LABORATORY	89,832	8,031,197	0.011185	229,864	2,571	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1,266	86,246	0.014679	23,536	345	62.00
64.00 06400 INTRAVENOUS THERAPY	571	487,522	0.001171	16,831	20	64.00
66.00 06600 PHYSICAL THERAPY	82,583	2,224,268	0.037128	68,588	2,547	66.00
67.00 06700 OCCUPATIONAL THERAPY	4,430	882,899	0.005018	60,391	303	67.00
68.00 06800 SPEECH PATHOLOGY	1,685	96,191	0.017517	2,975	52	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01 03160 CARDIOPULMONARY	49,922	1,797,616	0.027771	99,869	2,773	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	9,486	638,299	0.014861	149,276	2,218	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	60,170	969,365	0.062072	94,867	5,889	73.00
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	7,681	933,861	0.008225	0	0	76.00
76.01 03952 TELEMEDICINE PSYCH SERVICES	187	39,204	0.004770	0	0	76.01
76.02 03950 DIABETIC EDUCATION	5,809	23,231	0.250054	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 HAVANA MEDICAL ASSOCIATES RHC	120,959	4,055,895	0.029823	0	0	88.00
88.01 08801 MASON CITY MEDICAL ASSOCIATES	5,302	359,823	0.014735	0	0	88.01
88.02 08802 MANITO MEDICAL CLINIC RHC	7,131	725,691	0.009826	0	0	88.02
91.00 09100 EMERGENCY	81,426	2,826,372	0.028809	2,237	64	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	39,962	609,774	0.065536	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	841,413	35,959,052		1,024,060	25,954	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN:14-1313 Period: From 10/01/2018 To 09/30/2019 Worksheet D Part IV Date/Time Prepared: 2/19/2020 6:01 pm

Cost Center Description		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School Post-Stepdown Adjustments	Allied Health Post-Stepdown Adjustments	Allied Health Post-Stepdown Adjustments	
		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	313,624	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 RADIOLOGY-ULTRASOUND	0	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800 MRI	0	0	0	0	0	58.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160 CARDIOPULMONARY	0	0	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03952 TELEMEDICINE PSYCH SERVICES	0	0	0	0	0	76.01
76.02	03950 DIABETIC EDUCATION	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 HAVANA MEDICAL ASSOCIATES RHC	0	0	0	0	0	88.00
88.01	08801 MASON CITY MEDICAL ASSOCIATES	0	0	0	0	0	88.01
88.02	08802 MANITO MEDICAL CLINIC RHC	0	0	0	0	0	88.02
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00	Total (lines 50 through 199)	313,624	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN:14-1313 Period: From 10/01/2018 To 09/30/2019 Worksheet D Part IV Date/Time Prepared: 2/19/2020 6:01 pm

			Title XVIII		Hospital	Cost		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	1,129,546	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	313,624	0	656,591	0.477655	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,752,163	0.000000	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0	819,564	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	504,989	0.000000	56.00
58.00	05800	MRI	0	0	0	1,308,745	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	8,031,197	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	86,246	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	487,522	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,224,268	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	882,899	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	96,191	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	1,797,616	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	638,299	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	969,365	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	933,861	0.000000	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	0	39,204	0.000000	76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	23,231	0.000000	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0	0	0	4,055,895	0.000000	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0	0	0	359,823	0.000000	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0	0	0	725,691	0.000000	88.02
91.00	09100	EMERGENCY	0	0	0	2,826,372	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	609,774	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	313,624	0	35,959,052		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN:14-1313

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

Worksheet D
Part IV
Date/Time Prepared:
2/19/2020 6:01 pm

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	71,484	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	48,828	23,323	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	123,990	0	0	0	54.00
54.01	05401 RADIOLOGY-ULTRASOUND	0.000000	24,228	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	2,552	0	0	0	56.00
58.00	05800 MRI	0.000000	4,544	0	0	0	58.00
60.00	06000 LABORATORY	0.000000	229,864	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	23,536	0	0	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	16,831	0	0	0	64.00
66.00	06600 PHYSICAL THERAPY	0.000000	68,588	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	60,391	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	2,975	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03160 CARDIOPULMONARY	0.000000	99,869	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	149,276	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	94,867	0	0	0	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
76.01	03952 TELEMEDICINE PSYCH SERVICES	0.000000	0	0	0	0	76.01
76.02	03950 DIABETIC EDUCATION	0.000000	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 HAVANA MEDICAL ASSOCIATES RHC	0.000000	0	0	0	0	88.00
88.01	08801 MASON CITY MEDICAL ASSOCIATES	0.000000	0	0	0	0	88.01
88.02	08802 MANITO MEDICAL CLINIC RHC	0.000000	0	0	0	0	88.02
91.00	09100 EMERGENCY	0.000000	2,237	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		1,024,060	23,323	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part V
Date/Time Prepared:
2/19/2020 6:01 pm

		Title XVIII		Hospital		Cost	
Cost Center Description		Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Services	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.524706	0	477,257	0	50.00
53.00	05300	ANESTHESIOLOGY	0.484927	0	278,136	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202773	0	2,868,403	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.220650	0	308,600	0	54.01
56.00	05600	RADIOISOTOPE	0.287666	0	216,794	0	56.00
58.00	05800	MRI	0.115134	0	449,209	0	58.00
60.00	06000	LABORATORY	0.273971	0	3,398,567	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.885490	0	40,808	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.076425	0	176,660	0	64.00
66.00	06600	PHYSICAL THERAPY	0.468320	0	685,520	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.335182	0	69,863	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.359680	0	12,731	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.446701	0	733,446	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.896154	0	144,519	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.969121	0	328,759	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.515308	0	931,811	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.601316	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	3.705652	0	12,254	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0.000000			0	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0.000000			0	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0.000000			0	88.02
91.00	09100	EMERGENCY	1.222990	0	1,026,210	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.450200	0	142,615	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.264711		0		95.00
200.00		Subtotal (see instructions)		0	12,302,162	0	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0	201.00
202.00		Only Charges					
202.00		Net Charges (line 200 - line 201)		0	12,302,162	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part V
Date/Time Prepared:
2/19/2020 6:01 pm

			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	250,420	0	50.00
53.00	05300	ANESTHESIOLOGY	134,876	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	581,635	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	68,093	0	54.01
56.00	05600	RADIOISOTOPE	62,364	0	56.00
58.00	05800	MRI	51,719	0	58.00
60.00	06000	LABORATORY	931,109	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	36,135	0	62.00
64.00	06400	INTRAVENOUS THERAPY	13,501	0	64.00
66.00	06600	PHYSICAL THERAPY	321,043	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,417	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,579	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	03160	CARDIOPULMONARY	327,631	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	129,511	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	318,607	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	480,170	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0	76.01
76.02	03950	DIABETIC EDUCATION	45,409	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0	0	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0	0	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0	0	88.02
91.00	09100	EMERGENCY	1,255,045	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	64,205	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	5,099,469	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	5,099,469	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN:14-1313	Period: From 10/01/2018 To 09/30/2019	Worksheet D Part V Date/Time Prepared: 2/19/2020 6:01 pm
			Component CCN:14-Z313		
			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	0.524706	0	0	0	0 50.00
53.00 05300 ANESTHESIOLOGY	0.484927	0	0	0	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.202773	0	0	0	0 54.00
54.01 05401 RADIOLOGY-ULTRASOUND	0.220650	0	0	0	0 54.01
56.00 05600 RADIOISOTOPE	0.287666	0	0	0	0 56.00
58.00 05800 MRI	0.115134	0	0	0	0 58.00
60.00 06000 LABORATORY	0.273971	0	0	0	0 60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.885490	0	0	0	0 62.00
64.00 06400 INTRAVENOUS THERAPY	0.076425	0	0	0	0 64.00
66.00 06600 PHYSICAL THERAPY	0.468320	0	0	0	0 66.00
67.00 06700 OCCUPATIONAL THERAPY	0.335182	0	0	0	0 67.00
68.00 06800 SPEECH PATHOLOGY	0.359680	0	0	0	0 68.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0 69.00
69.01 03160 CARDIOPULMONARY	0.446701	0	0	0	0 69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.896154	0	0	0	0 71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.969121	0	0	0	0 73.00
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.515308	0	0	0	0 76.00
76.01 03952 TELEMEDICINE PSYCH SERVICES	0.601316	0	0	0	0 76.01
76.02 03950 DIABETIC EDUCATION	3.705652	0	0	0	0 76.02
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 HAVANA MEDICAL ASSOCIATES RHC	0.000000				0 88.00
88.01 08801 MASON CITY MEDICAL ASSOCIATES	0.000000				0 88.01
88.02 08802 MANITO MEDICAL CLINIC RHC	0.000000				0 88.02
91.00 09100 EMERGENCY	1.222990	0	0	0	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.450200	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES	0.264711		0		95.00
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:14-1313

Period:

Worksheet D

Component CCN:14-Z313

From 10/01/2018

Part V

To 09/30/2019

Date/Time Prepared:

2/19/2020 6:01 pm

				Title XVIII	Swing Beds - SNF	Cost
Cost Center Description	Costs					
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03160	CARDIOPULMONARY	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0	0		76.01
76.02	03950	DIABETIC EDUCATION	0	0		76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0	0		88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0	0		88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0	0		88.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN:14-1313	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/19/2020 6:01 pm
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,312 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			585 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.			19 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			435 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			146 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)			437 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			36 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)			108 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			312 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)			138 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)			414 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)			19 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			157.19 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			157.19 20.00
21.00	Total general inpatient routine service cost (see instructions)			2,470,263 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)			5,659 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)			16,977 25.00
26.00	Total swing-bed cost (see instructions)			1,244,353 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,225,910 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			897,627 28.00
29.00	Private room charges (excluding swing-bed charges)			40,407 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			857,220 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			1.365723 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			2,126.68 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			1,970.62 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			156.06 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			213.13 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			4,049 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27, minus line 36)			1,221,861 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			2,088.65 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			651,659 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			4,049 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			655,708 41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN:14-1313	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/19/2020 6:01 pm
			Title XVIII	Hospital	Cost
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00 CORONARY CARE UNIT					
45.00 BURN INTENSIVE CARE UNIT					
46.00 SURGICAL INTENSIVE CARE UNIT					
47.00 OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description					
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					504,527
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,160,235
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00 Total Program excludable cost (sum of lines 50 and 51)					0
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					288,234
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					864,701
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,152,935
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					
72.00 Program routine service cost (line 9 x line 71)					
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					
76.00 Per diem capital-related costs (line 75 ÷ line 2)					
77.00 Program capital-related costs (line 9 x line 76)					
78.00 Inpatient routine service cost (line 74 minus line 77)					
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					
81.00 Inpatient routine service cost per diem limitation					
82.00 Inpatient routine service cost limitation (line 9 x line 81)					
83.00 Reasonable inpatient routine service costs (see instructions)					
84.00 Program inpatient ancillary services (see instructions)					
85.00 Utilization review - physician compensation (see instructions)					
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					131
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,095.57
89.00 Observation bed cost (line 87 x line 88) (see instructions)					274,520

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN:14-1313

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

Worksheet D-1

Date/Time Prepared:
2/19/2020 6:01 pm

		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	359,599	2,470,263	0.145571	274,520	39,962
91.00	Nursing School cost	0	2,470,263	0.000000	274,520	0
92.00	Allied health cost	0	2,470,263	0.000000	274,520	0
93.00	All other Medical Education	0	2,470,263	0.000000	274,520	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN:14-1313

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

Worksheet D-3

Date/Time Prepared:
2/19/2020 6:01 pm

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		607,374	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.524706	71,484	50.00
53.00	05300	ANESTHESIOLOGY	0.484927	48,828	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202773	123,990	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.220650	24,228	54.01
56.00	05600	RADIOISOTOPE	0.287666	2,552	56.00
58.00	05800	MRI	0.115134	4,544	58.00
60.00	06000	LABORATORY	0.273971	229,864	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.885490	23,536	62.00
64.00	06400	INTRAVENOUS THERAPY	0.076425	16,831	64.00
66.00	06600	PHYSICAL THERAPY	0.468320	68,588	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.335182	60,391	67.00
68.00	06800	SPEECH PATHOLOGY	0.359680	2,975	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
69.01	03160	CARDIOPULMONARY	0.446701	99,869	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.896154	149,276	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.969121	94,867	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.515308	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.601316	0	76.01
76.02	03950	DIABETIC EDUCATION	3.705652	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0.000000	0	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0.000000	0	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0.000000	0	88.02
91.00	09100	EMERGENCY	1.222990	2,237	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.450200	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,024,060	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)		1,024,060	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN:14-1313

Period:

Worksheet D-3

Component CCN:14-Z313

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/19/2020 6:01 pm

Cost Center Description		Title XVIII	Swing Beds - SNF	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		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.524706	0	50.00
53.00	05300	ANESTHESIOLOGY	0.484927	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202773	23,333	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.220650	9,361	54.01
56.00	05600	RADIOISOTOPE	0.287666	2,317	56.00
58.00	05800	MRI	0.115134	0	58.00
60.00	06000	LABORATORY	0.273971	154,226	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.885490	8,947	62.00
64.00	06400	INTRAVENOUS THERAPY	0.076425	6,912	64.00
66.00	06600	PHYSICAL THERAPY	0.468320	215,117	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.335182	227,616	67.00
68.00	06800	SPEECH PATHOLOGY	0.359680	3,248	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
69.01	03160	CARDIOPULMONARY	0.446701	57,236	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.896154	86,060	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.969121	122,924	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.515308	0	76.00
76.01	03952	TELEMEDICINE PSYCH SERVICES	0.601316	0	76.01
76.02	03950	DIABETIC EDUCATION	3.705652	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	HAVANA MEDICAL ASSOCIATES RHC	0.000000	0	88.00
88.01	08801	MASON CITY MEDICAL ASSOCIATES	0.000000	0	88.01
88.02	08802	MANITO MEDICAL CLINIC RHC	0.000000	0	88.02
91.00	09100	EMERGENCY	1.222990	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.450200	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		917,297	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)		917,297	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-1313	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part B Date/Time Prepared: 2/19/2020 6:01 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,099,469	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		5,099,469	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		5,150,464	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)		45,372	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,766,254	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)		3,338,838	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)		3,338,838	30.00
31.00	Primary payer payments		380	31.00
32.00	Subtotal (line 30 minus line 31)		3,338,458	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)		237,872	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		154,617	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		148,505	36.00
37.00	Subtotal (see instructions)		3,493,075	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)		3,493,075	40.00
40.01	Sequestration adjustment (see instructions)		69,862	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		3,600,360	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-177,147	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet E-1
Part I
Date/Time Prepared:
2/19/2020 6:01 pm

		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		900,831		3,600,360	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	09/15/2019	241,000		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)		241,000		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,141,831		3,600,360	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		96,257		177,147	6.02
7.00	Total Medicare program liability (see instructions)		1,045,574		3,423,213	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN:14-1313

Period:

Worksheet E-1

Component CCN:14-Z313

From 10/01/2018

Part I

To 09/30/2019

Date/Time Prepared:

2/19/2020 6:01 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,535,101		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	09/15/2019	154,700		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)		154,700		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,689,801		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		103,781		0	6.02
7.00	Total Medicare program liability (see instructions)		1,586,020		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet E-1
Part II
Date/Time Prepared:
2/19/2020 6:01 pm

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN:14-1313

Period:

Worksheet E-2

Component CCN:14-Z313

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/19/2020 6:01 pm

		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1,164,464	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-3, col. 6 and 7, line 202, for Part B) (For CAH, see instructions)	Part 462,772		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	552		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		0	7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,627,236		0	8.00
9.00	Primary payer payments (see instructions)	0		0	9.00
10.00	Subtotal (line 8 minus line 9)	1,627,236		0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		0	11.00
12.00	Subtotal (line 10 minus line 11)	1,627,236		0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	8,848		0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,618,388		0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)	0			16.55
16.99	Demonstration payment adjustment amount before sequestration	0		0	16.99
17.00	Allowable bad debts (see instructions)	0		0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		0	18.00
19.00	Total (see instructions)	1,618,388		0	19.00
19.01	Sequestration adjustment (see instructions)	32,368		0	19.01
19.02	Demonstration payment adjustment amount after sequestration	0		0	19.02
20.00	Interim payments	1,689,801		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)	-103,781		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))	66			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)	1 and			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-1313	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part V Date/Time Prepared: 2/19/2020 6:01 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,160,235	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		1,160,235	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,160,235	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		1,160,235	19.00
20.00	Deductibles (exclude professional component)		105,888	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,054,347	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,054,347	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		19,331	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		12,565	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		19,331	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,066,912	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		1,066,912	30.00
30.01	Sequestration adjustment (see instructions)		21,338	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		1,141,831	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)		-96,257	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §15.2		0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)		Provider CCN:14-1313		Period: From 10/01/2018 To 09/30/2019		Worksheet G Date/Time Prepared: 2/19/2020 6:01 pm	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund		
		1.00	2.00	3.00	4.00		
CURRENT ASSETS							
1.00	Cash on hand in banks	8,855,986	0	0	0	1.00	
2.00	Temporary investments	1,233,903	0	0	0	2.00	
3.00	Notes receivable	0	0	0	0	3.00	
4.00	Accounts receivable	4,319,023	0	0	0	4.00	
5.00	Other receivable	0	0	0	0	5.00	
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00	
7.00	Inventory	518,929	0	0	0	7.00	
8.00	Prepaid expenses	154,750	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)	15,082,591	0	0	0	11.00	
FIXED ASSETS							
12.00	Land	0	0	0	0	12.00	
13.00	Land improvements	0	0	0	0	13.00	
14.00	Accumulated depreciation	0	0	0	0	14.00	
15.00	Buildings	11,124,312	0	0	0	15.00	
16.00	Accumulated depreciation	0	0	0	0	16.00	
17.00	Leasehold improvements	0	0	0	0	17.00	
18.00	Accumulated depreciation	0	0	0	0	18.00	
19.00	Fixed equipment	0	0	0	0	19.00	
20.00	Accumulated depreciation	0	0	0	0	20.00	
21.00	Automobiles and trucks	0	0	0	0	21.00	
22.00	Accumulated depreciation	0	0	0	0	22.00	
23.00	Major movable equipment	0	0	0	0	23.00	
24.00	Accumulated depreciation	0	0	0	0	24.00	
25.00	Minor equipment depreciable	0	0	0	0	25.00	
26.00	Accumulated depreciation	0	0	0	0	26.00	
27.00	HIT designated Assets	0	0	0	0	27.00	
28.00	Accumulated depreciation	0	0	0	0	28.00	
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00	
30.00	Total fixed assets (sum of lines 12-29)	11,124,312	0	0	0	30.00	
OTHER ASSETS							
31.00	Investments	0	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	6,066,314	0	0	0	34.00	
35.00	Total other assets (sum of lines 31-34)	6,066,314	0	0	0	35.00	
36.00	Total assets (sum of lines 11, 30, and 35)	32,273,217	0	0	0	36.00	
CURRENT LIABILITIES							
37.00	Accounts payable	788,273	0	0	0	37.00	
38.00	Salaries, wages, and fees payable	751,912	0	0	0	38.00	
39.00	Payroll taxes payable	0	0	0	0	39.00	
40.00	Notes and loans payable (short term)	862,990	0	0	0	40.00	
41.00	Deferred income	0	0	0	0	41.00	
42.00	Accelerated payments	0	0	0	0	42.00	
43.00	Due to other funds	1,406,804	0	0	0	43.00	
44.00	Other current liabilities	1,444,015	0	0	0	44.00	
45.00	Total current liabilities (sum of lines 37 thru 44)	5,253,994	0	0	0	45.00	
LONG TERM LIABILITIES							
46.00	Mortgage payable	0	0	0	0	46.00	
47.00	Notes payable	5,751,808	0	0	0	47.00	
48.00	Unsecured loans	0	0	0	0	48.00	
49.00	Other long term liabilities	8,253,208	0	0	0	49.00	
50.00	Total long term liabilities (sum of lines 46 thru 49)	14,005,016	0	0	0	50.00	
51.00	Total liabilities (sum of lines 45 and 50)	19,259,010	0	0	0	51.00	
CAPITAL ACCOUNTS							
52.00	General fund balance	13,014,207	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)	13,014,207	0	0	0	59.00	
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	32,273,217	0	0	0	60.00	

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN:14-1313

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

Worksheet G-1

Date/Time Prepared:
2/19/2020 6:01 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		11,266,381		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,747,826				2.00
3.00	Total (sum of line 1 and line 2)		13,014,207		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)		13,014,207		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		13,014,207		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN:14-1313

Period:
From 10/01/2018
To 09/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
2/19/2020 6:01 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,771,594		1,771,594	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	1,007,820		1,007,820	5.00
6.00	Swing bed - NF	3,650		3,650	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,783,064		2,783,064	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,783,064		2,783,064	17.00
18.00	Ancillary services	2,637,838	25,416,902	28,054,740	18.00
19.00	Outpatient services	11,423	5,305,445	5,316,868	19.00
20.00	HAVANA MEDICAL ASSOCIATES RHC	0	4,055,895	4,055,895	20.00
20.01	MASON CITY MEDICAL ASSOCIATES	0	359,823	359,823	20.01
20.02	MANITO MEDICAL CLINIC RHC	0	725,691	725,691	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,346,812	2,346,812	22.00
23.00	AMBULANCE SERVICES	2,198	2,539,413	2,541,611	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER NRCC	0	-49,054	-49,054	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. line 1)	6-3,5,434,523	40,700,927	46,135,450	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		26,782,676		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	EMPLOYEE PHYSICALS	19,803			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)		19,803		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		26,762,873		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN:14-1313

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

Worksheet G-3

Date/Time Prepared:
2/19/2020 6:01 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	46,135,450	1.00
2.00	Less contractual allowances and discounts on patients' accounts	22,300,204	2.00
3.00	Net patient revenues (line 1 minus line 2)	23,835,246	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	26,762,873	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,927,627	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	2,895,250	6.00
7.00	Income from investments	171,369	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	873,037	23.00
24.00	OTHER REVENUE	612,326	24.00
24.01	GRANT REVENUE	93,476	24.01
24.02	ELECTRONIC HEALTH RECORDS INCENTIVE	29,995	24.02
24.03	OTHER (SPECIFY)	0	24.03
24.04	OTHER (SPECIFY)	0	24.04
25.00	Total other income (sum of lines 6-24)	4,675,453	25.00
26.00	Total (line 5 plus line 25)	1,747,826	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
27.01	OTHER EXPENSES (SPECIFY)	0	27.01
27.02	OTHER EXPENSES (SPECIFY)	0	27.02
27.03	OTHER EXPENSES (SPECIFY)	0	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,747,826	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS					Provider CCN:14-1313 HHA CCN: 14-7202	Period: From 10/01/2018 To 09/30/2019	Worksheet H Date/Time Prepared: 2/19/2020 6:01 pm	
						Home Health Agency I	PPS	
		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Pur- chased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	153,843	11,272	55,452	0	48,149	268,716	5.00
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	419,778	30,757	0	0	0	450,535	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	31,019	2,273	0	0	0	33,292	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	604,640	44,302	55,452	0	48,149	752,543	24.00
		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	268,716	-180	268,536			5.00
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	0	450,535	0	450,535			6.00
7.00	Physical Therapy	0	0	0	0			7.00
8.00	Occupational Therapy	0	0	0	0			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	33,292	0	33,292			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	0	752,543	-180	752,363			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN:14-1313

Period:

Worksheet H-1

HHA CCN: 14-7202

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/19/2020 6:01 pmHome Health
Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
			Bldgs & Fixtures	Movable Equipment				
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	268,536	0	0	0	0	268,536	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	450,535	0	0	0	0	450,535	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	33,292	0	0	0	0	33,292	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	752,363	0	0	0	0	752,363	24.00
		Administrative	Total (cols. 4A					
		& General	+ 5)					
		5.00	6.00					
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	268,536						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	250,058	700,593					6.00
7.00	Physical Therapy	0	0					7.00
8.00	Occupational Therapy	0	0					8.00
9.00	Speech Pathology	0	0					9.00
10.00	Medical Social Services	0	0					10.00
11.00	Home Health Aide	18,478	51,770					11.00
12.00	Supplies (see instructions)	0	0					12.00
13.00	Drugs	0	0					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
23.50	Telemedicine	0	0					23.50
24.00	Total (sum of lines 1-23)		752,363					24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN:14-1313

Period:

Worksheet H-1

HHA CCN: 14-7202

From 10/01/2018
To 09/30/2019Part II
Date/Time Prepared:
2/19/2020 6:01 pmHome Health
Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00	3.00	4.00	5A.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-268,536	483,827 5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	450,535	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	33,292	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-268,536	483,827 24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		268,536 25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.555025 26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN:14-1313

Period:

Worksheet H-2

HHA CCN: 14-7202

From 10/01/2018

Part I

To 09/30/2019

Date/Time Prepared:

Home Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS				MVBLE EQUIP	
			BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	NEW CAP REL COSTS - WEST CAMPUS BUIL		
		0	1.00	1.01	1.02	1.03	2.00	
1.00	Administrative and General	0	0	3,881	0	0	7,130	1.00
2.00	Skilled Nursing Care	700,593	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	51,770	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	752,363	0	3,881	0	0	7,130	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE AND GENERAL	Subtotal	A&G HOSPITAL ONLY	MAINTENANCE & REPAIRS	
		4.00	4A	5.01	5A.01	5.02	6.00	
1.00	Administrative and General	94,976	105,987	12,844	118,831	0	14,574	1.00
2.00	Skilled Nursing Care	0	700,593	84,898	785,491	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	51,770	6,273	58,043	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	94,976	858,350	104,015	962,365	0	14,574	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.000000		0.000000			21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN:14-1313

Period:

Worksheet H-2

HHA CCN: 14-7202

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/19/2020 6:01 pmHome Health
Agency I

PPS

Cost Center Description		MAINTENANCE & REPAIRS - WEST CAMPUS	OPERATION OF PLANT	OPERATION OF PLANT-CLINIC	OPERATION OF PLANT - WEST CAMPUS BUI	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		6.01	7.00	7.01	7.02	8.00	9.00	
1.00	Administrative and General	0	0	0	0	76	10,664	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	76	10,664	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	6						21.00
Cost Center Description		HOUSEKEEPING - WEST CAMPUS BUILDING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.01	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	6						21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN:14-1313

Period:

Worksheet H-2

HHA CCN: 14-7202

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/19/2020 6:01 pmHome Health
Agency I

PPS

Cost Center Description		MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		16.00	19.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	16,479	0	160,624	0	160,624		1.00
2.00	Skilled Nursing Care	0	0	785,491	0	785,491	149,572	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	58,043	0	58,043	11,052	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	16,479	0	1,004,158	0	1,004,158	160,624	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						0.190418	21.00
Cost Center Description		Total HHA Costs						
		28.00						
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	935,063						2.00
3.00	Physical Therapy	0						3.00
4.00	Occupational Therapy	0						4.00
5.00	Speech Pathology	0						5.00
6.00	Medical Social Services	0						6.00
7.00	Home Health Aide	69,095						7.00
8.00	Supplies (see instructions)	0						8.00
9.00	Drugs	0						9.00
10.00	DME	0						10.00
11.00	Home Dialysis Aide Services	0						11.00
12.00	Respiratory Therapy	0						12.00
13.00	Private Duty Nursing	0						13.00
14.00	Clinic	0						14.00
15.00	Health Promotion Activities	0						15.00
16.00	Day Care Program	0						16.00
17.00	Home Delivered Meals Program	0						17.00
18.00	Homemaker Service	0						18.00
19.00	All Others (specify)	0						19.00
19.50	Telemedicine	0						19.50
20.00	Total (sum of lines 1-19) (2)	1,004,158						20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN:14-1313

Period:

Worksheet H-2

HHA CCN: 14-7202

From 10/01/2018

Part II

To 09/30/2019

Date/Time Prepared:

Home Health
Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS					EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	
		BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	NEW CAP REL COSTS - WEST CAMPUS BUIL (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)		
		1.00	1.01	1.02	1.03	2.00		
1.00	Administrative and General	0	1,594	0	0	6,992	604,641	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	1,594	0	0	6,992	604,641	20.00
21.00	Total cost to be allocated	0	3,881	0	0	7,130	94,976	21.00
22.00	Unit cost multiplier	0.000000	2.434755	0.000000	0.000000	1.019737	0.157078	22.00
Cost Center Description		Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	A&G HOSPITAL ONLY (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	MAINTENANCE & REPAIRS - WEST CAMPUS (SQUARE FEET)	
		5A.01	5.01	5A.02	5.02	6.00	6.01	
1.00	Administrative and General	0	105,987	-118,831	0	1,594	0	1.00
2.00	Skilled Nursing Care	0	700,593	-785,491	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	51,770	-58,043	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	858,350	0	0	1,594	0	20.00
21.00	Total cost to be allocated	0	104,015	0	0	14,574	0	21.00
22.00	Unit cost multiplier	0.121180	0.121180	0.000000	0.000000	9.143036	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS					Provider CCN:14-1313 HHA CCN: 14-7202	Period: From 10/01/2018 To 09/30/2019	Worksheet H-2 Part II Date/Time Prepared: 2/19/2020 6:01 pm
						Home Health Agency I	PPS
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-CLINIC (SQUARE FEET)	OPERATION OF PLANT - WEST CAMPUS BUI (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	HOUSEKEEPING - WEST CAMPUS BUILDING (SQUARE FEET)	
	7.00	7.01	7.02	8.00	9.00	9.01	
1.00 Administrative and General	0	0	0	45	1,594	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	0	0	0	45	1,594	0	20.00
21.00 Total cost to be allocated	0	0	0	76	10,664	0	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.000000	1.688889	6.690088	0.000000	22.00
Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQ UI SI)	PHARMACY (COSTED REQ UI SI)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	
	10.00	11.00	13.00	14.00	15.00	16.00	
1.00 Administrative and General	0	0	0	0	0	2,346,812	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	0	0	0	0	0	2,346,812	20.00
21.00 Total cost to be allocated	0	0	0	0	0	16,479	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	0.007022	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS		Provider CCN:14-1313	Period: From 10/01/2018 To 09/30/2019	Worksheet H-2 Part II Date/Time Prepared: 2/19/2020 6:01 pm
		HHA CCN: 14-7202		
			Home Health Agency I	PPS

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN:14-1313

Period:

Worksheet H-3

HHA CCN: 14-7202

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/19/2020 6:01 pm

				Title XVIII		Home Health Agency I	PPS	
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	935,063		935,063	5,247	178.21	1.00
2.00	Physical Therapy	3.00	0	227,755	227,755	1,539	147.99	2.00
3.00	Occupational Therapy	4.00	0	70,478	70,478	665	105.98	3.00
4.00	Speech Pathology	5.00	0	7,786	7,786	69	112.84	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	69,095		69,095	676	102.21	6.00
7.00	Total (sum of lines 1-6)		1,004,158	306,019	1,310,177	8,196		7.00
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits			
					Part B			
					Not Subject to Deductibles & Coinsurance	Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care		37900	0	8			8.00
8.01	Skilled Nursing Care		44100	0	85			8.01
8.02	Skilled Nursing Care		99914	0	3,637			8.02
9.00	Physical Therapy		37900	0	14			9.00
9.01	Physical Therapy		44100	0	19			9.01
9.02	Physical Therapy		99914	0	1,031			9.02
10.00	Occupational Therapy		37900	0	7			10.00
10.01	Occupational Therapy		44100	0	17			10.01
10.02	Occupational Therapy		99914	0	451			10.02
11.00	Speech Pathology		37900	0	0			11.00
11.01	Speech Pathology		44100	0	0			11.01
11.02	Speech Pathology		99914	0	28			11.02
12.00	Medical Social Services		37900	0	0			12.00
12.01	Medical Social Services		44100	0	0			12.01
12.02	Medical Social Services		99914	0	0			12.02
13.00	Home Health Aide		37900	0	1			13.00
13.01	Home Health Aide		44100	0	3			13.01
13.02	Home Health Aide		99914	0	653			13.02
14.00	Total (sum of lines 8-13)			0	5,954			14.00
Cost Center Description		From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	0	95,716	95,716	106,808	0.896150	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00
Cost Center Description		Program Visits			Cost of Services			
		Part A	Part B		Part A	Part B	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance				
6.00	7.00	8.00	9.00	10.00	11.00			
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	0	3,730		0	664,723		1.00
2.00	Physical Therapy	0	1,064		0	157,461		2.00
3.00	Occupational Therapy	0	475		0	50,341		3.00
4.00	Speech Pathology	0	28		0	3,160		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	657		0	67,152		6.00
7.00	Total (sum of lines 1-6)	0	5,954		0	942,837		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN:14-1313

Period:

Worksheet H-3

HHA CCN: 14-7202

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/19/2020 6:01 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description						Agency 1			
		6.00	7.00	8.00	9.00	10.00	11.00		
Limitation Cost Computation									
8.00	Skilled Nursing Care							8.00	
8.01	Skilled Nursing Care							8.01	
8.02	Skilled Nursing Care							8.02	
9.00	Physical Therapy							9.00	
9.01	Physical Therapy							9.01	
9.02	Physical Therapy							9.02	
10.00	Occupational Therapy							10.00	
10.01	Occupational Therapy							10.01	
10.02	Occupational Therapy							10.02	
11.00	Speech Pathology							11.00	
11.01	Speech Pathology							11.01	
11.02	Speech Pathology							11.02	
12.00	Medical Social Services							12.00	
12.01	Medical Social Services							12.01	
12.02	Medical Social Services							12.02	
13.00	Home Health Aide							13.00	
13.01	Home Health Aide							13.01	
13.02	Home Health Aide							13.02	
14.00	Total (sum of lines 8-13)							14.00	
Cost Center Description		Program Covered Charges			Cost of Services				
		Part A	Part B		Part A	Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
			6.00	7.00		8.00	9.00	10.00	11.00
Supplies and Drugs Cost Computations									
15.00	Cost of Medical Supplies	0	27,079	0	0	24,267	0	15.00	
16.00	Cost of Drugs		0	0		0	0	16.00	
Cost Center Description		Total Program Cost (sum of cols. 9-10)							
		12.00							
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	664,723						1.00	
2.00	Physical Therapy	157,461						2.00	
3.00	Occupational Therapy	50,341						3.00	
4.00	Speech Pathology	3,160						4.00	
5.00	Medical Social Services	0						5.00	
6.00	Home Health Aide	67,152						6.00	
7.00	Total (sum of lines 1-6)	942,837						7.00	
Cost Center Description									
		12.00							
Limitation Cost Computation									
8.00	Skilled Nursing Care							8.00	
8.01	Skilled Nursing Care							8.01	
8.02	Skilled Nursing Care							8.02	
9.00	Physical Therapy							9.00	
9.01	Physical Therapy							9.01	
9.02	Physical Therapy							9.02	
10.00	Occupational Therapy							10.00	
10.01	Occupational Therapy							10.01	
10.02	Occupational Therapy							10.02	
11.00	Speech Pathology							11.00	
11.01	Speech Pathology							11.01	
11.02	Speech Pathology							11.02	
12.00	Medical Social Services							12.00	
12.01	Medical Social Services							12.01	
12.02	Medical Social Services							12.02	
13.00	Home Health Aide							13.00	
13.01	Home Health Aide							13.01	
13.02	Home Health Aide							13.02	
14.00	Total (sum of lines 8-13)							14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN:14-1313

Period:

Worksheet H-3

HHA CCN: 14-7202

From 10/01/2018
To 09/30/2019Part II
Date/Time Prepared:
2/19/2020 6:01 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.468320	486,324	227,755	col. 2, line 2.00	1.00
2.00	Occupational Therapy	67.00	0.335182	210,268	70,478	col. 2, line 3.00	2.00
3.00	Speech Pathology	68.00	0.359680	21,646	7,786	col. 2, line 4.00	3.00
4.00	Cost of Medical Supplies	71.00	0.896154	106,808	95,716	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.969121	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN:14-1313

Period:

Worksheet H-4

HHA CCN: 14-7202

From 10/01/2018
To 09/30/2019Part I-II
Date/Time Prepared:
2/19/2020 6:01 pm

Title XVIII

Home Health
Agency I

PPS

		Part A		Part B		
		Not Subject to Deductibles & Coinsurance		Subject to Deductibles & Coinsurance		
		1.00		2.00		3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES						
Reasonable Cost of Part A & Part B Services						
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00	
2.00	Total charges	0	0	0	2.00	
Customary Charges						
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00	
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00	
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00	
6.00	Total customary charges (see instructions)	0	0	0	6.00	
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00	
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00	
9.00	Primary payer amounts	0	0	0	9.00	
			Part A Services		Part B Services	
			1.00		2.00	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT						
10.00	Total reasonable cost (see instructions)		0	0	10.00	
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	596,528	11.00	
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	138,279	12.00	
13.00	Total PPS Reimbursement - LUPA Episodes		0	8,685	13.00	
14.00	Total PPS Reimbursement - PEP Episodes		0	2,961	14.00	
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	30,932	15.00	
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0	16.00	
17.00	Total Other Payments		0	0	17.00	
18.00	DME Payments		0	0	18.00	
19.00	Oxygen Payments		0	0	19.00	
20.00	Prosthetic and Orthotic Payments		0	0	20.00	
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0	21.00	
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	777,385	22.00	
23.00	Excess reasonable cost (from line 8)		0	0	23.00	
24.00	Subtotal (line 22 minus line 23)		0	777,385	24.00	
25.00	Coinsurance billed to program patients (from your records)		0	0	25.00	
26.00	Net cost (line 24 minus line 25)		0	777,385	26.00	
27.00	Reimbursable bad debts (from your records)				27.00	
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)				28.00	
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	777,385	29.00	
30.00	OTHER ADJUSTMENTS (FROM PS&R)		0	0	30.00	
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	30.50	
30.99	Demonstration payment adjustment amount before sequestration		0	0	30.99	
31.00	Subtotal (see instructions)		0	777,385	31.00	
31.01	Sequestration adjustment (see instructions)		0	15,548	31.01	
31.02	Demonstration payment adjustment amount after sequestration		0	-1	31.02	
32.00	Interim payments (see instructions)		0	761,838	32.00	
33.00	Tentative settlement (for contractor use only)		0	0	33.00	
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0	34.00	
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	35.00	

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED PROGRAM BENEFICIARIES		Provider CCN:14-1313 HHA CCN: 14-7202		Period: From 10/01/2018 To 09/30/2019		Worksheet H-5 Date/Time Prepared: 2/19/2020 6:01 pm	
				Home Health Agency I		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		0		761,838	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01			0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50			0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		761,838	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01			0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50			0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		0		761,838	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN:14-1313

Period:

Worksheet M-1

Component CCN:14-3457

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/19/2020 6:01 pm

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassification	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,922,277	0	1,922,277	-90,115	1,832,162
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	538,380	0	538,380	0	538,380
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	789,808	0	789,808	0	789,808
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	3,250,465	0	3,250,465	-90,115	3,160,350
11.00	Physician Services Under Agreement	0	51,002	51,002	0	51,002
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	16,150	16,150	0	16,150
14.00	Subtotal (sum of lines 11 through 13)	0	67,152	67,152	0	67,152
15.00	Medical Supplies	0	79,583	79,583	0	79,583
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	91,415	91,415	0	91,415
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	170,998	170,998	0	170,998
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,250,465	238,150	3,488,615	-90,115	3,398,500
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	28,340	0	28,340	0	28,340
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)	28,340	0	28,340	0	28,340
FACILITY OVERHEAD						
29.00	Facility Costs	0	7,029	7,029	0	7,029
30.00	Administrative Costs	489,497	490,979	980,476	0	980,476
31.00	Total Facility Overhead (sum of lines 29 and 30)	489,497	498,008	987,505	0	987,505
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,768,302	736,158	4,504,460	-90,115	4,414,345

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN:14-1313

Period:

Worksheet M-1

Component CCN:14-3457

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/19/2020 6:01 pm

RHC I

Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,832,162	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	538,380	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	789,808	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	3,160,350	10.00
11.00	Physician Services Under Agreement	0	51,002	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	16,150	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	67,152	14.00
15.00	Medical Supplies	0	79,583	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	91,415	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	170,998	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	3,398,500	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	28,340	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	28,340	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	7,029	29.00
30.00	Administrative Costs	0	980,476	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	987,505	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	4,414,345	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN:14-1313

Period:

Worksheet M-1

Component CCN:14-3462

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/19/2020 6:01 pm

		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassification	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	80,952	0	80,952	0	80,952 1.00
2.00	Physician Assistant	0	0	0	0	0 2.00
3.00	Nurse Practitioner	157,640	0	157,640	0	157,640 3.00
4.00	Visiting Nurse	0	0	0	0	0 4.00
5.00	Other Nurse	67,133	0	67,133	0	67,133 5.00
6.00	Clinical Psychologist	0	0	0	0	0 6.00
7.00	Clinical Social Worker	0	0	0	0	0 7.00
8.00	Laboratory Technician	0	0	0	0	0 8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0 9.00
10.00	Subtotal (sum of lines 1 through 9)	305,725	0	305,725	0	305,725 10.00
11.00	Physician Services Under Agreement	0	0	0	0	0 11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0 12.00
13.00	Other Costs Under Agreement	0	4,379	4,379	0	4,379 13.00
14.00	Subtotal (sum of lines 11 through 13)	0	4,379	4,379	0	4,379 14.00
15.00	Medical Supplies	0	4,540	4,540	0	4,540 15.00
16.00	Transportation (Health Care Staff)	0	3,973	3,973	0	3,973 16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0 17.00
18.00	Professional Liability Insurance	0	4,390	4,390	0	4,390 18.00
19.00	Other Health Care Costs	0	0	0	0	0 19.00
20.00	Allowable GME Costs	0	0	0	0	0 20.00
21.00	Subtotal (sum of lines 15 through 20)	0	12,903	12,903	0	12,903 21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	305,725	17,282	323,007	0	323,007 22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0 23.00
24.00	Dental	0	0	0	0	0 24.00
25.00	Optometry	0	0	0	0	0 25.00
25.01	Telehealth	0	0	0	0	0 25.01
25.02	Chronic Care Management	0	0	0	0	0 25.02
26.00	All other nonreimbursable costs	0	0	0	0	0 26.00
27.00	Nonallowable GME costs	0	0	0	0	0 27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0 28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	6,895	6,895	0	6,895 29.00
30.00	Administrative Costs	52,916	59,208	112,124	0	112,124 30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	52,916	66,103	119,019	0	119,019 31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	358,641	83,385	442,026	0	442,026 32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN:14-1313

Period:

Worksheet M-1

Component CCN:14-3462

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/19/2020 6:01 pm

RHC II

Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	80,952	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	157,640	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	67,133	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	305,725	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	4,379	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	4,379	14.00
15.00	Medical Supplies	0	4,540	15.00
16.00	Transportation (Health Care Staff)	0	3,973	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	4,390	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	12,903	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	323,007	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	6,895	29.00
30.00	Administrative Costs	0	112,124	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	119,019	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	442,026	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN:14-1313

Period:

Worksheet M-1

Component CCN:14-8592

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/19/2020 6:01 pm

		RHC III		Cost	
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
	1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS					
1.00 Physician	322,730	0	322,730	0	322,730
2.00 Physician Assistant	0	0	0	0	0
3.00 Nurse Practitioner	113,367	0	113,367	0	113,367
4.00 Visiting Nurse	0	0	0	0	0
5.00 Other Nurse	118,970	0	118,970	0	118,970
6.00 Clinical Psychologist	0	0	0	0	0
7.00 Clinical Social Worker	0	0	0	0	0
8.00 Laboratory Technician	0	0	0	0	0
9.00 Other Facility Health Care Staff Costs	0	0	0	0	0
10.00 Subtotal (sum of lines 1 through 9)	555,067	0	555,067	0	555,067
11.00 Physician Services Under Agreement	0	13	13	0	13
12.00 Physician Supervision Under Agreement	0	0	0	0	0
13.00 Other Costs Under Agreement	0	4,337	4,337	0	4,337
14.00 Subtotal (sum of lines 11 through 13)	0	4,350	4,350	0	4,350
15.00 Medical Supplies	0	43,363	43,363	0	43,363
16.00 Transportation (Health Care Staff)	0	1,887	1,887	0	1,887
17.00 Depreciation-Medical Equipment	0	0	0	0	0
18.00 Professional Liability Insurance	0	8,988	8,988	0	8,988
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	54,238	54,238	0	54,238
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	555,067	58,588	613,655	0	613,655
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	31,034	31,034	0	31,034
30.00 Administrative Costs	76,368	71,987	148,355	0	148,355
31.00 Total Facility Overhead (sum of lines 29 and 30)	76,368	103,021	179,389	0	179,389
32.00 Total facility costs (sum of lines 22, 28 and 31)	631,435	161,609	793,044	0	793,044

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN:14-1313

Period:

Worksheet M-1

Component CCN:14-8592

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/19/2020 6:01 pm

RHC III

Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	322,730	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	113,367	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	118,970	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	555,067	10.00
11.00	Physician Services Under Agreement	0	13	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	4,337	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	4,350	14.00
15.00	Medical Supplies	0	43,363	15.00
16.00	Transportation (Health Care Staff)	0	1,887	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	8,988	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	54,238	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	613,655	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	31,034	29.00
30.00	Administrative Costs	-300	148,055	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-300	179,089	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-300	792,744	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES			Provider CCN:14-1313 Component CCN:14-3457		Period: From 10/01/2018 To 09/30/2019		Worksheet M-2 Date/Time Prepared: 2/19/2020 6:01 pm	
			RHC I		Cost			
			Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
			1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY								
Positions								
1.00	Physician	2.75	10,222	4,200	11,550			1.00
2.00	Physician Assistant	0.00	0	2,100	0			2.00
3.00	Nurse Practitioner	2.55	5,399	2,100	5,355			3.00
4.00	Subtotal (sum of lines 1 through 3)	5.30	15,621		16,905		16,905	4.00
5.00	Visiting Nurse	0.00	0				0	5.00
6.00	Clinical Psychologist	0.00	0				0	6.00
7.00	Clinical Social Worker	0.96	901				901	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0				0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0				0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	6.26	16,522				17,806	8.00
9.00	Physician Services Under Agreements		0				0	9.00
							1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES								
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)						3,398,500	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)						28,340	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)						3,426,840	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)						0.991730	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)						987,505	14.00
15.00	Parent provider overhead allocated to facility (see instructions)						1,646,127	15.00
16.00	Total overhead (sum of lines 14 and 15)						2,633,632	16.00
17.00	Allowable GME overhead (see instructions)						0	17.00
18.00	Enter the amount from line 16						2,633,632	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)						2,611,852	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)						6,010,352	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES			Provider CCN:14-1313 Component CCN:14-3462		Period: From 10/01/2018 To 09/30/2019		Worksheet M-2 Date/Time Prepared: 2/19/2020 6:01 pm	
					RHC II		Cost	
			Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
			1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY								
Positions								
1.00	Physician	0.21	300	4,200	882			1.00
2.00	Physician Assistant	0.00	0	2,100	0			2.00
3.00	Nurse Practitioner	0.61	1,518	2,100	1,281			3.00
4.00	Subtotal (sum of lines 1 through 3)	0.82	1,818		2,163		2,163	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)	0.82	1,818				2,163	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)						323,007	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)						323,007	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)						119,019	14.00
15.00	Parent provider overhead allocated to facility (see instructions)						121,287	15.00
16.00	Total overhead (sum of lines 14 and 15)						240,306	16.00
17.00	Allowable GME overhead (see instructions)						0	17.00
18.00	Enter the amount from line 16						240,306	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)						240,306	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)						563,313	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES			Provider CCN:14-1313 Component CCN:14-8592	Period: From 10/01/2018 To 09/30/2019	Worksheet M-2 Date/Time Prepared: 2/19/2020 6:01 pm	
			RHC III		Cost	
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.59	2,129	4,200	2,478	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.52	1,393	2,100	1,092	3.00
4.00	Subtotal (sum of lines 1 through 3)	1.11	3,522		3,570	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.11	3,522		3,570	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)				613,655	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)				613,655	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)				179,089	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				249,973	15.00
16.00	Total overhead (sum of lines 14 and 15)				429,062	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				429,062	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				429,062	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				1,042,717	20.00

Health Financial Systems		MASON DISTRICT HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN:14-1313	Period: From 10/01/2018 To 09/30/2019	Worksheet M-3	
		Component CCN:14-3457		Date/Time Prepared: 2/19/2020 6:01 pm	
		Title XVIII	RHC I	Cost	
			1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			6,010,352	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			137,868	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			5,872,484	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			17,806	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)			17,806	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			329.80	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	84.70	8.00
9.00	Rate for Program covered visits (see instructions)		329.80	329.80	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	5,230	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	1,724,854	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	1,724,854	16.00
16.01	Total program charges (see instructions)(from contractor's records)			1,139,292	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			58,204	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			88,119	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			1,243,739	16.04
16.05	Total program cost (see instructions)		0	1,331,858	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			82,061	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			199,805	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			1,331,858	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			64,047	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			1,395,905	22.00
23.00	Allowable bad debts (see instructions)			44,722	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			29,069	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			44,722	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			1,424,974	26.00
26.01	Sequestration adjustment (see instructions)			28,499	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			1,368,319	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)			28,156	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II chapter I, §115.2			0	30.00

Health Financial Systems		MASON DISTRICT HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN:14-1313	Period: From 10/01/2018 To 09/30/2019	Worksheet M-3	
		Component CCN:14-3462		Date/Time Prepared: 2/19/2020 6:01 pm	
		Title XVIII	RHC II	Cost	
			1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			563,313	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			3,413	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			559,900	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,163	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			2,163	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			258.85	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	84.70	8.00	
9.00	Rate for Program covered visits (see instructions)	258.85	258.85	9.00	
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	253	10.00	
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	65,489	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	65,489	16.00	
16.01	Total program charges (see instructions)(from contractor's records)		53,694	16.01	
16.02	Total program preventive charges (see instructions)(from provider's records)		2,380	16.02	
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		2,903	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.)		45,490	16.04	
16.05	Total program cost (see instructions)	0	48,393	16.05	
17.00	Primary payer amounts		0	17.00	
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		5,723	18.00	
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		9,118	19.00	
20.00	Net Medicare cost excluding vaccines (see instructions)		48,393	20.00	
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		2,459	21.00	
22.00	Total reimbursable Program cost (line 20 plus line 21)		50,852	22.00	
23.00	Allowable bad debts (see instructions)		2,615	23.00	
23.01	Adjusted reimbursable bad debts (see instructions)		1,700	23.01	
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		2,615	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)		52,552	26.00	
26.01	Sequestration adjustment (see instructions)		1,051	26.01	
26.02	Demonstration payment adjustment amount after sequestration		0	26.02	
27.00	Interim payments		50,048	27.00	
28.00	Tentative settlement (for contractor use only)		0	28.00	
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		1,453	29.00	
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II chapter I, §115.2		0	30.00	

Health Financial Systems		MASON DISTRICT HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN:14-1313	Period: From 10/01/2018 To 09/30/2019	Worksheet M-3	
		Component CCN:14-8592		Date/Time Prepared: 2/19/2020 6:01 pm	
		Title XVIII	RHC III	Cost	
			1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,042,717	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			38,641	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,004,076	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,570	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)			3,570	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			281.25	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	84.70	8.00
9.00	Rate for Program covered visits (see instructions)		281.25	281.25	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	278	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	78,188	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	78,188	16.00
16.01	Total program charges (see instructions)(from contractor's records)			54,843	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			9,204	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			13,122	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.)			49,102	16.04
16.05	Total program cost (see instructions)		0	62,224	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			3,689	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			8,390	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			62,224	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			4,436	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			66,660	22.00
23.00	Allowable bad debts (see instructions)			1,406	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			914	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			1,406	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)			67,574	26.00
26.01	Sequestration adjustment (see instructions)			1,351	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			40,866	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			25,357	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II chapter I, §115.2			0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN:14-1313 Component CCN:14-3457	Period: From 10/01/2018 To 09/30/2019	Worksheet M-4 Date/Time Prepared: 2/19/2020 6:01 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		3,160,350	3,160,350	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000919	0.002814	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		2,904	8,893	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		35,092	31,068	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		37,996	39,961	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		3,398,500	3,398,500	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		2,611,852	2,611,852	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.011180	0.011758	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		29,201	30,710	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		67,197	70,671	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		294	900	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		228.56	78.52	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		127	446	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		29,027	35,020	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)			137,868	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)			64,047	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN:14-1313 Component CCN:14-3462	Period: From 10/01/2018 To 09/30/2019	Worksheet M-4 Date/Time Prepared: 2/19/2020 6:01 pm	
		Title XVIII	RHC II	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		305,725	305,725	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000244	0.001150	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		75	352	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		956	574	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		1,031	926	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		323,007	323,007	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		240,306	240,306	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.003192	0.002867	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		767	689	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		1,798	1,615	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		7	33	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		256.86	48.94	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		5	24	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		1,284	1,175	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)			3,413	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)			2,459	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN:14-1313 Component CCN:14-8592	Period: From 10/01/2018 To 09/30/2019	Worksheet M-4 Date/Time Prepared: 2/19/2020 6:01 pm	
		Title XVIII	RHC III	Cost	
			Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		555,067	555,067	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.002438	0.006386	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		1,353	3,545	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		12,330	5,513	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		13,683	9,058	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		613,655	613,655	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		429,062	429,062	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.022298	0.014761	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		9,567	6,333	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		23,250	15,391	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		121	317	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		192.15	48.55	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		15	32	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		2,882	1,554	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			38,641	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			4,436	16.00

Health Financial Systems		MASON DISTRICT HOSPITAL		In Lieu of Form CMS-2552-10	
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN:14-1313	Period: From 10/01/2018 To 09/30/2019	Worksheet M-5	
		Component CCN:14-3457		Date/Time Prepared: 2/19/2020 6:01 pm	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,330,819	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01		04/11/2019	37,500		3.01
3.02			0		3.02
3.03			0		3.03
3.04			0		3.04
3.05			0		3.05
Provider to Program					
3.50			0		3.50
3.51			0		3.51
3.52			0		3.52
3.53			0		3.53
3.54			0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		37,500		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,368,319		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		28,156		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		1,396,475		7.00
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN:14-1313 Component CCN:14-3462	Period: From 10/01/2018 To 09/30/2019	Worksheet M-5 Date/Time Prepared: 2/19/2020 6:01 pm
		RHC II	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		50,048	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)		50,048	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		1,453	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		51,501	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00

Health Financial Systems		MASON DISTRICT HOSPITAL		In Lieu of Form CMS-2552-10	
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN:14-1313	Period: From 10/01/2018 To 09/30/2019	Worksheet M-5	
		Component CCN:14-8592		Date/Time Prepared: 2/19/2020 6:01 pm	
		RHC III	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		40,866	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)		40,866		4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01			0		5.01
5.02			0		5.02
5.03			0		5.03
Provider to Program					
5.50			0		5.50
5.51			0		5.51
5.52			0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER		25,357		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		66,223		7.00
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00