

State Copy

Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050 EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1302	Period: From 10/01/2019 To 09/30/2020	Worksheet S Parts I-III Date/Time Prepared: 4/12/2021 8:39 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 4/12/2021	Time: 8:39 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MIDWEST MEDICAL CENTER (14-1302) for the cost reporting period beginning 10/01/2019 and ending 09/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

CEO

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	60,473	-600,417	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I						4.00
5.00	Swing Bed - SNF	0	-20,103	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
10.00	RURAL HEALTH CLINIC I	0		175,929		0	10.00
10.01	RURAL HEALTH CLINIC II	0		31,022		0	10.01
200.00	Total	0	40,370	-393,466	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1302	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part I Date/Time Prepared: 4/12/2021 8:39 am
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	1.00		2.00		3.00		4.00		7/12/2022 8:00 am			
	Hospital and Hospital Health Care Complex Address:											
1.00	Street:1 MEDICAL CENTER DRIVE			PO Box:				1.00				
2.00	City: GALENA			State: IL		Zip Code: 61036-		County: JO DAVIESS			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	MIDWEST MEDICAL CENTER	141302	99914	1	02/01/2000	N	O	O	3.00		
4.00	Subprovider - IPF									4.00		
5.00	Subprovider - IRF									5.00		
6.00	Subprovider - (Other)									6.00		
7.00	Swing Beds - SNF	MIDWEST MEDICAL CENTER	142302	99914		02/01/2000	N	O	N	7.00		
8.00	Swing Beds - NF									8.00		
9.00	Hospital-Based SNF	GALENA STAUSS NURSING HOME	146140	99914		02/17/2010	N	P	N	9.00		
10.00	Hospital-Based NF									10.00		
11.00	Hospital-Based OLTC									11.00		
12.00	Hospital-Based HHA									12.00		
13.00	Separately Certified ASC									13.00		
14.00	Hospital-Based Hospice									14.00		
15.00	Hospital-Based Health Clinic - RHC	MIDWEST HEALTH CLINIC	148511	99914		12/09/2010	N	O	N	15.00		
15.01	Hospital-Based Health Clinic - RHC II	MIDWEST HEALTH CLINIC OF ELIZABETH	148557	99914		07/15/2016	N	O	N	15.01		
16.00	Hospital-Based Health Clinic - FQHC									16.00		
17.00	Hospital-Based (CMHC) I									17.00		
18.00	Renal Dialysis									18.00		
19.00	Other									19.00		
						From:		To:				
						1.00		2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)					10/01/2019		09/30/2020		20.00		
21.00	Type of Control (see instructions)					2				21.00		
					1.00		2.00		3.00			

Inpatient PPS Information							
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				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.				2	N	23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1302

Period:
From 10/01/2019
To 09/30/2020Worksheet S-2
Part I
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	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00
					Urban/Rural S	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1302		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 4/12/2021 8:39 am	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00
					0.000000		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1302

Period:
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To 09/30/2020Worksheet 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	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS					
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0
	Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1302	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part I Date/Time Prepared: 4/12/2021 8:39 am
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	1.00	
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	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

	V	XIX	
	1.00	2.00	

	Title V and XIX Services				
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		Y		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.06

Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y	105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y	106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	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	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	Y	Y	N	109.00

	1.00	
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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
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1302	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part I Date/Time Prepared: 4/12/2021 8:39 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	43,518	0	0 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.04	122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1302		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part I Date/Time Prepared: 4/12/2021 8:39 am	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:		Contractor's Number:				141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:		Zip Code:				143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	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	Y	Y	N	N	155.00			
156.00	Subprovider - IPF	N	N	N	N	156.00			
157.00	Subprovider - IRF	N	N	N	N	157.00			
158.00	SUBPROVIDER					158.00			
159.00	SNF	N	N	N	N	159.00			
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00			
161.00	CMHC		N	N	N	161.00			
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1302		Period: From 10/01/2019 To 09/30/2020		Worksheet S-2 Part II Date/Time Prepared: 4/12/2021 8:39 am	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A	02/02/2021	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			Y			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			Y	04/01/2021	Y	04/01/2021
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1302	Period: From 10/01/2019 To 09/30/2020	Worksheet S-2 Part II Date/Time Prepared: 4/12/2021 8:39 am
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		Y	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		Y	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N	40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAVID	GOODMAN	41.00
42.00	Enter the employer/company name of the cost report preparer.	WIPFLI LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	6082702962	DGOODMAN@WIPFLI.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1302

Period:
From 10/01/2019
To 09/30/2020Worksheet S-2
Part II
Date/Time Prepared:
4/12/2021 8:39 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1302

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/12/2021 8:39 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	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	9,150	12,905.16	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	9,150	12,905.16	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,150	12,905.16	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	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY	44.00	5	1,830		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	46.00	52	19,032			21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		82				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1302

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/12/2021 8:39 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	428	5	572			1.00
2.00	HMO and other (see instructions)	47	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	1,350	0	1,614			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	110			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,778	5	2,296			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,778	5	2,296	0.00	102.08	14.00
15.00	CAH visits	5,649	0	23,195			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER		0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	3.29	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE			14,705	0.00	39.12	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	2,091	0	7,885	0.00	15.19	26.00
26.01	RURAL HEALTH CLINIC II	571	0	2,686	0.00	4.44	26.01
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	164.12	27.00
28.00	Observation Bed Days		0	121			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1302

Period:
From 10/01/2019
To 09/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/12/2021 8:39 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	137	2	183	1.00
2.00 HMO and other (see instructions)			14	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	137	2	183	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER	0.00	0		0	0	18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	0.00				48	21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 RURAL HEALTH CLINIC II	0.00					26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

Health Financial Systems		MIDWEST MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1302 Component CCN: 14-8511		Period: From 10/01/2019 To 09/30/2020 Worksheet S-8 Date/Time Prepared: 4/12/2021 8:39 am	
		RHC I		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	ONE MEDICAL CENTER DRIVE		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	GALENA IL 61036		2.00	
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0 3.00	
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
7.00	Appalachian Regional Commission			7.00	
8.00	Look-Alikes			8.00	
9.00	OTHER (SPECIFY)			9.00	
9.01				9.01	
9.02				9.02	
9.03				9.03	
9.04				9.04	
9.05				9.05	
9.06				9.06	
9.07				9.07	
9.08				9.08	
9.09				9.09	
9.10				9.10	
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0 10.00	
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
		1.00		5.00	
Facility hours of operations (1)					
11.00	CLINIC	07:30		17:00 07:30 11.00	
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	Y		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0 13.00	
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			14.00	
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
		Total Visits		5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1302

Period:

Worksheet S-8

Component CCN: 14-8511

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/12/2021 8:39 am

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

Health Financial Systems		MIDWEST MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1302 Component CCN: 14-8557		Period: From 10/01/2019 To 09/30/2020 Worksheet S-8 Date/Time Prepared: 4/12/2021 8:39 am	
		RHC II		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	560 PLEASANT STREET			1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	ELIZABETH IL 61028			2.00
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0			3.00
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)				4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00
7.00	Appalachian Regional Commission				7.00
8.00	Look-Alikes				8.00
9.00	OTHER (SPECIFY)				9.00
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N 0			10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	CLINIC	07:30		17:00	07:30
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	Y			12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N 0			13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number				14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
		Total Visits			5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				15.00
		County			
		4.00			
2.00	City, State, ZIP Code, County	JO DAVIESS			2.00
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00			
Facility hours of operations (1)					
11.00	CLINIC	17:00	07:30	17:00	07:30
		17:00		17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1302 Component CCN: 14-8557		Period: From 10/01/2019 To 09/30/2020		Worksheet S-8 Date/Time Prepared: 4/12/2021 8:39 am	
						RHC II		Cost	
				Friday		Saturday			
				from	to	from	to		
				11.00	12.00	13.00	14.00		
Facility hours of operations (1)									
11.00	CLINIC	07:30	17:00						11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1302

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

Worksheet S-10

Date/Time Prepared:
4/12/2021 8:39 am

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.738366	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		2,928,241	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		6,312,198	6.00
7.00	Medicaid cost (line 1 times line 6)		4,660,712	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)		1,732,471	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		1,732,471	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	319,991	0	319,991
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	236,270	0	236,270
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	236,270	0	236,270
			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)		226,907	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		100,479	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		154,584	27.01
28.00	Non-Medicare bad debt expense (see instructions)		72,323	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		107,506	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		343,776	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,076,247	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1302

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

Worksheet A

Date/Time Prepared:
4/12/2021 8:39 am

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	NEW CAP REL COSTS-BLDG & FIXT		1,396,559	1,396,559	-1,337,635	58,924	1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG		0	0	63,505	63,505	1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL		0	0	2,494,529	2,494,529	1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB		0	0	0	0	1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,038,019	1,038,019	-1,017,237	20,782	2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO		0	0	1,203,792	1,203,792	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,589,162	2,589,162	-132,430	2,456,732	4.00
5.01	00570	ADMITTING	305,728	3,075	308,803	0	308,803	5.01
5.02	00550	INFORMATION TECHNOLOGY	308,291	339,890	648,181	0	648,181	5.02
5.03	00590	HOSPITAL BILLING	0	0	0	283,001	283,001	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	652,544	1,438,557	2,091,101	-452,424	1,638,677	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	125,794	540,761	666,555	0	666,555	7.00
7.01	00701	OPERATION OF PLANT-SCC	92,202	197,665	289,867	0	289,867	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	44,802	44,802	0	44,802	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	10,848	18,560	29,408	0	29,408	8.01
9.00	00900	HOUSEKEEPING	171,024	29,716	200,740	0	200,740	9.00
9.01	00901	HOUSEKEEPING-SCC	80,678	17,904	98,582	0	98,582	9.01
10.00	01000	DIETARY	215,625	160,575	376,200	0	376,200	10.00
10.01	01001	DIETARY-SCC	256,525	223,776	480,301	79,282	559,583	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	233,174	3,772	236,946	0	236,946	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	72,752	4,319	77,071	0	77,071	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	175,762	34,845	210,607	0	210,607	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	803,649	79,606	883,255	192,767	1,076,022	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	11,557	11,557	44.00
46.00	04600	OTHER LONG TERM CARE	1,650,774	338,920	1,989,694	91,734	2,081,428	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	225,458	570,114	795,572	101,721	897,293	50.00
53.00	05300	ANESTHESIOLOGY	203,603	54,862	258,465	0	258,465	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	342,659	851,080	1,193,739	20,735	1,214,474	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	304,710	545,659	850,369	0	850,369	60.00
64.00	06400	INTRAVENOUS THERAPY	0	23,536	23,536	0	23,536	64.00
65.00	06500	RESPIRATORY THERAPY	87,552	42,070	129,622	-98,630	30,992	65.00
66.00	06600	PHYSICAL THERAPY	1,000,287	86,663	1,086,950	-22,678	1,064,272	66.00
66.01	06601	CARDIAC REHAB	0	0	0	138,909	138,909	66.01
67.00	06700	OCCUPATIONAL THERAPY	71,017	6,877	77,894	16,871	94,765	67.00
68.00	06800	SPEECH PATHOLOGY	46,361	14,427	60,788	0	60,788	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	126,453	126,453	0	126,453	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	590,776	590,776	0	590,776	73.00
76.00	03020	SLEEP LAB	36,641	15,790	52,431	4,460	56,891	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	11,304	11,304	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,630,788	196,772	1,827,560	-83,944	1,743,616	88.00
88.01	08801	RURAL HEALTH CLINIC II	472,548	86,122	558,670	-27,821	530,849	88.01
90.00	09000	CLINIC	0	561,899	561,899	-100,756	461,143	90.00
91.00	09100	EMERGENCY	396,477	1,802,165	2,198,642	0	2,198,642	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	1,350,963	1,350,963	-1,350,963	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,973,471	15,426,711	25,400,182	89,649	25,489,831	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	43,278	43,278	-34,040	9,238	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	301,345	106,710	408,055	-56,570	351,485	194.01
194.02	07952	ADULT DAY CARE	48,342	23,031	71,373	-4,846	66,527	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1302

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

Worksheet A

Date/Time Prepared:
4/12/2021 8:39 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	5,807	5,807	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	10,323,158	15,599,730	25,922,888	0	25,922,888	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1302

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

Worksheet A

Date/Time Prepared:
4/12/2021 8:39 am

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	58,924	1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG	0	63,505	1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL	-63,953	2,430,576	1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB	0	0	1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	20,782	2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	-349,733	854,059	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,456,732	4.00
5.01	00570	ADMITTING	0	308,803	5.01
5.02	00550	INFORMATION TECHNOLOGY	0	648,181	5.02
5.03	00590	HOSPITAL BILLING	-38,388	244,613	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	-398,589	1,240,088	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-6,259	660,296	7.00
7.01	00701	OPERATION OF PLANT-SCC	0	289,867	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	44,802	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	29,408	8.01
9.00	00900	HOUSEKEEPING	0	200,740	9.00
9.01	00901	HOUSEKEEPING-SCC	0	98,582	9.01
10.00	01000	DIETARY	-67,450	308,750	10.00
10.01	01001	DIETARY-SCC	-129,072	430,511	10.01
11.00	01100	CAFETERIA	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	0	236,946	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	77,071	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,398	208,209	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-4,281	1,071,741	30.00
42.00	04200	SUBPROVIDER	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	11,557	44.00
46.00	04600	OTHER LONG TERM CARE	-135,147	1,946,281	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-101,529	795,764	50.00
53.00	05300	ANESTHESIOLOGY	0	258,465	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-383,547	830,927	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	850,369	60.00
64.00	06400	INTRAVENOUS THERAPY	0	23,536	64.00
65.00	06500	RESPIRATORY THERAPY	0	30,992	65.00
66.00	06600	PHYSICAL THERAPY	-37,299	1,026,973	66.00
66.01	06601	CARDIAC REHAB	0	138,909	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	94,765	67.00
68.00	06800	SPEECH PATHOLOGY	0	60,788	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	126,453	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-60,825	529,951	73.00
76.00	03020	SLEEP LAB	0	56,891	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	11,304	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-15,919	1,727,697	88.00
88.01	08801	RURAL HEALTH CLINIC II	-2,500	528,349	88.01
90.00	09000	CLINIC	-457,336	3,807	90.00
91.00	09100	EMERGENCY	-257,580	1,941,062	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	93.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,511,805	22,978,026	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	9,238	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	351,485	194.01
194.02	07952	ADULT DAY CARE	0	66,527	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	194.03
194.04	07954	IDLE SPACE	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	5,807	194.05

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1302

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

Worksheet A

Date/Time Prepared:
4/12/2021 8:39 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
200.00	TOTAL (SUM OF LINES 118 through 199)	-2,511,805	23,411,083	200.00

RECLASSIFICATIONS

Provider CCN: 14-1302

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

Worksheet A-6

Date/Time Prepared:
4/12/2021 8:39 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS ADC AND ALU DIETARY EXPENSE					
1.00	DIETARY-SCC	10.01	0	79,282		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	79,282		
	C - RECLASS ASSISTED LIVING BUILDING DEP					
1.00	NEW CAP REL COSTS-ALU BLDG	1.01	0	60,814		1.00
	TOTALS		0	60,814		
	D - RECLASS PT/MOB SPACE DEPRECIATION					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	5,196		1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	28,844		2.00
	TOTALS		0	34,040		
	E - RECLASS NURSING HOME ADMIN AND GEN					
1.00	SKILLED NURSING FACILITY	44.00	0	11,557		1.00
2.00	OTHER LONG TERM CARE	46.00	0	120,193		2.00
	TOTALS		0	131,750		
	G - RECLASS PHYSICIAN HOSPITAL MED DIRCT					
1.00	ADULTS & PEDIATRICS	30.00	10,809	1,081		1.00
	TOTALS		10,809	1,081		
	H - RECLASS NEW HOSPITAL DEPRECIATION					
1.00	NEW CAP REL COSTS-2007 HOSPITAL	1.02	0	1,302,981		1.00
	TOTALS		0	1,302,981		
	J - RECLASS NEW HOSPITAL MME DEPRECIATN					
1.00	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	0	1,019,338		1.00
	TOTALS		0	1,019,338		
	K - RECLASS INTEREST EXPENSE - NEW HOSP					
1.00	NEW CAP REL COSTS-2007 HOSPITAL	1.02	0	1,155,299		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	0	174,490		2.00
	TOTALS		0	1,329,789		
	M - RECLASS PHYSICIAN IP ROUND TIME					
1.00	ADULTS & PEDIATRICS	30.00	4,198	630		1.00
2.00		0.00	0	0		2.00
	TOTALS		4,198	630		
	P - RECLASS PHYSICIAN BENEFITS					
1.00	RURAL HEALTH CLINIC	88.00	0	101,295		1.00
2.00	RURAL HEALTH CLINIC II	88.01	0	31,135		2.00
	TOTALS		0	132,430		
	U - RECLASS COMMUNITY FITNESS CTR USE					
1.00	COMMUNITY FITNESS CENTER	194.05	5,275	532		1.00
2.00	OCCUPATIONAL THERAPY	67.00	15,419	1,452		2.00
	TOTALS		20,694	1,984		
	X - RECLASS SURGEON FEES					
1.00	OPERATING ROOM	50.00	0	88,451		1.00
	TOTALS		0	88,451		
	Y - RECLASS PROPERTY INSURANCE EXP					
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	55,684		1.00
	TOTALS		0	55,684		
	AA - RECLASS CLINIC MGR TIME TO HOSP/NH					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	18,011	0		1.00
2.00	RURAL HEALTH CLINIC II	88.01	4,384	0		2.00
3.00	ASSISTED LIVING UNITS	194.01	711	0		3.00
	TOTALS		23,106	0		
	BB - RECLASS SR CARE ADMINISTRATOR TIME					
1.00	ASSISTED LIVING UNITS	194.01	15,113	0		1.00
2.00	ADULT DAY CARE	194.02	2,042	0		2.00
	TOTALS		17,155	0		
	FF - RECLASS EXPENSES TO MATCH REVENUES					
1.00	SNF PHYSICAL THERAPY - SCC THERAPY	76.02	11,304	0		1.00
	TOTALS		11,304	0		
	HH - RECLASS HOSP MED DIRECTOR TIME					
1.00	ADULTS & PEDIATRICS	30.00	88,855	11,843		1.00
2.00	CARDIAC REHAB	66.01	35,542	4,737		2.00
	TOTALS		124,397	16,580		
	JJ - RECLASS CAP LEASE INTEREST EXPENSE					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	20,735		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	439		2.00
	TOTALS		0	21,174		

RECLASSIFICATIONS

Provider CCN: 14-1302

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

Worksheet A-6

Date/Time Prepared:
4/12/2021 8:39 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
1.00	KK - RECLASS ELIZABETH CLINIC DEPR				1.00
	RURAL HEALTH CLINIC II	88.01	0	12,559	
	TOTALS		0	12,559	
1.00	MM - RECLASS CLINIC MD SALARY				1.00
	ADULTS & PEDIATRICS	30.00	75,351	0	
	TOTALS		75,351	0	
1.00	NN - ENT MD TIME IN OR				1.00
	OPERATING ROOM	50.00	0	7,845	
	TOTALS		0	7,845	
1.00	PP - RECLASS HOSPITAL BILLING EXPENSES				1.00
	HOSPITAL BILLING	5.03	0	283,001	
	TOTALS		0	283,001	
1.00	QQ - RECLASS CARDIAC REHAB EXP				1.00
	CARDIAC REHAB	66.01	87,552	11,078	
	TOTALS		87,552	11,078	
1.00	SS - RECLASS PHYSICIAN SURGERY TIME				1.00
	OPERATING ROOM	50.00	4,025	1,400	
	TOTALS		4,025	1,400	
1.00	TT - RECLASS SLEEP LAB EXPENSES				1.00
	SLEEP LAB	76.00	0	4,460	
	TOTALS		0	4,460	
500.00	Grand Total: Increases		378,591	4,596,351	500.00

RECLASSIFICATIONS

Provider CCN: 14-1302

Period:
From 10/01/2019
To 09/30/2020Worksheet A-6
Date/Time Prepared:
4/12/2021 8:39 am

		Decreases				wkst. A-7 Ref.	
		Cost Center	Line #	Salary	Other		
		6.00	7.00	8.00	9.00	10.00	
A - RECLASS ADC AND ALU DIETARY EXPENSE							
1.00	ADULT DAY CARE		194.02	0	6,888	0	1.00
2.00	ASSISTED LIVING UNITS		194.01	0	72,394	0	2.00
	TOTALS			0	79,282		
C - RECLASS ASSISTED LIVING BUILDING DEP							
1.00	NEW CAP REL COSTS-BLDG & FIXT		1.00	0	60,814	9	1.00
	TOTALS			0	60,814		
D - RECLASS PT/MOB SPACE DEPRECIATION							
1.00	PHYSICIANS' PRIVATE OFFICES		192.00	0	5,196	9	1.00
2.00	PHYSICIANS' PRIVATE OFFICES		192.00	0	28,844	9	2.00
	TOTALS			0	34,040		
E - RECLASS NURSING HOME ADMIN AND GEN							
1.00	OTHER ADMINISTRATIVE AND GENERAL		5.04	0	131,750	0	1.00
2.00			0.00	0	0	0	2.00
	TOTALS			0	131,750		
G - RECLASS PHYSICIAN HOSPITAL MED DIRCT							
1.00	RURAL HEALTH CLINIC		88.00	10,809	1,081	0	1.00
	TOTALS			10,809	1,081		
H - RECLASS NEW HOSPITAL DEPRECIATION							
1.00	NEW CAP REL COSTS-BLDG & FIXT		1.00	0	1,302,981	9	1.00
	TOTALS			0	1,302,981		
J - RECLASS NEW HOSPITAL MME DEPRECIATN							
1.00	NEW CAP REL COSTS-MVBLE EQUIP		2.00	0	1,019,338	9	1.00
	TOTALS			0	1,019,338		
K - RECLASS INTEREST EXPENSE - NEW HOSP							
1.00	INTEREST EXPENSE		113.00	0	1,329,789	11	1.00
2.00			0.00	0	0	11	2.00
	TOTALS			0	1,329,789		
M - RECLASS PHYSICIAN IP ROUND TIME							
1.00	RURAL HEALTH CLINIC		88.00	3,722	558	0	1.00
2.00	RURAL HEALTH CLINIC II		88.01	476	72	0	2.00
	TOTALS			4,198	630		
P - RECLASS PHYSICIAN BENEFITS							
1.00	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	132,430	0	1.00
2.00			0.00	0	0	0	2.00
	TOTALS			0	132,430		
U - RECLASS COMMUNITY FITNESS CTR USE							
1.00	PHYSICAL THERAPY		66.00	20,694	1,984	0	1.00
2.00			0.00	0	0	0	2.00
	TOTALS			20,694	1,984		
X - RECLASS SURGEON FEES							
1.00	CLINIC		90.00	0	88,451	0	1.00
	TOTALS			0	88,451		
Y - RECLASS PROPERTY INSURANCE EXP							
1.00	OTHER ADMINISTRATIVE AND GENERAL		5.04	0	55,684	12	1.00
	TOTALS			0	55,684		
AA - RECLASS CLINIC MGR TIME TO HOSP/NH							
1.00	RURAL HEALTH CLINIC		88.00	23,106	0	0	1.00
2.00			0.00	0	0	0	2.00
3.00			0.00	0	0	0	3.00
	TOTALS			23,106	0		
BB - RECLASS SR CARE ADMINISTRATOR TIME							
1.00	OTHER LONG TERM CARE		46.00	17,155	0	0	1.00
2.00			0.00	0	0	0	2.00
	TOTALS			17,155	0		
FF - RECLASS EXPENSES TO MATCH REVENUES							
1.00	OTHER LONG TERM CARE		46.00	11,304	0	0	1.00
	TOTALS			11,304	0		
HH - RECLASS HOSP MED DIRECTOR TIME							
1.00	RURAL HEALTH CLINIC		88.00	124,397	16,580	0	1.00
2.00			0.00	0	0	0	2.00
	TOTALS			124,397	16,580		
JJ - RECLASS CAP LEASE INTEREST EXPENSE							
1.00	INTEREST EXPENSE		113.00	0	21,174	0	1.00
2.00			0.00	0	0	0	2.00
	TOTALS			0	21,174		

RECLASSIFICATIONS

Provider CCN: 14-1302

Period:
From 10/01/2019
To 09/30/2020Worksheet A-6
Date/Time Prepared:
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	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	KK - RECLASS ELIZABETH CLINIC DEPR						
	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	12,559	9		1.00
	TOTALS		0	12,559			
1.00	MM - RECLASS CLINIC MD SALARY						
	RURAL HEALTH CLINIC II	88.01	75,351	0	0		1.00
	TOTALS		75,351	0			
1.00	NN - ENT MD TIME IN OR						
	CLINIC	90.00	0	7,845	0		1.00
	TOTALS		0	7,845			
1.00	PP - RECLASS HOSPITAL BILLING EXPENSES						
	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	283,001	0		1.00
	TOTALS		0	283,001			
1.00	QQ - RECLASS CARDIAC REHAB EXP						
	RESPIRATORY THERAPY	65.00	87,552	11,078	0		1.00
	TOTALS		87,552	11,078			
1.00	SS - RECLASS PHYSICIAN SURGERY TIME						
	RURAL HEALTH CLINIC	88.00	4,025	1,400	0		1.00
	TOTALS		4,025	1,400			
1.00	TT - RECLASS SLEEP LAB EXPENSES						
	CLINIC	90.00	0	4,460	0		1.00
	TOTALS		0	4,460			
500.00	Grand Total: Decreases		378,591	4,596,351			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1302

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part I
Date/Time Prepared:
4/12/2021 8:39 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	448,597	0	0	0	0	1.00
2.00	Land Improvements	3,933,619	50,250	0	50,250	0	2.00
3.00	Buildings and Fixtures	38,703,856	136,896	0	136,896	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	8,993,753	1,534,382	0	1,534,382	1,382,676	6.00
7.00	HIT designated Assets	2,639,630	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	54,719,455	1,721,528	0	1,721,528	1,382,676	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	54,719,455	1,721,528	0	1,721,528	1,382,676	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	448,597	0				1.00
2.00	Land Improvements	3,983,869	0				2.00
3.00	Buildings and Fixtures	38,840,752	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	9,145,459	0				6.00
7.00	HIT designated Assets	2,639,630	0				7.00
8.00	Subtotal (sum of lines 1-7)	55,058,307	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	55,058,307	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1302

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part II
Date/Time Prepared:
4/12/2021 8:39 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,396,559	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-ALU BLDG	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	0	0	0	0	0	1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0	0	0	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,038,019	0	0	0	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	2,434,578	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,396,559				1.00
1.01	NEW CAP REL COSTS-ALU BLDG	0	0				1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	0	0				1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0				1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,038,019				2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	0				2.01
3.00	Total (sum of lines 1-2)	0	2,434,578				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1302

Period:
From 10/01/2019
To 09/30/2020Worksheet A-7
Part III
Date/Time Prepared:
4/12/2021 8:39 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
		1.00	2.00	3.00	4.00	5.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	4,560,343	0	4,560,343	0.084029	4,679	1.00	
1.01	NEW CAP REL COSTS-ALU BLDG	2,623,068	0	2,623,068	0.048333	2,691	1.01	
1.02	NEW CAP REL COSTS-2007 HOSPITAL	35,328,474	0	35,328,474	0.650966	36,249	1.02	
1.03	NEW CAP REL COSTS-2007 MOB	0	0	0	0.000000	0	1.03	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,047,530	0	2,047,530	0.037728	2,101	2.00	
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	9,711,441	0	9,711,441	0.178944	9,964	2.01	
3.00	Total (sum of lines 1-2)	54,270,856	0	54,270,856	1.000000	55,684	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	4,679	54,245	0	1.00	
1.01	NEW CAP REL COSTS-ALU BLDG	0	0	2,691	60,814	0	1.01	
1.02	NEW CAP REL COSTS-2007 HOSPITAL	0	0	36,249	1,302,981	0	1.02	
1.03	NEW CAP REL COSTS-2007 MOB	0	0	0	0	0	1.03	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2,101	18,681	0	2.00	
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	0	9,964	682,900	0	2.01	
3.00	Total (sum of lines 1-2)	0	0	55,684	2,119,621	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	NEW CAP REL COSTS-BLDG & FIXT	0	4,679	0	0	58,924	1.00	
1.01	NEW CAP REL COSTS-ALU BLDG	0	2,691	0	0	63,505	1.01	
1.02	NEW CAP REL COSTS-2007 HOSPITAL	1,091,346	36,249	0	0	2,430,576	1.02	
1.03	NEW CAP REL COSTS-2007 MOB	0	0	0	0	0	1.03	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	2,101	0	0	20,782	2.00	
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	161,195	9,964	0	0	854,059	2.01	
3.00	Total (sum of lines 1-2)	1,252,541	55,684	0	0	3,427,846	3.00	

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1302

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

Worksheet A-8

Date/Time Prepared:
4/12/2021 8:39 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP REL COSTS-ALU BLDG (chapter 2)			0 NEW CAP REL COSTS-ALU BLDG	1.01	0	1.01
1.02	Investment income - NEW CAP REL COSTS-2007 HOSPITAL (chapter 2)	B	-88,023	0 NEW CAP REL COSTS-2007 HOSPITAL	1.02	11	1.02
1.03	Investment income - NEW CAP REL COSTS-2007 MOB (chapter 2)			0 NEW CAP REL COSTS-2007 MOB	1.03	0	1.03
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			0 NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - NEW CAP REL COSTS-MVBLE EQUIP NEW HO (chapter 2)	B	-13,295	0 NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	11	2.01
3.00	Investment income - other (chapter 2)	B	-1,580	0 RADIOLOGY-DIAGNOSTIC	54.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-5,828	0 OPERATION OF PLANT	7.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,202,693		0.00	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-67,450	0 DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-2,398	0 MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0 RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0 PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0 *** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-ALU BLDG			0 NEW CAP REL COSTS-ALU BLDG	1.01	0	26.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1302

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

Worksheet A-8

Date/Time Prepared:
4/12/2021 8:39 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
26.02	Depreciation - NEW CAP REL COSTS-2007 HOSPITAL			0 NEW CAP REL COSTS-2007 HOSPITAL	1.02	0	26.02
26.03	Depreciation - NEW CAP REL COSTS-2007 MOB			0 NEW CAP REL COSTS-2007 MOB	1.03	0	26.03
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0 NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP NEW HO			0 NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	0	27.01
28.00	Non-physician Anesthetist			0 NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0 OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0 ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0 SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-336,438	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	9	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)			0	0.00	0	33.00
33.01	INTEREST INCOME	B	-33	RURAL HEALTH CLINIC	88.00	0	33.01
33.05	PROVIDER RHC REVENUE	B	-9,721	RURAL HEALTH CLINIC	88.00	0	33.05
33.06	PART B BILLING COSTS	A	-38,388	HOSPITAL BILLING	5.03	0	33.06
33.07	SCHOOL ATHLETIC TRAINING REVENUE	B	-37,299	PHYSICAL THERAPY	66.00	0	33.07
33.08	HOSPITAL BED ASSESS (UP TO PAID AMT)	A	-287,940	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.08
33.09	MARKETING EXPENSES - NONALLOW	A	-86,408	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.09
34.00	LOBBYING EXPENSE ON DUES PAID	A	-22,100	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	34.00
35.00	COMMUNITY GRANTS / DONATIONS / PROM	A	-2,141	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	35.00
36.00	NH BED ASSESSMENT	A	-125,014	OTHER LONG TERM CARE	46.00	0	36.00
37.00	AR INSURANCE REVENUE	B	-10,133	OTHER LONG TERM CARE	46.00	0	37.00
38.00	MISC CLINIC REVENUE	B	-2,500	RURAL HEALTH CLINIC II	88.01	0	38.00
40.00	SENIOR CARE CAMPUS CAFETERIA	B	-46,289	DIETARY-SCC	10.01	0	40.00
41.00	OFFSET INTERNAL ALLOCATION FOR ADC/A	B	-82,783	DIETARY-SCC	10.01	0	41.00
42.00	RHC PROVIDER OR TIME	A	-6,165	RURAL HEALTH CLINIC	88.00	0	42.00
43.00	SLEEP MISC REVENUE	B	-431	OPERATION OF PLANT	7.00	0	43.00
43.01	PHARMACY CONTRACT PROG EXPENSE	A	-60,825	DRUGS CHARGED TO PATIENTS	73.00	0	43.01
43.02	OTHER ADJUSTMENTS (SPECIFY) (3)			0	0.00	0	43.02
43.03	LAPSE CY PORT OF ADV REFUND 2006	A	24,070	NEW CAP REL COSTS-2007 HOSPITAL	1.02	11	43.03
43.04	OTHER ADJUSTMENTS (SPECIFY) (3)			0	0.00	0	43.04
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,511,805				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1302

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

Worksheet A-8-2

Date/Time Prepared:
4/12/2021 8:39 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,555,620	257,580	1,298,040	0	0	1.00
2.00	60.00	LABORATORY	11,779	0	11,779	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	381,967	381,967	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	4,281	4,281	0	0	0	4.00
5.00	50.00	OPERATING ROOM	101,529	101,529	0	0	0	5.00
6.00	90.00	CLINIC	457,336	457,336	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,512,512	1,202,693	1,309,819			200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	257,580		1.00
2.00	60.00	LABORATORY	0	0	0	0		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	381,967		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	4,281		4.00
5.00	50.00	OPERATING ROOM	0	0	0	101,529		5.00
6.00	90.00	CLINIC	0	0	0	457,336		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	1,202,693		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1302		Period: From 10/01/2019 To 09/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 4/12/2021 8:39 am	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					4	1.00
2.00	Line 1 multiplied by 15 hours per week					60	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					11	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.55	7.00
8.00	Optional travel expense rate per mile					0.56	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	65.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	82.80	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	41.40	41.40	0.00			11.00
12.00	Number of travel hours (provider site)	0	17	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	240	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
							1.00
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					5,423	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					5,423	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					5,423	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					5,423	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					455	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					455	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					61	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					516	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					1,408	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					1,408	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					134	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					516	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1302		Period: From 10/01/2019 To 09/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 4/12/2021 8:39 am	
				Occupational Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	82.80	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					5,423	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					516	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					5,939	63.00
64.00	Total cost of outside supplier services (from your records)					5,706	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					455	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					61	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					516	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					61	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					1,408	101.01
101.02	Line 34 = sum of lines 27 and 31					1,469	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					1,408	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					134	102.01
102.02	Line 35 = sum of lines 31 and 32					1,542	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1302		Period: From 10/01/2019 To 09/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 4/12/2021 8:39 am	
				Speech Pathology		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					10	1.00
2.00	Line 1 multiplied by 15 hours per week					150	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					29	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.55	7.00
8.00	Optional travel expense rate per mile					0.56	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	176.75	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	79.60	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.80	39.80	0.00			11.00
12.00	Number of travel hours (provider site)	0	22	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	1,324	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
							1.00
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					14,069	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					14,069	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					14,069	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					14,069	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					1,154	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					1,154	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					161	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					1,315	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					1,751	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					1,751	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					741	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					1,315	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1302		Period: From 10/01/2019 To 09/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 4/12/2021 8:39 am		
				Speech Pathology		Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	79.60	0.00	0.00	0.00	0.00	52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0	54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0	55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						14,069	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						1,315	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						15,384	63.00
64.00	Total cost of outside supplier services (from your records)						13,898	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						1,154	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						161	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						1,315	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						161	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						1,751	101.01
101.02	Line 34 = sum of lines 27 and 31						1,912	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						1,751	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						741	102.01
102.02	Line 35 = sum of lines 31 and 32						2,492	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
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Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
			NEW BLDG & FIXT	NEW ALU BLDG	NEW 2007 HOSPITAL	NEW 2007 MOB	
		0	1.00	1.01	1.02	1.03	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	58,924	58,924			1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG	63,505	0	63,505		1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL	2,430,576	0	0	2,430,576	1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB	0	0	0	0	1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	20,782				2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	854,059				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,456,732	0	0		4.00
5.01	00570	ADMITTING	308,803	0	0	35,130	5.01
5.02	00550	INFORMATION TECHNOLOGY	648,181	669	0	17,449	5.02
5.03	00590	HOSPITAL BILLING	244,613	0	0	0	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	1,240,088	8,760	19,093	210,824	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	660,296	0	0	163,489	7.00
7.01	00701	OPERATION OF PLANT-SCC	289,867	2,245	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	44,802	0	0	16,521	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	29,408	225	0	0	8.01
9.00	00900	HOUSEKEEPING	200,740	0	0	12,530	9.00
9.01	00901	HOUSEKEEPING-SCC	98,582	427	0	0	9.01
10.00	01000	DIETARY	308,750	0	0	148,779	10.00
10.01	01001	DIETARY-SCC	430,511	1,660	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	236,946	744	0	5,940	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	77,071	0	0	31,649	14.00
15.00	01500	PHARMACY	0	0	0	35,872	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	208,209	0	0	31,881	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,071,741	0	0	410,696	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	11,557	1,948	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	1,946,281	20,262	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	795,764	0	0	249,851	50.00
53.00	05300	ANESTHESIOLOGY	258,465	0	0	2,506	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	830,927	0	0	168,501	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	850,369	0	0	49,933	60.00
64.00	06400	INTRAVENOUS THERAPY	23,536	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	30,992	0	0	8,724	65.00
66.00	06600	PHYSICAL THERAPY	1,026,973	0	0	200,707	66.00
66.01	06601	CARDIAC REHAB	138,909	0	0	13,922	66.01
67.00	06700	OCCUPATIONAL THERAPY	94,765	0	0	17,263	67.00
68.00	06800	SPEECH PATHOLOGY	60,788	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	126,453	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	529,951	0	0	0	73.00
76.00	03020	SLEEP LAB	56,891	0	0	16,242	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	11,304	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,727,697	0	0	266,047	88.00
88.01	08801	RURAL HEALTH CLINIC II	528,349	0	0	0	88.01
90.00	09000	CLINIC	3,807	0	0	30,164	90.00
91.00	09100	EMERGENCY	1,941,062	0	0	257,137	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,978,026	36,940	19,093	2,401,757	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	13,783	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,238	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	351,485	0	41,087	0	194.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2019
To 09/30/2020Worksheet B
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Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW ALU BLDG	NEW 2007 HOSPITAL	NEW 2007 MOB	
			0	1.00	1.01	1.02	1.03	
194.02	07952	ADULT DAY CARE	66,527	0	3,325	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	21,984	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	5,807	0	0	15,036	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	23,411,083	58,924	63,505	2,430,576	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part I
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	INFORMATION TECHNOLOGY	
			NEW MVBLE EQUIP	NEW MVBLE EQUIP NEW HO				
			2.00	2.01				
GENERAL SERVICE COST CENTERS			2.00	2.01	4.00	5.01	5.02	
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	20,782					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	854,059				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	2,456,732			4.00
5.01	00570	ADMITTING	0	0	83,656	427,589		5.01
5.02	00550	INFORMATION TECHNOLOGY	0	61,329	84,357	0	811,985	5.02
5.03	00590	HOSPITAL BILLING	0	0	0	0	0	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	334	98,336	207,961	0	51,719	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	24,081	34,421	0	25,859	7.00
7.01	00701	OPERATION OF PLANT-SCC	245	0	25,229	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	550	0	0	0	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	0	2,968	0	0	8.01
9.00	00900	HOUSEKEEPING	0	319	46,797	0	0	9.00
9.01	00901	HOUSEKEEPING-SCC	0	0	22,076	0	0	9.01
10.00	01000	DIETARY	0	44,785	59,001	0	15,516	10.00
10.01	01001	DIETARY-SCC	14	0	70,192	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	0	86	63,803	0	5,172	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	19,907	0	0	14.00
15.00	01500	PHARMACY	0	3,506	0	0	10,344	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,182	48,093	0	20,688	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	32,917	219,901	45,944	82,750	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	12,218	0	443,914	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	193,575	63,081	56,565	77,578	50.00
53.00	05300	ANESTHESIOLOGY	0	12,115	0	11,321	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	246,758	93,761	91,725	51,719	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	29,641	83,377	56,462	25,859	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	10,859	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,065	0	4,634	0	65.00
66.00	06600	PHYSICAL THERAPY	72	11,885	268,044	51,083	155,155	66.00
66.01	06601	CARDIAC REHAB	0	7,299	33,682	4,324	5,172	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	23,651	5,550	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	12,686	3,303	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	14,929	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	35,204	0	73.00
76.00	03020	SLEEP LAB	0	4,348	10,026	276	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	3,093	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	34	26,022	174,243	0	139,641	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	12,134	48,504	0	46,547	88.01
90.00	09000	CLINIC	0	5,875	0	0	41,375	90.00
91.00	09100	EMERGENCY	64	27,405	108,487	35,410	56,891	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,981	848,213	2,354,911	427,589	811,985	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	207	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	6,914	3,762	86,592	0	0	194.01
194.02	07952	ADULT DAY CARE	876	0	13,786	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	INFORMATION TECHNOLOGY	
			NEW MVBLE EQUIP	NEW MVBLE EQUIP NEW HO				
			2.00	2.01				
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	11	1,877	1,443	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	20,782	854,059	2,456,732	427,589	811,985	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			HOSPITAL BILLING	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
			5.03	5A.03	5.04	6.00	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING	244,613					5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	0	1,837,115	1,837,115			5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0		6.00
7.00	00700	OPERATION OF PLANT	0	908,146	94,849	0	1,002,995	7.00
7.01	00701	OPERATION OF PLANT-SCC	0	317,586	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	61,873	6,462	0	8,270	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	32,601	0	0	0	8.01
9.00	00900	HOUSEKEEPING	0	260,386	27,195	0	6,272	9.00
9.01	00901	HOUSEKEEPING-SCC	0	121,085	0	0	0	9.01
10.00	01000	DIETARY	0	576,831	60,245	0	74,475	10.00
10.01	01001	DIETARY-SCC	0	502,377	0	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	0	312,691	32,658	0	2,973	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	128,627	13,434	0	15,843	14.00
15.00	01500	PHARMACY	0	49,722	5,193	0	17,957	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	311,053	32,487	0	15,959	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	23,921	1,887,870	197,173	0	205,584	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	13,505	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	2,422,675	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	29,451	1,465,865	153,098	0	125,069	50.00
53.00	05300	ANESTHESIOLOGY	5,894	290,301	30,320	0	1,254	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,765	1,531,156	159,917	0	84,348	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	29,398	1,125,039	117,501	0	24,995	60.00
64.00	06400	INTRAVENOUS THERAPY	5,654	40,049	4,183	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,413	49,828	5,204	0	4,367	65.00
66.00	06600	PHYSICAL THERAPY	26,597	1,740,516	181,783	0	108,600	66.00
66.01	06601	CARDIAC REHAB	2,251	205,559	21,469	0	6,969	66.01
67.00	06700	OCCUPATIONAL THERAPY	2,890	144,119	15,052	0	8,642	67.00
68.00	06800	SPEECH PATHOLOGY	1,719	78,496	8,198	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,773	149,155	15,578	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,329	583,484	60,940	0	0	73.00
76.00	03020	SLEEP LAB	144	87,927	9,183	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	14,397	1,504	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	15,265	2,348,949	245,329	0	133,177	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,608	640,142	66,858	0	0	88.01
90.00	09000	CLINIC	2,104	83,325	8,703	0	15,099	90.00
91.00	09100	EMERGENCY	18,437	2,444,893	255,352	0	128,717	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	244,613	22,767,343	1,829,868	0	988,570	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,990	1,461	0	6,899	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	9,238	965	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	489,840	0	0	0	194.01
194.02	07952	ADULT DAY CARE	0	84,514	0	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	21,984	2,296	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	24,174	2,525	0	7,526	194.05

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		HOSPITAL BILLING	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
		5.03	5A.03	5.04	6.00	7.00	
200.00	Cross Foot Adjustments		0				200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	244,613	23,411,083	1,837,115	0	1,002,995	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			OPERATION OF PLANT-SCC	LAUNDRY & LINEN SERVICE	LAUNDRY & LINEN SERVICE-SCC	HOUSEKEEPING	HOUSEKEEPING-S CC	
			7.01	8.00	8.01	9.00	9.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING						5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-SCC	317,586					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	76,605				8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	1,001	0	33,602			8.01
9.00	00900	HOUSEKEEPING	0	0	0	293,853		9.00
9.01	00901	HOUSEKEEPING-SCC	1,905	0	0	0	122,990	9.01
10.00	01000	DIETARY	0	0	0	24,256	0	10.00
10.01	01001	DIETARY-SCC	7,402	0	0	0	4,202	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	3,319	0	0	968	1,884	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	5,160	0	14.00
15.00	01500	PHARMACY	0	0	0	5,848	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	5,198	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	76,605	0	66,957	0	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	8,687	0	0	0	4,932	44.00
46.00	04600	OTHER LONG TERM CARE	90,369	0	33,602	0	51,306	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	40,734	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	409	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	27,471	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	8,141	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,422	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	12,892	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	1,324	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,021	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	44,698	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	4,539	0	90.00
91.00	09100	EMERGENCY	0	0	0	41,922	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	112,683	76,605	33,602	292,960	62,324	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	98,854	0	0	0	56,124	194.01
194.02	07952	ADULT DAY CARE	8,000	0	0	0	4,542	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	98,049	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	893	0	194.05

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		OPERATION OF PLANT-SCC	LAUNDRY & LINEN SERVICE	LAUNDRY & LINEN SERVICE-SCC	HOUSEKEEPING	HOUSEKEEPING-S CC	
		7.01	8.00	8.01	9.00	9.01	
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)	317,586	76,605	33,602	293,853	122,990	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			DIETARY	DIETARY-SCC	CAFETERIA	CAFETERIA-SCC	NURSING ADMINISTRATION	
			10.00	10.01	11.00	11.01	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING						5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-SCC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC						8.01
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING-SCC						9.01
10.00	01000	DIETARY	735,807					10.00
10.01	01001	DIETARY-SCC	0	513,981				10.01
11.00	01100	CAFETERIA	0	0	0			11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0		11.01
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	354,493	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	735,807	0	0	0	283,531	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	326,681	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	35,481	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	35,481	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	735,807	326,681	0	0	354,493	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	16,306	0	0	0	194.01
194.02	07952	ADULT DAY CARE	0	170,994	0	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		DIETARY	DIETARY-SCC	CAFETERIA	CAFETERIA-SCC	NURSING ADMINISTRATION	
		10.00	10.01	11.00	11.01	13.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	735,807	513,981	0	0	354,493	202.00

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Cost Center Description			CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
			14.00	15.00	16.00	19.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING						5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-SCC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC						8.01
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING-SCC						9.01
10.00	01000	DIETARY						10.00
10.01	01001	DIETARY-SCC						10.01
11.00	01100	CAFETERIA						11.00
11.01	01101	CAFETERIA-SCC						11.01
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	163,064					14.00
15.00	01500	PHARMACY	0	78,720				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,171	0	365,868			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,600	0	35,781	0	3,497,908	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	27,124	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	2,924,633	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	90,684	0	44,053	0	1,954,984	50.00
53.00	05300	ANESTHESIOLOGY	1,180	0	8,817	0	332,281	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	71,426	0	1,874,318	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	43,973	0	1,319,649	60.00
64.00	06400	INTRAVENOUS THERAPY	4,535	0	8,457	0	57,224	64.00
65.00	06500	RESPIRATORY THERAPY	133	0	3,609	0	64,563	65.00
66.00	06600	PHYSICAL THERAPY	11,474	0	39,783	0	2,095,048	66.00
66.01	06601	CARDIAC REHAB	0	0	3,367	0	238,688	66.01
67.00	06700	OCCUPATIONAL THERAPY	402	0	4,322	0	173,558	67.00
68.00	06800	SPEECH PATHOLOGY	102	0	2,572	0	89,368	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,364	0	11,627	0	200,724	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	78,720	27,416	0	750,560	73.00
76.00	03020	SLEEP LAB	3,040	0	215	0	100,365	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	15,901	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,642	0	22,833	0	2,800,628	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,841	0	6,892	0	716,733	88.01
90.00	09000	CLINIC	20	0	3,148	0	114,834	90.00
91.00	09100	EMERGENCY	8,876	0	27,577	0	2,942,818	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	163,064	78,720	365,868	0	22,291,909	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	22,350	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	10,203	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	0	0	0	661,124	194.01
194.02	07952	ADULT DAY CARE	0	0	0	0	268,050	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	0	122,329	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	0	35,118	194.05

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
		14.00	15.00	16.00	19.00	24.00	
200.00	Cross Foot Adjustments				0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	163,064	78,720	365,868	0	23,411,083	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
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Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG			1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL			1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB			1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO			2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00570	ADMITTING			5.01
5.02	00550	INFORMATION TECHNOLOGY			5.02
5.03	00590	HOSPITAL BILLING			5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL			5.04
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT-SCC			7.01
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC			8.01
9.00	00900	HOUSEKEEPING			9.00
9.01	00901	HOUSEKEEPING-SCC			9.01
10.00	01000	DIETARY			10.00
10.01	01001	DIETARY-SCC			10.01
11.00	01100	CAFETERIA			11.00
11.01	01101	CAFETERIA-SCC			11.01
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICE & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	3,497,908	30.00
42.00	04200	SUBPROVIDER	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	27,124	44.00
46.00	04600	OTHER LONG TERM CARE	0	2,924,633	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,954,984	50.00
53.00	05300	ANESTHESIOLOGY	0	332,281	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,874,318	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	1,319,649	60.00
64.00	06400	INTRAVENOUS THERAPY	0	57,224	64.00
65.00	06500	RESPIRATORY THERAPY	0	64,563	65.00
66.00	06600	PHYSICAL THERAPY	0	2,095,048	66.00
66.01	06601	CARDIAC REHAB	0	238,688	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	173,558	67.00
68.00	06800	SPEECH PATHOLOGY	0	89,368	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	200,724	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	750,560	73.00
76.00	03020	SLEEP LAB	0	100,365	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	15,901	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	2,800,628	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	716,733	88.01
90.00	09000	CLINIC	0	114,834	90.00
91.00	09100	EMERGENCY	0	2,942,818	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	93.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	22,291,909	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22,350	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,203	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	661,124	194.01
194.02	07952	ADULT DAY CARE	0	268,050	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	194.03

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
194.04	07954	IDLE SPACE	0	122,329	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	35,118	194.05
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	23,411,083	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2019
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Cost Center Description			CAPITAL RELATED COSTS					
			Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW ALU BLDG	NEW 2007 HOSPITAL		NEW 2007 MOB
			0	1.00	1.01	1.02	1.03	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00570	ADMITTING	0	0	0	35,130	0	5.01
5.02	00550	INFORMATION TECHNOLOGY	0	669	0	17,449	0	5.02
5.03	00590	HOSPITAL BILLING	0	0	0	0	0	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	0	8,760	19,093	210,824	0	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	163,489	0	7.00
7.01	00701	OPERATION OF PLANT-SCC	0	2,245	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	16,521	0	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	225	0	0	0	8.01
9.00	00900	HOUSEKEEPING	0	0	0	12,530	0	9.00
9.01	00901	HOUSEKEEPING-SCC	0	427	0	0	0	9.01
10.00	01000	DIETARY	0	0	0	148,779	0	10.00
10.01	01001	DIETARY-SCC	0	1,660	0	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	0	744	0	5,940	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	31,649	0	14.00
15.00	01500	PHARMACY	0	0	0	35,872	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	31,881	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	410,696	0	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	1,948	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	20,262	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	249,851	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,506	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,174	0	0	168,501	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	49,933	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,724	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	200,707	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	13,922	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	17,263	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	16,242	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	266,047	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	30,164	0	90.00
91.00	09100	EMERGENCY	0	0	0	257,137	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,174	36,940	19,093	2,401,757	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	13,783	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	0	41,087	0	0	194.01
194.02	07952	ADULT DAY CARE	0	0	3,325	0	0	194.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW ALU BLDG	NEW 2007 HOSPITAL	NEW 2007 MOB	
0			1.00	1.01	1.02	1.03		
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	21,984	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	15,036	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	21,174	58,924	63,505	2,430,576	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
			NEW MVBLE EQUIP	NEW MVBLE EQUIP NEW HO				
			2.00	2.01	2A	4.00	5.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0		4.00
5.01	00570	ADMITTING	0	0	35,130	0	35,130	5.01
5.02	00550	INFORMATION TECHNOLOGY	0	61,329	79,447	0	0	5.02
5.03	00590	HOSPITAL BILLING	0	0	0	0	0	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	334	98,336	337,347	0	0	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	24,081	187,570	0	0	7.00
7.01	00701	OPERATION OF PLANT-SCC	245	0	2,490	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	550	17,071	0	0	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	0	225	0	0	8.01
9.00	00900	HOUSEKEEPING	0	319	12,849	0	0	9.00
9.01	00901	HOUSEKEEPING-SCC	0	0	427	0	0	9.01
10.00	01000	DIETARY	0	44,785	193,564	0	0	10.00
10.01	01001	DIETARY-SCC	14	0	1,674	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	0	86	6,770	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	31,649	0	0	14.00
15.00	01500	PHARMACY	0	3,506	39,378	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,182	34,063	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	32,917	443,613	0	3,776	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	1,948	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	12,218	0	32,480	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	193,575	443,426	0	4,649	50.00
53.00	05300	ANESTHESIOLOGY	0	12,115	14,621	0	930	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	246,758	436,433	0	7,529	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	29,641	79,574	0	4,640	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	892	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,065	11,789	0	381	65.00
66.00	06600	PHYSICAL THERAPY	72	11,885	212,664	0	4,198	66.00
66.01	06601	CARDIAC REHAB	0	7,299	21,221	0	355	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	17,263	0	456	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	271	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,227	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,893	73.00
76.00	03020	SLEEP LAB	0	4,348	20,590	0	23	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	34	26,022	292,103	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	12,134	12,134	0	0	88.01
90.00	09000	CLINIC	0	5,875	36,039	0	0	90.00
91.00	09100	EMERGENCY	64	27,405	284,606	0	2,910	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,981	848,213	3,340,158	0	35,130	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	207	13,990	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	6,914	3,762	51,763	0	0	194.01
194.02	07952	ADULT DAY CARE	876	0	4,201	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
			NEW MVBLE EQUIP	NEW MVBLE EQUIP NEW HO				
			2.00	2.01	2A	4.00	5.01	
194.04	07954	IDLE SPACE	0	0	21,984	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	11	1,877	16,924	0	0	194.05
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	20,782	854,059	3,449,020	0	35,130	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
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Cost Center Description			INFORMATION TECHNOLOGY	HOSPITAL BILLING	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
			5.02	5.03	5.04	6.00	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY	79,447					5.02
5.03	00590	HOSPITAL BILLING	0	0				5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	5,060	0	342,407			5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0		6.00
7.00	00700	OPERATION OF PLANT	2,530		17,678	0	207,778	7.00
7.01	00701	OPERATION OF PLANT-SCC	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,204	0	1,713	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	0	0	0	0	8.01
9.00	00900	HOUSEKEEPING	0	0	5,069	0	1,299	9.00
9.01	00901	HOUSEKEEPING-SCC	0	0	0	0	0	9.01
10.00	01000	DIETARY	1,518	0	11,229	0	15,428	10.00
10.01	01001	DIETARY-SCC	0	0	0	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	506	0	6,087	0	616	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	2,504	0	3,282	14.00
15.00	01500	PHARMACY	1,012	0	968	0	3,720	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,024	0	6,055	0	3,306	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,097	0	36,749	0	42,588	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,590	0	28,535	0	25,909	50.00
53.00	05300	ANESTHESIOLOGY	0	0	5,651	0	260	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,060	0	29,805	0	17,473	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,530	0	21,900	0	5,178	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	780	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	970	0	905	65.00
66.00	06600	PHYSICAL THERAPY	15,183	0	33,881	0	22,497	66.00
66.01	06601	CARDIAC REHAB	506	0	4,001	0	1,444	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,805	0	1,790	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,528	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,903	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	11,358	0	0	73.00
76.00	03020	SLEEP LAB	0	0	1,712	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	280	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	13,663	0	45,725	0	27,589	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,554	0	12,461	0	0	88.01
90.00	09000	CLINIC	4,048	0	1,622	0	3,128	90.00
91.00	09100	EMERGENCY	5,566	0	47,596	0	26,665	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	79,447	0	341,056	0	204,790	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	272	0	1,429	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	180	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	0	0	0	0	194.01
194.02	07952	ADULT DAY CARE	0	0	0	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	428	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	471	0	1,559	194.05

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

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Cost Center Description		INFORMATION TECHNOLOGY	HOSPITAL BILLING	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
		5.02	5.03	5.04	6.00	7.00	
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)	79,447	0	342,407	0	207,778	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
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Cost Center Description			OPERATION OF PLANT-SCC	LAUNDRY & LINEN SERVICE	LAUNDRY & LINEN SERVICE-SCC	HOUSEKEEPING	HOUSEKEEPING-S CC	
			7.01	8.00	8.01	9.00	9.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING						5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-SCC	2,490					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	19,988				8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	0	233			8.01
9.00	00900	HOUSEKEEPING	0	0	0	19,217		9.00
9.01	00901	HOUSEKEEPING-SCC	15	0	0	0	442	9.01
10.00	01000	DIETARY	0	0	0	1,586	0	10.00
10.01	01001	DIETARY-SCC	58	0	0	0	15	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	26	0	0	63	7	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	337	0	14.00
15.00	01500	PHARMACY	0	0	0	382	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	340	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	19,988	0	4,379	0	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	68	0	0	0	18	44.00
46.00	04600	OTHER LONG TERM CARE	709	0	233	0	184	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	2,664	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	27	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,797	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	532	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	93	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	843	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	87	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,923	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	297	0	90.00
91.00	09100	EMERGENCY	0	0	0	2,742	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	884	19,988	233	19,159	224	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	774	0	0	0	202	194.01
194.02	07952	ADULT DAY CARE	63	0	0	0	16	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	769	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	58	0	194.05

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description		OPERATION OF PLANT-SCC	LAUNDRY & LINEN SERVICE	LAUNDRY & LINEN SERVICE-SCC	HOUSEKEEPING	HOUSEKEEPING-S CC	
		7.01	8.00	8.01	9.00	9.01	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2,490	19,988	233	19,217	442	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			DIETARY	DIETARY-SCC	CAFETERIA	CAFETERIA-SCC	NURSING ADMINISTRATION	
			10.00	10.01	11.00	11.01	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING						5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-SCC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC						8.01
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING-SCC						9.01
10.00	01000	DIETARY	223,325					10.00
10.01	01001	DIETARY-SCC	0	1,747				10.01
11.00	01100	CAFETERIA	0	0	0			11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0		11.01
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	14,075	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	223,325	0	0	0	11,257	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	1,111	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	1,409	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	1,409	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	223,325	1,111	0	0	14,075	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	55	0	0	0	194.01
194.02	07952	ADULT DAY CARE	0	581	0	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

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Cost Center Description		DIETARY	DIETARY-SCC	CAFETERIA	CAFETERIA-SCC	NURSING ADMINISTRATION	
		10.00	10.01	11.00	11.01	13.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	223,325	1,747	0	0	14,075	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

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Cost Center Description			CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
			14.00	15.00	16.00	19.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING						5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-SCC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC						8.01
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING-SCC						9.01
10.00	01000	DIETARY						10.00
10.01	01001	DIETARY-SCC						10.01
11.00	01100	CAFETERIA						11.00
11.01	01101	CAFETERIA-SCC						11.01
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	37,772					14.00
15.00	01500	PHARMACY	0	45,460				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	271	0	46,059			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,992	0	4,504		800,268	30.00
42.00	04200	SUBPROVIDER	0	0	0		0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		2,034	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0		34,717	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	21,006	0	5,546		540,734	50.00
53.00	05300	ANESTHESIOLOGY	273	0	1,110		22,872	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	8,993		507,090	54.00
57.00	05700	CT SCAN	0	0	0		0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		0	58.00
60.00	06000	LABORATORY	0	0	5,535		119,889	60.00
64.00	06400	INTRAVENOUS THERAPY	1,050	0	1,065		3,787	64.00
65.00	06500	RESPIRATORY THERAPY	31	0	454		14,623	65.00
66.00	06600	PHYSICAL THERAPY	2,658	0	5,008		296,932	66.00
66.01	06601	CARDIAC REHAB	0	0	424		28,038	66.01
67.00	06700	OCCUPATIONAL THERAPY	93	0	544		23,018	67.00
68.00	06800	SPEECH PATHOLOGY	24	0	324		2,147	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,644	0	1,464		11,238	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	45,460	3,451		63,162	73.00
76.00	03020	SLEEP LAB	704	0	27		23,056	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0		0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0		280	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,307	0	2,874		386,184	88.00
88.01	08801	RURAL HEALTH CLINIC II	658	0	868		30,675	88.01
90.00	09000	CLINIC	5	0	396		45,535	90.00
91.00	09100	EMERGENCY	2,056	0	3,472		377,022	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	0	0		0	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,772	45,460	46,059	0	3,333,301	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		15,691	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		180	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0		0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0		0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	0	0		52,794	194.01
194.02	07952	ADULT DAY CARE	0	0	0		4,861	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0		0	194.03
194.04	07954	IDLE SPACE	0	0	0		23,181	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0		19,012	194.05

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
		14.00	15.00	16.00	19.00	24.00	
200.00	Cross Foot Adjustments				0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	37,772	45,460	46,059	0	3,449,020	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2019
To 09/30/2020Worksheet B
Part II
Date/Time Prepared:
4/12/2021 8:39 am

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG		1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL		1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB		1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00570	ADMITTING		5.01
5.02	00550	INFORMATION TECHNOLOGY		5.02
5.03	00590	HOSPITAL BILLING		5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL		5.04
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
7.01	00701	OPERATION OF PLANT-SCC		7.01
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC		8.01
9.00	00900	HOUSEKEEPING		9.00
9.01	00901	HOUSEKEEPING-SCC		9.01
10.00	01000	DIETARY		10.00
10.01	01001	DIETARY-SCC		10.01
11.00	01100	CAFETERIA		11.00
11.01	01101	CAFETERIA-SCC		11.01
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
42.00	04200	SUBPROVIDER	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	46.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
60.00	06000	LABORATORY	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
66.01	06601	CARDIAC REHAB	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03020	SLEEP LAB	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	76.02
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	88.01
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
93.00	04040	FAMILY PRACTICE	0	93.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	194.01
194.02	07952	ADULT DAY CARE	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	194.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

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

 Worksheet B
 Part II
 Date/Time Prepared:
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total		
		25.00	26.00		
194.04	07954	IDLE SPACE	0	23,181	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	19,012	194.05
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	3,449,020	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

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

Worksheet B-1

Date/Time Prepared:
4/12/2021 8:39 am

Cost Center Description			CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW ALU BLDG (SQUARE FEET)	NEW 2007 HOSPITAL (SQUARE FEET)	NEW 2007 MOB (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	
			1.00	1.01	1.02	1.03	2.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	50,914					1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG	0	29,602				1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL	0	0	52,376			1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB	0	0	0	0		1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					96,563	2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO					0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00570	ADMITTING	0	0	757	0	0	5.01
5.02	00550	INFORMATION TECHNOLOGY	578	0	376	0	0	5.02
5.03	00590	HOSPITAL BILLING	0	0	0	0	0	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	7,569	8,900	4,543	0	1,551	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	3,523	0	0	7.00
7.01	00701	OPERATION OF PLANT-SCC	1,940	0	0	0	1,138	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	356	0	0	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	194	0	0	0	0	8.01
9.00	00900	HOUSEKEEPING	0	0	270	0	0	9.00
9.01	00901	HOUSEKEEPING-SCC	369	0	0	0	0	9.01
10.00	01000	DIETARY	0	0	3,206	0	0	10.00
10.01	01001	DIETARY-SCC	1,434	0	0	0	66	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	643	0	128	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	682	0	0	14.00
15.00	01500	PHARMACY	0	0	773	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	687	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	8,850	0	0	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	1,683	0	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	17,508	0	0	0	56,765	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	5,384	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	54	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,631	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	1,076	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	188	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	4,325	0	336	66.00
66.01	06601	CARDIAC REHAB	0	0	300	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	372	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	350	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	5,733	0	160	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	650	0	0	90.00
91.00	09100	EMERGENCY	0	0	5,541	0	298	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,918	8,900	51,755	0	60,314	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	297	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	19,152	0	0	32,128	194.01
194.02	07952	ADULT DAY CARE	0	1,550	0	0	4,068	194.02

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

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

Worksheet B-1

Date/Time Prepared:
4/12/2021 8:39 am

Cost Center Description			CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW ALU BLDG (SQUARE FEET)	NEW 2007 HOSPITAL (SQUARE FEET)	NEW 2007 MOB (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	
			1.00	1.01	1.02	1.03	2.00	
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	18,996	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	324	0	53	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	58,924	63,505	2,430,576	0	20,782	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.157324	2.145294	46.406293	0.000000	0.215217	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

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

Worksheet B-1

Date/Time Prepared:
4/12/2021 8:39 am

Cost Center Description		CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	INFORMATION TECHNOLOGY (NO. OF COMPUTERS)	HOSPITAL BILLING (GROSS CHARGES HOSP BILLING)	
		NEW MVBLE EQUIP NEW HO (DOLLAR VALUE)					
		2.01	4.00	5.01	5.02	5.03	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG					1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL					1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB					1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	883,956				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,978,357			4.00
5.01	00570	ADMITTING	0	305,728	24,036,216		5.01
5.02	00550	INFORMATION TECHNOLOGY	63,476	308,291	0	157	5.02
5.03	00590	HOSPITAL BILLING	0	0	0	26,409,091	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	101,778	760,014	0	10	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	24,924	125,794	0	5	7.00
7.01	00701	OPERATION OF PLANT-SCC	0	92,202	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	569	0	0	0	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	10,848	0	0	8.01
9.00	00900	HOUSEKEEPING	330	171,024	0	0	9.00
9.01	00901	HOUSEKEEPING-SCC	0	80,678	0	0	9.01
10.00	01000	DIETARY	46,353	215,625	0	3	10.00
10.01	01001	DIETARY-SCC	0	256,525	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	89	233,174	0	1	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	72,752	0	0	14.00
15.00	01500	PHARMACY	3,629	0	0	2	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,258	175,762	0	4	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	34,069	803,649	2,582,728	16	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	1,622,315	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	200,351	230,534	3,179,799	15	50.00
53.00	05300	ANESTHESIOLOGY	12,539	0	636,394	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	255,396	342,659	5,155,853	10	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	30,679	304,710	3,174,000	5	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	610,412	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,172	0	260,501	0	65.00
66.00	06600	PHYSICAL THERAPY	12,301	979,593	2,871,588	30	66.00
66.01	06601	CARDIAC REHAB	7,555	123,094	243,052	1	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	86,436	311,975	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	46,361	185,651	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	839,235	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,978,959	0	73.00
76.00	03020	SLEEP LAB	4,500	36,641	15,504	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	11,304	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	26,933	636,788	0	27	88.00
88.01	08801	RURAL HEALTH CLINIC II	12,559	177,262	0	9	88.01
90.00	09000	CLINIC	6,081	0	0	8	90.00
91.00	09100	EMERGENCY	28,364	396,477	1,990,565	11	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	877,905	8,606,240	24,036,216	157	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	214	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	3,894	316,458	0	0	194.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

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

Worksheet B-1

Date/Time Prepared:
4/12/2021 8:39 am

Cost Center Description			CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	INFORMATION TECHNOLOGY (NO. OF COMPUTERS)	HOSPITAL BILLING (GROSS CHARGES HOSP BILLING)	
			NEW MVBLE EQUIP NEW HO (DOLLAR VALUE)					
			2.01	4.00	5.01	5.02	5.03	
194.02	07952	ADULT DAY CARE	0	50,384	0	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	1,943	5,275	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	854,059	2,456,732	427,589	811,985	244,613	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.966178	0.273628	0.017789	5,171.878981	0.009262	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		0	35,130	79,447	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000000	0.001462	506.031847	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

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

Worksheet B-1

Date/Time Prepared:
4/12/2021 8:39 am

Cost Center Description		Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FT)	OPERATION OF PLANT-SCC (SQUARE FT SCC)	
		5A.04	5.04	6.00	7.00	7.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG					1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL					1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB					1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00570	ADMITTING					5.01
5.02	00550	INFORMATION TECHNOLOGY					5.02
5.03	00590	HOSPITAL BILLING					5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	-1,837,115	17,589,785			5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0		6.00
7.00	00700	OPERATION OF PLANT	0	908,146	0	43,177	7.00
7.01	00701	OPERATION OF PLANT-SCC	-317,586	0	0	61,529	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	61,873	0	356	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	-32,601	0	0	194	8.01
9.00	00900	HOUSEKEEPING	0	260,386	0	270	9.00
9.01	00901	HOUSEKEEPING-SCC	-121,085	0	0	369	9.01
10.00	01000	DIETARY	0	576,831	0	3,206	10.00
10.01	01001	DIETARY-SCC	-502,377	0	0	1,434	10.01
11.00	01100	CAFETERIA	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	0	312,691	0	128	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	128,627	0	682	14.00
15.00	01500	PHARMACY	0	49,722	0	773	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	311,053	0	687	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,887,870	0	8,850	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	-13,505	0	0	1,683	44.00
46.00	04600	OTHER LONG TERM CARE	-2,422,675	0	0	17,508	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,465,865	0	5,384	50.00
53.00	05300	ANESTHESIOLOGY	0	290,301	0	54	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,531,156	0	3,631	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	1,125,039	0	1,076	60.00
64.00	06400	INTRAVENOUS THERAPY	0	40,049	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	49,828	0	188	65.00
66.00	06600	PHYSICAL THERAPY	0	1,740,516	0	4,675	66.00
66.01	06601	CARDIAC REHAB	0	205,559	0	300	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	144,119	0	372	67.00
68.00	06800	SPEECH PATHOLOGY	0	78,496	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	149,155	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	583,484	0	0	73.00
76.00	03020	SLEEP LAB	0	87,927	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	14,397	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,348,949	0	5,733	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	640,142	0	0	88.01
90.00	09000	CLINIC	0	83,325	0	650	90.00
91.00	09100	EMERGENCY	0	2,444,893	0	5,541	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,246,944	17,520,399	0	42,556	21,831
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,990	0	297	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	9,238	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	-489,840	0	0	19,152	194.01
194.02	07952	ADULT DAY CARE	-84,514	0	0	1,550	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	21,984	0	0	18,996

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FT)	OPERATION OF PLANT-SCC (SQUARE FT SCC)	
			5A.04	5.04	6.00	7.00	7.01	
194.05	07955	COMMUNITY FITNESS CENTER	0	24,174	0	324	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		1,837,115	0	1,002,995	317,586	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.104442	0.000000	23.229845	5.161566	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		342,407	0	207,778	2,490	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.019466	0.000000	4.812238	0.040469	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			LAUNDRY & LINEN SERVICE (PATIENT DAYS)	LAUNDRY & LINEN SERVICE-SCC (PATIENT DAYS SCC)	HOUSEKEEPING (SQUARE FT)	HOUSEKEEPING-S CC (SQUARE FT SCC)	DIETARY (PATIENT DAYS)	
			8.00	8.01	9.00	9.01	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING						5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-SCC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE	2,417					8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	14,705				8.01
9.00	00900	HOUSEKEEPING	0	0	38,840			9.00
9.01	00901	HOUSEKEEPING-SCC	0	0	0	41,970		9.01
10.00	01000	DIETARY	0	0	3,206	0	2,417	10.00
10.01	01001	DIETARY-SCC	0	0	0	1,434	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
11.01	01101	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	01300	NURSING ADMINISTRATION	0	0	128	643	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	682	0	0	14.00
15.00	01500	PHARMACY	0	0	773	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	687	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,417	0	8,850	0	2,417	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	1,683	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	14,705	0	17,508	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	5,384	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	54	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	3,631	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	1,076	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	188	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,704	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	175	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	135	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	5,908	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	600	0	0	90.00
91.00	09100	EMERGENCY	0	0	5,541	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,417	14,705	38,722	21,268	2,417	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	0	0	19,152	0	194.01
194.02	07952	ADULT DAY CARE	0	0	0	1,550	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			LAUNDRY & LINEN SERVICE (PATIENT DAYS)	LAUNDRY & LINEN SERVICE-SCC (PATIENT DAYS SCC)	HOUSEKEEPING (SQUARE FT)	HOUSEKEEPING-S CC (SQUARE FT SCC)	DIETARY (PATIENT DAYS)	
			8.00	8.01	9.00	9.01	10.00	
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	118	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	76,605	33,602	293,853	122,990	735,807	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	31.694249	2.285073	7.565731	2.930426	304.429872	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	19,988	233	19,217	442	223,325	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	8.269756	0.015845	0.494773	0.010531	92.397600	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

Period:
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To 09/30/2020

Worksheet B-1

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Cost Center Description			DIETARY-SCC (PATIENT DAYS SCC)	CAFETERIA (FTE)	CAFETERIA-SCC (FTE'S -SCC)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	
			10.01	11.00	11.01	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING						5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-SCC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC						8.01
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING-SCC						9.01
10.00	01000	DIETARY						10.00
10.01	01001	DIETARY-SCC	23,136					10.01
11.00	01100	CAFETERIA	0	0				11.00
11.01	01101	CAFETERIA-SCC	0	0	0			11.01
13.00	01300	NURSING ADMINISTRATION	0	0	0	2,208		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	846,330	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	6,080	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	1,766	44,633	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	14,705	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	221	470,671	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	6,122	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	23,536	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	688	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	59,553	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	2,089	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	529	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	126,453	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	15,778	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	29,283	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	14,743	88.01
90.00	09000	CLINIC	0	0	0	0	102	90.00
91.00	09100	EMERGENCY	0	0	0	221	46,070	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,705	0	0	2,208	846,330	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	734	0	0	0	0	194.01
194.02	07952	ADULT DAY CARE	7,697	0	0	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			DIETARY-SCC (PATIENT DAYS SCC)	CAFETERIA (FTE)	CAFETERIA-SCC (FTE'S -SCC)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	
			10.01	11.00	11.01	13.00	14.00	
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	513,981	0	0	354,493	163,064	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.215638	0.000000	0.000000	160.549366	0.192672	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,747	0	0	14,075	37,772	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.075510	0.000000	0.000000	6.374547	0.044630	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

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

Worksheet B-1

Date/Time Prepared:
4/12/2021 8:39 am

Cost Center Description			PHARMACY (GROSS CHARGES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES HOSP BILLING)	NONPHYSICIAN ANESTHETISTS (TIME SPENT)	
			15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG				1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL				1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB				1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00570	ADMITTING				5.01
5.02	00550	INFORMATION TECHNOLOGY				5.02
5.03	00590	HOSPITAL BILLING				5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL				5.04
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT-SCC				7.01
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC				8.01
9.00	00900	HOUSEKEEPING				9.00
9.01	00901	HOUSEKEEPING-SCC				9.01
10.00	01000	DIETARY				10.00
10.01	01001	DIETARY-SCC				10.01
11.00	01100	CAFETERIA				11.00
11.01	01101	CAFETERIA-SCC				11.01
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY				14.00
15.00	01500	PHARMACY	1,978,959			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	26,409,091		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,582,728	0	30.00
42.00	04200	SUBPROVIDER	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,179,799	0	50.00
53.00	05300	ANESTHESIOLOGY	0	636,394	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,155,853	0	54.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
60.00	06000	LABORATORY	0	3,174,000	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	610,412	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	260,501	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,871,588	0	66.00
66.01	06601	CARDIAC REHAB	0	243,052	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	311,975	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	185,651	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	839,235	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,978,959	1,978,959	0	73.00
76.00	03020	SLEEP LAB	0	15,504	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,648,152	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	497,509	0	88.01
90.00	09000	CLINIC	0	227,214	0	90.00
91.00	09100	EMERGENCY	0	1,990,565	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	FAMILY PRACTICE	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,978,959	26,409,091	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	0	0	194.01
194.02	07952	ADULT DAY CARE	0	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	194.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			PHARMACY (GROSS CHARGES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES HOSP BILLING)	NONPHYSICIAN ANESTHETISTS (TIME SPENT)	
			15.00	16.00	19.00	
194.04	07954	IDLE SPACE	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	194.05
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	78,720	365,868	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.039778	0.013854	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	45,460	46,059	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.022972	0.001744	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1302

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
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				Title XVIII	Hospital	Cost		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	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	3,497,908		3,497,908	0	3,497,908	30.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	27,124		27,124	0	27,124	44.00
46.00	04600	OTHER LONG TERM CARE	2,924,633		2,924,633	0	2,924,633	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,954,984		1,954,984	0	1,954,984	50.00
53.00	05300	ANESTHESIOLOGY	332,281		332,281	0	332,281	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,874,318		1,874,318	0	1,874,318	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
60.00	06000	LABORATORY	1,319,649		1,319,649	0	1,319,649	60.00
64.00	06400	INTRAVENOUS THERAPY	57,224		57,224	0	57,224	64.00
65.00	06500	RESPIRATORY THERAPY	64,563	0	64,563	0	64,563	65.00
66.00	06600	PHYSICAL THERAPY	2,095,048	0	2,095,048	0	2,095,048	66.00
66.01	06601	CARDIAC REHAB	238,688	0	238,688	0	238,688	66.01
67.00	06700	OCCUPATIONAL THERAPY	173,558	0	173,558	0	173,558	67.00
68.00	06800	SPEECH PATHOLOGY	89,368	0	89,368	0	89,368	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	200,724		200,724	0	200,724	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	750,560		750,560	0	750,560	73.00
76.00	03020	SLEEP LAB	100,365		100,365	0	100,365	76.00
76.01	03950	PAIN CLINIC / SERVICE	0		0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	15,901		15,901	0	15,901	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,800,628		2,800,628	0	2,800,628	88.00
88.01	08801	RURAL HEALTH CLINIC II	716,733		716,733	0	716,733	88.01
90.00	09000	CLINIC	114,834		114,834	0	114,834	90.00
91.00	09100	EMERGENCY	2,942,818		2,942,818	0	2,942,818	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	182,654		182,654	0	182,654	92.00
93.00	04040	FAMILY PRACTICE	0		0	0	0	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	22,474,563	0	22,474,563	0	22,474,563	200.00
201.00		Less Observation Beds	182,654		182,654		182,654	201.00
202.00		Total (see instructions)	22,291,909	0	22,291,909	0	22,291,909	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1302

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
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			Title XVIII		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,442,015		2,442,015		30.00
42.00	04200	SUBPROVIDER	0		0		42.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
46.00	04600	OTHER LONG TERM CARE	3,781,773		3,781,773		46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	758,811	2,420,988	3,179,799	0.614814	50.00
53.00	05300	ANESTHESIOLOGY	24,084	612,310	636,394	0.522131	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	155,678	5,000,175	5,155,853	0.363532	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	197,251	2,976,749	3,174,000	0.415768	60.00
64.00	06400	INTRAVENOUS THERAPY	39,620	570,792	610,412	0.093747	64.00
65.00	06500	RESPIRATORY THERAPY	224,132	36,369	260,501	0.247842	65.00
66.00	06600	PHYSICAL THERAPY	556,108	2,315,479	2,871,587	0.729578	66.00
66.01	06601	CARDIAC REHAB	0	243,052	243,052	0.982045	66.01
67.00	06700	OCCUPATIONAL THERAPY	212,233	99,742	311,975	0.556320	67.00
68.00	06800	SPEECH PATHOLOGY	116,111	69,540	185,651	0.481376	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	480,160	359,076	839,236	0.239175	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	871,326	1,107,633	1,978,959	0.379270	73.00
76.00	03020	SLEEP LAB	0	15,504	15,504	6.473491	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0.000000	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0.000000	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,648,152	1,648,152		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	497,509	497,509		88.01
90.00	09000	CLINIC	0	227,214	227,214	0.505400	90.00
91.00	09100	EMERGENCY	8,481	1,982,084	1,990,565	1.478383	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	140,712	140,712	1.298070	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0.000000	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	9,867,783	20,323,080	30,190,863		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	9,867,783	20,323,080	30,190,863		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1302

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/12/2021 8:39 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
42.00	04200	SUBPROVIDER			42.00
44.00	04400	SKILLED NURSING FACILITY			44.00
46.00	04600	OTHER LONG TERM CARE			46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.614814		50.00
53.00	05300	ANESTHESIOLOGY	0.522131		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.363532		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.415768		60.00
64.00	06400	INTRAVENOUS THERAPY	0.093747		64.00
65.00	06500	RESPIRATORY THERAPY	0.247842		65.00
66.00	06600	PHYSICAL THERAPY	0.729578		66.00
66.01	06601	CARDIAC REHAB	0.982045		66.01
67.00	06700	OCCUPATIONAL THERAPY	0.556320		67.00
68.00	06800	SPEECH PATHOLOGY	0.481376		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.239175		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.379270		73.00
76.00	03020	SLEEP LAB	6.473491		76.00
76.01	03950	PAIN CLINIC / SERVICE	0.000000		76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0.000000		76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
90.00	09000	CLINIC	0.505400		90.00
91.00	09100	EMERGENCY	1.478383		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.298070		92.00
93.00	04040	FAMILY PRACTICE	0.000000		93.00
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

Worksheet C
Part I
Date/Time Prepared:

MCRIF32 - 16.9.172.4

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1302

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
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			Title XIX		Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,442,015		2,442,015			30.00
42.00	04200	SUBPROVIDER	0		0			42.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
46.00	04600	OTHER LONG TERM CARE	3,781,773		3,781,773			46.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	758,811	2,420,988	3,179,799	0.614814	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	24,084	612,310	636,394	0.522131	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	155,678	5,000,175	5,155,853	0.363532	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	197,251	2,976,749	3,174,000	0.415768	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	39,620	570,792	610,412	0.093747	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	224,132	36,369	260,501	0.247842	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	556,108	2,315,479	2,871,587	0.729578	0.000000	66.00
66.01	06601	CARDIAC REHAB	0	243,052	243,052	0.982045	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	212,233	99,742	311,975	0.556320	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	116,111	69,540	185,651	0.481376	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	480,160	359,076	839,236	0.239175	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	871,326	1,107,633	1,978,959	0.379270	0.000000	73.00
76.00	03020	SLEEP LAB	0	15,504	15,504	6.473491	0.000000	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0.000000	0.000000	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0.000000	0.000000	76.02
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,648,152	1,648,152	1.699253	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	497,509	497,509	1.440643	0.000000	88.01
90.00	09000	CLINIC	0	227,214	227,214	0.505400	0.000000	90.00
91.00	09100	EMERGENCY	8,481	1,982,084	1,990,565	1.478383	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	140,712	140,712	1.298070	0.000000	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0.000000	0.000000	93.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	9,867,783	20,323,080	30,190,863			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,867,783	20,323,080	30,190,863			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1302

Period:
From 10/01/2019
To 09/30/2020Worksheet C
Part I
Date/Time Prepared:
4/12/2021 8:39 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
42.00	04200	SUBPROVIDER				42.00
44.00	04400	SKILLED NURSING FACILITY				44.00
46.00	04600	OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
66.01	06601	CARDIAC REHAB	0.000000			66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03020	SLEEP LAB	0.000000			76.00
76.01	03950	PAIN CLINIC / SERVICE	0.000000			76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0.000000			76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000			88.01
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
93.00	04040	FAMILY PRACTICE	0.000000			93.00
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: 14-1302

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part II
Date/Time Prepared:
4/12/2021 8:39 am

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	540,734	3,179,799	0.170053	464,210	78,940	50.00
53.00	05300 ANESTHESIOLOGY	22,872	636,394	0.035940	14,049	505	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	507,090	5,155,853	0.098352	75,625	7,438	54.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
60.00	06000 LABORATORY	119,889	3,174,000	0.037772	79,736	3,012	60.00
64.00	06400 INTRAVENOUS THERAPY	3,787	610,412	0.006204	5,675	35	64.00
65.00	06500 RESPIRATORY THERAPY	14,623	260,501	0.056134	69,026	3,875	65.00
66.00	06600 PHYSICAL THERAPY	296,932	2,871,587	0.103403	61,372	6,346	66.00
66.01	06601 CARDIAC REHAB	28,038	243,052	0.115358	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	23,018	311,975	0.073782	21,336	1,574	67.00
68.00	06800 SPEECH PATHOLOGY	2,147	185,651	0.011565	6,678	77	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11,238	839,236	0.013391	291,978	3,910	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	63,162	1,978,959	0.031917	240,860	7,688	73.00
76.00	03020 SLEEP LAB	23,056	15,504	1.487100	0	0	76.00
76.01	03950 PAIN CLINIC / SERVICE	0	0	0.000000	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	280	0	0.000000	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	386,184	1,648,152	0.234313	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	30,675	497,509	0.061657	0	0	88.01
90.00	09000 CLINIC	45,535	227,214	0.200406	0	0	90.00
91.00	09100 EMERGENCY	377,022	1,990,565	0.189405	4,222	800	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	41,788	140,712	0.296975	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0.000000	0	0	93.00
200.00	Total (lines 50 through 199)	2,538,070	23,967,075		1,334,767	114,200	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1302

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

Worksheet D
Part IV
Date/Time Prepared:
4/12/2021 8:39 am

			Title XVIII		Hospital		Cost
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health
			1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0 66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00	03020	SLEEP LAB	0	0	0	0	0 76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0 76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0 76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0 88.01
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0 93.00
200.00		Total (lines 50 through 199)	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1302

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part IV
Date/Time Prepared:
4/12/2021 8:39 am

Cost Center Description			Title XVIII		Hospital	Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
			4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	3,179,799	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	636,394	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,155,853	0.000000
57.00	05700	CT SCAN	0	0	0	0	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000
60.00	06000	LABORATORY	0	0	0	3,174,000	0.000000
64.00	06400	INTRAVENOUS THERAPY	0	0	0	610,412	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	260,501	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	2,871,587	0.000000
66.01	06601	CARDIAC REHAB	0	0	0	243,052	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	311,975	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	185,651	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	839,236	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,978,959	0.000000
76.00	03020	SLEEP LAB	0	0	0	15,504	0.000000
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0.000000
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,648,152	0.000000
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	497,509	0.000000
90.00	09000	CLINIC	0	0	0	227,214	0.000000
91.00	09100	EMERGENCY	0	0	0	1,990,565	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	140,712	0.000000
93.00	04040	FAMILY PRACTICE	0	0	0	0	0.000000
200.00		Total (lines 50 through 199)	0	0	0	23,967,075	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1302

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

Worksheet D
Part IV
Date/Time Prepared:
4/12/2021 8:39 am

Cost Center Description		Title XVIII			Hospital		Cost	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	464,210	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	14,049	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	75,625	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	79,736	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	5,675	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	69,026	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	61,372	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	21,336	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	6,678	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	291,978	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	240,860	0	0	0	73.00
76.00	03020	SLEEP LAB	0.000000	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0.000000	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0.000000	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	4,222	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	0	0	0	93.00
200.00		Total (lines 50 through 199)		1,334,767	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1302

Period:
From 10/01/2019
To 09/30/2020Worksheet D
Part V
Date/Time Prepared:
4/12/2021 8:39 am

			Title XVIII		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.614814	0	884,627	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.522131	0	180,301	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.363532	0	1,751,734	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.415768	0	1,036,573	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.093747	0	234,419	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.247842	0	7,093	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.729578	0	1,066,457	0	0	66.00
66.01	06601	CARDIAC REHAB	0.982045	0	151,853	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.556320	0	49,518	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.481376	0	44,432	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.239175	0	123,923	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.379270	0	563,881	3,937	0	73.00
76.00	03020	SLEEP LAB	6.473491	0	5,291	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0.000000	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0.000000	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
90.00	09000	CLINIC	0.505400	0	15,179	0	0	90.00
91.00	09100	EMERGENCY	1.478383	0	769,431	2,362	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.298070	0	62,839	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	0	0	0	93.00
200.00		Subtotal (see instructions)		0	6,947,551	6,299	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	6,947,551	6,299	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-1302		Period: From 10/01/2019 To 09/30/2020	Worksheet D Part V Date/Time Prepared: 4/12/2021 8:39 am
			Title XVIII		Hospital	Cost
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	543,881	0		50.00
53.00	05300	ANESTHESIOLOGY	94,141	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	636,811	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	430,974	0		60.00
64.00	06400	INTRAVENOUS THERAPY	21,976	0		64.00
65.00	06500	RESPIRATORY THERAPY	1,758	0		65.00
66.00	06600	PHYSICAL THERAPY	778,064	0		66.00
66.01	06601	CARDIAC REHAB	149,126	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	27,548	0		67.00
68.00	06800	SPEECH PATHOLOGY	21,388	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	29,639	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	213,863	1,493		73.00
76.00	03020	SLEEP LAB	34,251	0		76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0		76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0		76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
90.00	09000	CLINIC	7,671	0		90.00
91.00	09100	EMERGENCY	1,137,514	3,492		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	81,569	0		92.00
93.00	04040	FAMILY PRACTICE	0	0		93.00
200.00		Subtotal (see instructions)	4,210,174	4,985		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	4,210,174	4,985		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1302

Period:

Worksheet D

Component CCN: 14-Z302

From 10/01/2019
To 09/30/2020Part V
Date/Time Prepared:
4/12/2021 8:39 am

			Title XVIII	Swing Beds - SNF		Cost	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
				1.00	2.00	3.00	4.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.614814	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.522131	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.363532	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
60.00	06000	LABORATORY	0.415768	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.093747	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.247842	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.729578	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0.982045	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.556320	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.481376	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.239175	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.379270	0	0	0	73.00
76.00	03020	SLEEP LAB	6.473491	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0.000000	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0.000000	0	0	0	76.02
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC					88.00
88.01	08801	RURAL HEALTH CLINIC II					88.01
90.00	09000	CLINIC	0.505400	0	0	0	90.00
91.00	09100	EMERGENCY	1.478383	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.298070	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	0	0	93.00
200.00		Subtotal (see instructions)		0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1302

Period:

Worksheet D

Component CCN: 14-Z302

From 10/01/2019
To 09/30/2020Part V
Date/Time Prepared:
4/12/2021 8:39 am

			Title XVIII		Swing Beds - SNF	Cost
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
66.01	06601	CARDIAC REHAB	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	SLEEP LAB	0	0		76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0		76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0		76.02
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	FAMILY PRACTICE	0	0		93.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1302 Component CCN: 14-6140		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/12/2021 8:39 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	0	58.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB		0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
76.00	03020	SLEEP LAB		0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE		0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY		0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II		0	0	0	0	0	88.01
90.00	09000	CLINIC		0	0	0	0	0	90.00
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE		0	0	0	0	0	93.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1302 Component CCN: 14-6140		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/12/2021 8:39 am	
			Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	3,179,799	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	636,394	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,155,853	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	3,174,000	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	610,412	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	260,501	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,871,587	0.000000	66.00
66.01	06601	CARDIAC REHAB	0	0	0	243,052	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	311,975	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	185,651	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	839,236	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,978,959	0.000000	73.00
76.00	03020	SLEEP LAB	0	0	0	15,504	0.000000	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0.000000	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0.000000	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,648,152	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	497,509	0.000000	88.01
90.00	09000	CLINIC	0	0	0	227,214	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	1,990,565	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	140,712	0.000000	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0.000000	93.00
200.00		Total (lines 50 through 199)	0	0	0	23,967,075		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1302 Component CCN: 14-6140		Period: From 10/01/2019 To 09/30/2020		Worksheet D Part IV Date/Time Prepared: 4/12/2021 8:39 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0.000000	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0.000000	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0.000000	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0.000000	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	0	0	0	0	93.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1302	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/12/2021 8:39 am
		Title XVIII	Hospital	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,417	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		693	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		572	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		378	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		1,236	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		59	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		51	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		428	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		378	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		972	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		140.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		140.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,497,908	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		8,260	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		7,140	25.00
26.00	Total swing-bed cost (see instructions)		2,451,798	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,046,110	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,046,110	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,509.54	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		646,083	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		646,083	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1302

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

Worksheet D-1

Date/Time Prepared:
4/12/2021 8:39 am

Cost Center Description		Title XVIII		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					598,310	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,244,393	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					570,606	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					1,467,273	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					2,037,879	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					121	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,509.54	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					182,654	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1302

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

Worksheet D-1

Date/Time Prepared:
4/12/2021 8:39 am

		Title XVIII		Hospital	Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	800,268	3,497,908	0.228785	182,654	41,788
91.00	Nursing School cost	0	3,497,908	0.000000	182,654	0
92.00	Allied health cost	0	3,497,908	0.000000	182,654	0
93.00	All other Medical Education	0	3,497,908	0.000000	182,654	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1302 Component CCN: 14-6140	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/12/2021 8:39 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		0	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		0	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		0	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		27,124	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		27,124	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		27,124	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-1302 Component CCN: 14-6140	Period: From 10/01/2019 To 09/30/2020	Worksheet D-1 Date/Time Prepared: 4/12/2021 8:39 am	
				Title XVIII		Skilled Nursing Facility	PPS
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					27,124	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					0.00	71.00
72.00	Program routine service cost (line 9 x line 71)					0	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					0	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)					0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00	Inpatient routine service cost per diem limitation					0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)					0	83.00
84.00	Program inpatient ancillary services (see instructions)					0	84.00
85.00	Utilization review - physician compensation (see instructions)					0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					0	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1302

Period:

Worksheet D-1

Component CCN: 14-6140

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/12/2021 8:39 am

Title XVIII

Skilled Nursing
Facility

PPS

Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1302	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3 Date/Time Prepared: 4/12/2021 8:39 am	
			Title XVIII	Hospital	Cost	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		596,518		30.00
42.00	04200	SUBPROVIDER		0		42.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.614814	464,210	285,403	50.00
53.00	05300	ANESTHESIOLOGY	0.522131	14,049	7,335	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.363532	75,625	27,492	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.415768	79,736	33,152	60.00
64.00	06400	INTRAVENOUS THERAPY	0.093747	5,675	532	64.00
65.00	06500	RESPIRATORY THERAPY	0.247842	69,026	17,108	65.00
66.00	06600	PHYSICAL THERAPY	0.729578	61,372	44,776	66.00
66.01	06601	CARDIAC REHAB	0.982045	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.556320	21,336	11,870	67.00
68.00	06800	SPEECH PATHOLOGY	0.481376	6,678	3,215	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.239175	291,978	69,834	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.379270	240,860	91,351	73.00
76.00	03020	SLEEP LAB	6.473491	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0.000000	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0.000000	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000	CLINIC	0.505400	0	0	90.00
91.00	09100	EMERGENCY	1.478383	4,222	6,242	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.298070	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,334,767	598,310	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)		1,334,767		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1302 Component CCN: 14-Z302	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3 Date/Time Prepared: 4/12/2021 8:39 am	
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
42.00	04200	SUBPROVIDER		0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.614814	0	50.00
53.00	05300	ANESTHESIOLOGY	0.522131	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.363532	45,849	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
60.00	06000	LABORATORY	0.415768	100,392	60.00
64.00	06400	INTRAVENOUS THERAPY	0.093747	33,025	64.00
65.00	06500	RESPIRATORY THERAPY	0.247842	79,621	65.00
66.00	06600	PHYSICAL THERAPY	0.729578	377,238	66.00
66.01	06601	CARDIAC REHAB	0.982045	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.556320	147,027	67.00
68.00	06800	SPEECH PATHOLOGY	0.481376	89,777	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.239175	36,165	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.379270	371,071	73.00
76.00	03020	SLEEP LAB	6.473491	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0.000000	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0.000000	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	88.01
90.00	09000	CLINIC	0.505400	0	90.00
91.00	09100	EMERGENCY	1.478383	4,140	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.298070	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,284,305	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)		1,284,305	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1302 Component CCN: 14-6140	Period: From 10/01/2019 To 09/30/2020	Worksheet D-3 Date/Time Prepared: 4/12/2021 8:39 am	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
42.00	04200 SUBPROVIDER		0		42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.614814	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.522131	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.363532	0	0	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.415768	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.093747	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.247842	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.729578	0	0	66.00
66.01	06601 CARDIAC REHAB	0.982045	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.556320	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.481376	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.239175	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.379270	0	0	73.00
76.00	03020 SLEEP LAB	6.473491	0	0	76.00
76.01	03950 PAIN CLINIC / SERVICE	0.000000	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0.000000	0	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000 CLINIC	0.505400	0	0	90.00
91.00	09100 EMERGENCY	1.478383	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.298070	0	0	92.00
93.00	04040 FAMILY PRACTICE	0.000000	0	0	93.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1302	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part B Date/Time Prepared: 4/12/2021 8:39 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			4,215,159 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)			4,215,159 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (see instructions)			4,257,311 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)			29,080 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			1,142,670 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)			3,085,561 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)			3,085,561 30.00
31.00	Primary payer payments			2,381 31.00
32.00	Subtotal (line 30 minus line 31)			3,083,180 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)			25,168 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			16,359 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			19,668 36.00
37.00	Subtotal (see instructions)			3,099,539 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)			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)			3,099,539 40.00
40.01	Sequestration adjustment (see instructions)			35,955 40.01
40.02	Demonstration payment adjustment amount after sequestration			0 40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments			3,664,001 41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)			0 42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)			-600,417 43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1302 Component CCN: 14-6140	Period: From 10/01/2019 To 09/30/2020	Worksheet E Part B Date/Time Prepared: 4/12/2021 8:39 am
		Title XVIII	Skilled Nursing Facility	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
4.01	Outlier reconciliation amount (see instructions)			4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)			18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		0	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)			34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		0	37.00
38.00	MSP-LCC reconciliation amount from PS&R			38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		0	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		0	41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		0	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1302

Period:
From 10/01/2019
To 09/30/2020Worksheet E-1
Part I
Date/Time Prepared:
4/12/2021 8:39 am

		Title XVIII		Hospital	Cost	
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,074,992		3,683,557	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	09/02/2020	28,758		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	09/02/2020	19,556	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)		28,758		-19,556	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)		1,103,750		3,664,001	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		60,473		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		600,417	6.02
7.00	Total Medicare program liability (see instructions)		1,164,223		3,063,584	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1302

Period:

Worksheet E-1

Component CCN: 14-Z302

From 10/01/2019
To 09/30/2020Part I
Date/Time Prepared:
4/12/2021 8:39 am

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,722,151		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	09/02/2020	77,400		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)		-77,400		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,644,751		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		20,103		0	6.02
7.00	Total Medicare program liability (see instructions)		2,624,648		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

 Provider CCN: 14-1302
 Component CCN: 14-6140

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 4/12/2021 8:39 am

		Title XVIII		Skilled Nursing Facility		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		0		0	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		0		0	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		0		0	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1302

Period:
From 10/01/2019
To 09/30/2020Worksheet E-1
Part II
Date/Time Prepared:
4/12/2021 8:39 am

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1302 Component CCN: 14-Z302	Period: From 10/01/2019 To 09/30/2020	Worksheet E-2 Date/Time Prepared: 4/12/2021 8:39 am	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		2,058,258	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		643,349	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)				3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		1,350	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		2,701,607	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		2,701,607	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		2,701,607	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		46,156	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		2,655,451	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		2,655,451	0	19.00
19.01	Sequestration adjustment (see instructions)		30,803	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
20.00	Interim payments		2,644,751	0	20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		-20,103	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1302	Period: From 10/01/2019 To 09/30/2020	Worksheet E-3 Part V Date/Time Prepared: 4/12/2021 8:39 am
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,244,393	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)		1,244,393	4.00
5.00	Primary payer payments		2,999	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,253,838	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)		1,253,838	19.00
20.00	Deductibles (exclude professional component)		157,960	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,095,878	22.00
23.00	Coinsurance		2,112	23.00
24.00	Subtotal (line 22 minus line 23)		1,093,766	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		129,416	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		84,120	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		91,187	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,177,886	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)		1,177,886	30.00
30.01	Sequestration adjustment (see instructions)		13,663	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM		0	30.03
31.00	Interim payments		1,103,750	31.00
31.01	Interim payments-PARHM		0	31.01
32.00	Tentative settlement (for contractor use only)		0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		0	32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		60,473	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1302 Component CCN: 14-6140	Period: From 10/01/2019 To 09/30/2020	Worksheet E-3 Part VI Date/Time Prepared: 4/12/2021 8:39 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		0	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		0	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		0	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		0	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Demonstration payment adjustment amount before sequestration		0	14.99
15.00	Subtotal (see instructions)		0	15.00
15.01	Sequestration adjustment (see instructions)		0	15.01
15.02	Demonstration payment adjustment amount after sequestration		0	15.02
15.75	Sequestration for non-claims based amounts (see instructions)		0	15.75
16.00	Interim payments		0	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)		0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

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

Provider CCN: 14-1302

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

Worksheet G

Date/Time Prepared:
4/12/2021 8:39 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	10,243,015	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,572,571	0	0	0	4.00
5.00	Other receivable	228,415	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,681,625	0	0	0	6.00
7.00	Inventory	393,868	0	0	0	7.00
8.00	Prepaid expenses	150,902	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)	14,907,146	0	0	0	11.00
FIXED ASSETS						
12.00	Land	448,597	0	0	0	12.00
13.00	Land improvements	3,983,868	0	0	0	13.00
14.00	Accumulated depreciation	-2,685,069	0	0	0	14.00
15.00	Buildings	38,715,162	0	0	0	15.00
16.00	Accumulated depreciation	-21,520,616	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	9,145,458	0	0	0	23.00
24.00	Accumulated depreciation	-6,331,767	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	2,639,630	0	0	0	27.00
28.00	Accumulated depreciation	-2,418,218	0	0	0	28.00
29.00	Minor equipment-nondepreciable	208,170	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	22,185,215	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	2,909,056	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,561,590	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,470,646	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	41,563,007	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	965,798	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,119,660	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,068,433	0	0	0	40.00
41.00	Deferred income	1,224,285	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	300,000	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,678,176	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	37,346,724	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,190,493	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	38,537,217	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	43,215,393	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-1,652,386	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)	-1,652,386	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	41,563,007	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1302

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

Worksheet G-1

Date/Time Prepared:
4/12/2021 8:39 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-4,250,432		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,564,289				2.00
3.00	Total (sum of line 1 and line 2)		-1,686,143		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	CHANGE IN NET DEFICIT	33,757		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)		33,757		0		10.00
11.00	Subtotal (line 3 plus line 10)		-1,652,386		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)		-1,652,386		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	CHANGE IN NET DEFICIT		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: 14-1302

Period:
From 10/01/2019
To 09/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
4/12/2021 8:39 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,442,015		2,442,015	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	3,781,773		3,781,773	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	6,223,788		6,223,788	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,223,788		6,223,788	17.00
18.00	Ancillary services	3,642,995	0	3,642,995	18.00
19.00	Outpatient services	0	18,178,420	18,178,420	19.00
20.00	RURAL HEALTH CLINIC	0	1,648,152	1,648,152	20.00
20.01	RURAL HEALTH CLINIC II	0	497,509	497,509	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	0	4,144,454	4,144,454	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	9,866,783	24,468,535	34,335,318	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		25,922,888		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	PROVISION FOR BAD DEBTS	225,491			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)		225,491		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		26,148,379		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1302

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

Worksheet G-3

Date/Time Prepared:
4/12/2021 8:39 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	34,335,318	1.00
2.00	Less contractual allowances and discounts on patients' accounts	11,379,125	2.00
3.00	Net patient revenues (line 1 minus line 2)	22,956,193	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	26,148,379	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,192,186	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	38,406	6.00
7.00	Income from investments	158,939	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	196,522	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	580,308	17.00
18.00	Revenue from sale of medical records and abstracts	2,398	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	5,828	22.00
23.00	Governmental appropriations	0	23.00
24.00	AQUATICS REVENUE	14,111	24.00
24.01	ASSISTED LIVING UNITS	678,562	24.01
24.02	ADULT DAY CARE PROGRAM	84,182	24.02
24.03	FITNESS CENTER REVENUE	83,158	24.03
24.04	GRANT REVENUE	310,581	24.04
24.05	MISCELLANEOUS REVENUE	45,490	24.05
24.06	OTHER (SPECIFY)	0	24.06
24.50	COVID-19 PHE Funding	3,570,027	24.50
25.00	Total other income (sum of lines 6-24)	5,768,512	25.00
26.00	Total (line 5 plus line 25)	2,576,326	26.00
27.00	LOSS ON SALE OF EQUIPMENT	12,037	27.00
27.01	OTHER EXPENSES (SPECIFY)	0	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	12,037	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,564,289	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1302

Period:

Worksheet M-1

Component CCN: 14-8511

From 10/01/2019

Date/Time Prepared:

To 09/30/2020

4/12/2021 8:39 am

				RHC I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	994,000	0	994,000	-65,569	928,431	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	153,876	0	153,876	1,982	155,858	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	308,448	0	308,448	0	308,448	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	10,854	0	10,854	0	10,854	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	27,401	27,401	-23,107	4,294	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,467,178	27,401	1,494,579	-86,694	1,407,885	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	29,283	29,283	0	29,283	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	29,283	29,283	0	29,283	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,467,178	56,684	1,523,862	-86,694	1,437,168	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	2,311	2,311	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	2,311	2,311	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	163,610	140,088	303,698	439	304,137	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	163,610	140,088	303,698	439	304,137	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,630,788	196,772	1,827,560	-83,944	1,743,616	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1302

Period:

Worksheet M-1

Component CCN: 14-8511

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/12/2021 8:39 am

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-20,889	907,542	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	155,858	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	308,448	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	10,854	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	4,294	9.00
10.00	Subtotal (sum of lines 1 through 9)	-20,889	1,386,996	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	29,283	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	29,283	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-20,889	1,416,279	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	5,003	5,003	25.01
25.02	Chronic Care Management	0	2,311	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	5,003	7,314	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	-33	304,104	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-33	304,104	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-15,919	1,727,697	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1302

Period:

Worksheet M-1

Component CCN: 14-8557

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/12/2021 8:39 am

		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	299,710	0	299,710	-44,763	254,947
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	24,014	0	24,014	0	24,014
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	112,010	0	112,010	0	112,010
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	18,097	18,097	0	18,097
10.00	Subtotal (sum of lines 1 through 9)	435,734	18,097	453,831	-44,763	409,068
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	35,726	35,726	0	35,726
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	35,726	35,726	0	35,726
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	435,734	53,823	489,557	-44,763	444,794
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	5,538	5,538	12,559	18,097
30.00	Administrative Costs	36,814	26,761	63,575	4,383	67,958
31.00	Total Facility Overhead (sum of lines 29 and 30)	36,814	32,299	69,113	16,942	86,055
32.00	Total facility costs (sum of lines 22, 28 and 31)	472,548	86,122	558,670	-27,821	530,849

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1302

Period:

Worksheet M-1

Component CCN: 14-8557

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/12/2021 8:39 am

		RHC II		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	254,947	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	24,014	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	112,010	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	18,097	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	409,068	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	35,726	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	35,726	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	444,794	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	18,097	29.00
30.00	Administrative Costs	-2,500	65,458	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-2,500	83,555	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-2,500	528,349	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1302

Period:

Worksheet M-2

Component CCN: 14-8511

From 10/01/2019
To 09/30/2020Date/Time Prepared:
4/12/2021 8:39 am

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	2.58	6,510	2,478	6,393		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.21	1,375	1,050	1,271		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.79	7,885		7,664	7,885	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	0.17	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)	3.96	7,885			7,885	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,416,279	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					7,314	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,423,593	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.994862	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					304,104	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,072,931	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,377,035	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,377,035	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,369,960	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,786,239	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1302

Period:

Worksheet M-2

Component CCN: 14-8557

From 10/01/2019

Date/Time Prepared:

To 09/30/2020

4/12/2021 8:39 am

				RHC II		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.66	2,410	3,402	2,245		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.24	276	1,134	272		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.90	2,686		2,517	2,686	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)	0.90	2,686			2,686	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)					444,794	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)					444,794	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)					83,555	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					188,384	15.00
16.00	Total overhead (sum of lines 14 and 15)					271,939	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					271,939	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					271,939	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					716,733	20.00

Health Financial Systems		MIDWEST MEDICAL CENTER		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1302	Period: From 10/01/2019 To 09/30/2020	Worksheet M-3	
		Component CCN: 14-8511		Date/Time Prepared: 4/12/2021 8:39 am	
		Title XVIII	RHC I	Cost	
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,786,239	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			69,857	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,716,382	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			7,885	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)			7,885	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			344.50	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)		84.70	86.31	8.00
9.00	Rate for Program covered visits (see instructions)		344.50	344.50	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		2,091	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		720,350	0	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	720,350	16.00
16.01	Total program charges (see instructions)(from contractor's records)			392,957	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			7,337	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			13,450	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.)			528,332	16.04
16.05	Total program cost (see instructions)		0	541,782	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			46,485	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			67,828	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			541,782	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			21,948	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			563,730	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	SEQUESTRATION			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			563,730	26.00
26.01	Sequestration adjustment (see instructions)			6,539	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			381,262	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)			175,929	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

Health Financial Systems		MIDWEST MEDICAL CENTER		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1302	Period: From 10/01/2019 To 09/30/2020	Worksheet M-3	
		Component CCN: 14-8557		Date/Time Prepared: 4/12/2021 8:39 am	
		Title XVIII	RHC II	Cost	
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			716,733	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			14,180	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			702,553	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,686	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)			2,686	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			261.56	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)		84.70	86.31	8.00
9.00	Rate for Program covered visits (see instructions)		261.56	261.56	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		571	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		149,351	0	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	149,351	16.00
16.01	Total program charges (see instructions)(from contractor's records)			101,586	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			2,792	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			4,105	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.)			106,068	16.04
16.05	Total program cost (see instructions)		0	110,173	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			12,661	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			17,201	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			110,173	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			3,286	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			113,459	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			113,459	26.00
26.01	Sequestration adjustment (see instructions)			1,316	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			81,121	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			31,022	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1302 Component CCN: 14-8511	Period: From 10/01/2019 To 09/30/2020	Worksheet M-4 Date/Time Prepared: 4/12/2021 8:39 am	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1,386,996	1,386,996	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000422	0.000957	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		585	1,327	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		19,814	13,783	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		20,399	15,110	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,416,279	1,416,279	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,369,960	1,369,960	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.014403	0.010669	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		19,732	14,616	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		40,131	29,726	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		160	363	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		250.82	81.89	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		48	121	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		12,039	9,909	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)			69,857	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)			21,948	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1302 Component CCN: 14-8557	Period: From 10/01/2019 To 09/30/2020	Worksheet M-4 Date/Time Prepared: 4/12/2021 8:39 am	
		Title XVIII	RHC II	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		409,068	409,068	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000379	0.000605	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		155	247	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		5,760	2,638	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		5,915	2,885	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		444,794	444,794	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		271,939	271,939	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.013298	0.006486	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		3,616	1,764	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		9,531	4,649	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		42	67	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		226.93	69.39	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		5	31	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		1,135	2,151	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)			14,180	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			3,286	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1302 Component CCN: 14-8511	Period: From 10/01/2019 To 09/30/2020	Worksheet M-5 Date/Time Prepared: 4/12/2021 8:39 am	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		381,262	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)		381,262	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		175,929	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		557,191	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00 2.00		
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1302 Component CCN: 14-8557	Period: From 10/01/2019 To 09/30/2020	Worksheet M-5 Date/Time Prepared: 4/12/2021 8:39 am
		RHC II	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		81,121	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)		81,121	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		31,022	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		112,143	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00