

State Copy

Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

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

OMB NO. 0938-0050
EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1302	Period: From 10/01/2020 To 09/30/2021	Worksheet S Parts I-III Date/Time Prepared: 2/15/2022 11:13 am
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 2. ☐ Manually prepared cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.		

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)
 MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MIDWEST MEDICAL CENTER (14-1302) for the cost reporting period beginning 10/01/2020 and ending 09/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1	Tracy Bauer	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Tracy Bauer		2
3	Signatory Title	CEO		3
4	Date	02/15/2022 11:13:53 AM		4

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	18,190	-591,449	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	70,591	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		-23,528		0	10.00
10.01 RURAL HEALTH CLINIC II	0		11,411		0	10.01
200.00 Total	0	88,781	-603,566	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 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/15/2022 11:13 am		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1 MEDICAL CENTER DRIVE			PO Box:				1.00			
2.00	City: GALENA			State: IL		Zip Code: 61036-		County: JO DAVIESS 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)						10/01/2020	09/30/2021		20.00	
21.00	Type of Control (see instructions)						2			21.00	
							1.00	2.00	3.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					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	
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.04	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N			23.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1302

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part I
Date/Time Prepared:
2/15/2022 11:13 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1302		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/15/2022 11:13 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
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1302

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part I
Date/Time Prepared:
2/15/2022 11:13 am

			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1302	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 2/15/2022 11:13 am	
			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			Y	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y			106.00
107.00	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1302		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/15/2022 11:13 am	
				V	XIX		
				1.00	2.00		
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	N	N	109.00	
				1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N				110.00	
				1.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00	
				1.00			
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	
				1.00			
				2.00			
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	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:	50,952		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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1302		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/15/2022 11:13 am	
		1.00		2.00			
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00	
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		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.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	Y		Y		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC			N		N	
						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	
		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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1302	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 2/15/2022 11:13 am
			Beginning 1.00	Ending 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	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1302		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part II Date/Time Prepared: 2/15/2022 11:13 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	02/01/2022	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 a nursing program? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			Y	02/01/2022	Y	02/01/2022 17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1302	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part II Date/Time Prepared: 2/15/2022 11:13 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.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	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 10/01/2020
To 09/30/2021Worksheet S-2
Part II
Date/Time Prepared:
2/15/2022 11:13 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 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/15/2022 11:13 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	17,068.08	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	17,068.08	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	17,068.08	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	1,825		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	46.00	52	18,980			21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
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 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/15/2022 11:13 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)	443	40	731		1.00
2.00	HMO and other (see instructions)	112	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	1,295	0	1,589		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	109		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,738	40	2,429		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)	1,738	40	2,429	0.00	83.77
15.00	CAH visits	6,871	0	23,526		14.00
16.00	SUBPROVIDER - IPF					15.00
17.00	SUBPROVIDER - IRF					16.00
18.00	SUBPROVIDER		0	0	0.00	17.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00
20.00	NURSING FACILITY					2.39
21.00	OTHER LONG TERM CARE			12,624	0.00	19.00
22.00	HOME HEALTH AGENCY					20.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					21.00
24.00	HOSPICE					22.00
24.10	HOSPICE (non-distinct part)			0		23.00
25.00	CMHC - CMHC					24.00
26.00	RURAL HEALTH CLINIC	2,353	0	9,049	0.00	24.10
26.01	RURAL HEALTH CLINIC II	539	0	2,474	0.00	25.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	12.62
27.00	Total (sum of lines 14-26)				0.00	3.52
28.00	Observation Bed Days		0	182		0.00
29.00	Ambulance Trips	0				0.00
30.00	Employee discount days (see instruction)			0		0.00
31.00	Employee discount days - IRF			0		0.00
32.00	Labor & delivery days (see instructions)	0	0	0		0.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		0.00
33.00	LTCH non-covered days	0				130.67
33.01	LTCH site neutral days and discharges	0				27.00
						28.00
						29.00
						30.00
						31.00
						32.00
						32.01
						33.00
						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1302

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/15/2022 11:13 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	138	12	228	1.00
2.00 HMO and other (see instructions)			31	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	138	12	228	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				49	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 10/01/2020 To 09/30/2021 Worksheet S-8 Date/Time Prepared: 2/15/2022 11:13 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	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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1302

Period:

Worksheet S-8

Component CCN: 14-8511

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

Date/Time Prepared:

2/15/2022 11:13 am

RHC I

Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1302 Component CCN: 14-8557		Period: From 10/01/2020 To 09/30/2021		Worksheet S-8 Date/Time Prepared: 2/15/2022 11:13 am	
				RHC II		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street				560 PLEASANT STREET				1.00
				City	State	ZIP Code			
				1.00	2.00	3.00			
2.00	City, State, ZIP Code, County				ELIZABETH IL 61028				2.00
				1.00					
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0		3.00
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)								4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)								5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)								6.00
7.00	Appalachian Regional Commission								7.00
8.00	Look-Alikes								8.00
9.00	OTHER (SPECIFY)								9.00
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N		0		10.00
				Sunday		Monday		Tuesday	
				from	to	from	to	from	
				1.00	2.00	3.00	4.00	5.00	
Facility hours of operations (1)									
11.00	CLINIC				07:30		17:00		07:30
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?				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	Total Visits	
				1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)								15.00
				County					
				4.00					
2.00	City, State, ZIP Code, County				JO DAVIESS				2.00
				Tuesday	Wednesday	Thursday			
				to	from	to	from	to	
				6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)									
11.00	CLINIC				17:00		07:30		17:00

Health Financial Systems		MIDWEST MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1302	Period: From 10/01/2020	Worksheet S-8
			Component CCN: 14-8557	To 09/30/2021	Date/Time Prepared: 2/15/2022 11:13 am
			RHC II		Cost
			Friday		Saturday
			from	to	from
			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 10/01/2020 To 09/30/2021	Worksheet S-10 Date/Time Prepared: 2/15/2022 11:13 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)			0.655549 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	4,175,311		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	7,744,601		6.00
7.00	Medicaid cost (line 1 times line 6)	5,076,965		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)	901,654		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)	901,654		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	382,845	0	382,845 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	250,974	0	250,974 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	250,974	0	250,974 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	537,332		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	72,733		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	111,896		27.01
28.00	Non-Medicare bad debt expense (see instructions)	425,436		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	318,057		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	569,031		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,470,685		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1302

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

Worksheet A

Date/Time Prepared:
2/15/2022 11:13 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,389,477	1,389,477	-1,375,280	14,197	1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG		0	0	64,914	64,914	1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL		0	0	2,524,351	2,524,351	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		1,005,361	1,005,361	-976,158	29,203	2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO		0	0	1,160,617	1,160,617	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,795,394	2,795,394	-148,471	2,646,923	4.00
5.01	00570	ADMITTING	362,583	8,147	370,730	0	370,730	5.01
5.02	00550	INFORMATION TECHNOLOGY	319,183	363,983	683,166	0	683,166	5.02
5.03	00590	HOSPITAL BILLING	0	0	0	375,950	375,950	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	735,133	1,847,986	2,583,119	-550,744	2,032,375	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	123,790	567,582	691,372	0	691,372	7.00
7.01	00701	OPERATION OF PLANT-SCC	91,807	189,624	281,431	0	281,431	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	59,690	59,690	0	59,690	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	21,891	21,891	0	21,891	8.01
9.00	00900	HOUSEKEEPING	187,871	18,717	206,588	0	206,588	9.00
9.01	00901	HOUSEKEEPING-SCC	80,693	17,197	97,890	0	97,890	9.01
10.00	01000	DIETARY	235,383	157,713	393,096	0	393,096	10.00
10.01	01001	DIETARY-SCC	262,865	214,071	476,936	78,372	555,308	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	298,775	2,983	301,758	0	301,758	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	84,160	1,847	86,007	0	86,007	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	202,438	7,846	210,284	0	210,284	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	886,589	122,716	1,009,305	196,615	1,205,920	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	11,700	11,700	44.00
46.00	04600	OTHER LONG TERM CARE	1,580,035	311,106	1,891,141	14,015	1,905,156	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	372,821	726,062	1,098,883	107,769	1,206,652	50.00
53.00	05300	ANESTHESIOLOGY	242,148	46,559	288,707	0	288,707	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	383,424	844,993	1,228,417	41,588	1,270,005	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	318,113	722,624	1,040,737	0	1,040,737	60.00
64.00	06400	INTRAVENOUS THERAPY	0	32,695	32,695	0	32,695	64.00
65.00	06500	RESPIRATORY THERAPY	92,101	41,279	133,380	-93,187	40,193	65.00
66.00	06600	PHYSICAL THERAPY	1,220,762	88,554	1,309,316	-30,026	1,279,290	66.00
66.01	06601	CARDIAC REHAB	0	0	0	133,711	133,711	66.01
67.00	06700	OCCUPATIONAL THERAPY	79,282	8,942	88,224	21,279	109,503	67.00
68.00	06800	SPEECH PATHOLOGY	75,725	1,208	76,933	0	76,933	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	180,998	180,998	0	180,998	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	1,146,920	1,146,920	0	1,146,920	73.00
76.00	03020	SLEEP LAB	296,100	16,337	312,437	-312,437	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	9,572	9,572	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,768,185	170,276	1,938,461	-86,856	1,851,605	88.00
88.01	08801	RURAL HEALTH CLINIC II	490,937	84,126	575,063	-40,754	534,309	88.01
90.00	09000	CLINIC	0	897,605	897,605	223,026	1,120,631	90.00
91.00	09100	EMERGENCY	420,271	1,831,412	2,251,683	0	2,251,683	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		1,347,377	1,347,377	-1,347,377	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,211,174	17,291,298	28,502,472	2,189	28,504,661	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	36,061	36,061	-31,441	4,620	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	322,314	87,488	409,802	2,306	412,108	194.01
194.02	07952	ADULT DAY CARE	0	46	46	18,199	18,245	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 10/01/2020
To 09/30/2021

Worksheet A

Date/Time Prepared:
2/15/2022 11:13 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	8,747	8,747	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	11,533,488	17,414,893	28,948,381	0	28,948,381	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1302

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

Worksheet A

Date/Time Prepared:
2/15/2022 11:13 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	14,197	1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG	0	64,914	1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL	-101,772	2,422,579	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	29,203	2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	-191,280	969,337	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,646,923	4.00
5.01	00570	ADMITTING	0	370,730	5.01
5.02	00550	INFORMATION TECHNOLOGY	0	683,166	5.02
5.03	00590	HOSPITAL BILLING	-48,848	327,102	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	-437,169	1,595,206	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-18,795	672,577	7.00
7.01	00701	OPERATION OF PLANT-SCC	0	281,431	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	59,690	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	21,891	8.01
9.00	00900	HOUSEKEEPING	0	206,588	9.00
9.01	00901	HOUSEKEEPING-SCC	0	97,890	9.01
10.00	01000	DIETARY	-50,320	342,776	10.00
10.01	01001	DIETARY-SCC	-111,434	443,874	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	301,758	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	86,007	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,008	206,276	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-6,117	1,199,803	30.00
42.00	04200	SUBPROVIDER	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	11,700	44.00
46.00	04600	OTHER LONG TERM CARE	-158,835	1,746,321	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-105,922	1,100,730	50.00
53.00	05300	ANESTHESIOLOGY	0	288,707	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-469,716	800,289	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	1,040,737	60.00
64.00	06400	INTRAVENOUS THERAPY	0	32,695	64.00
65.00	06500	RESPIRATORY THERAPY	0	40,193	65.00
66.00	06600	PHYSICAL THERAPY	-36,419	1,242,871	66.00
66.01	06601	CARDIAC REHAB	0	133,711	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	109,503	67.00
68.00	06800	SPEECH PATHOLOGY	0	76,933	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	180,998	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-43,192	1,103,728	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	9,572	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-23,283	1,828,322	88.00
88.01	08801	RURAL HEALTH CLINIC II	-2,500	531,809	88.01
90.00	09000	CLINIC	-784,840	335,791	90.00
91.00	09100	EMERGENCY	-312,706	1,938,977	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			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)	-2,907,156	25,597,505	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,620	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	412,108	194.01
194.02	07952	ADULT DAY CARE	0	18,245	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	194.03
194.04	07954	IDLE SPACE	0	0	194.04

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1302

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

Worksheet A

Date/Time Prepared:
2/15/2022 11:13 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
194.05	07955	COMMUNITY FITNESS CENTER	0	8,747	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,907,156	26,041,225	200.00

RECLASSIFICATIONS

Provider CCN: 14-1302

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

Worksheet A-6

Date/Time Prepared:
2/15/2022 11:13 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	78,372		1.00
	TOTALS		0	78,372		
	C - RECLASS ASSISTED LIVING BUILDING DEP					
1.00	NEW CAP REL COSTS-ALU BLDG	1.01	0	61,948		1.00
	TOTALS		0	61,948		
	D - RECLASS PT/MOB SPACE DEPRECIATION					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	2,597		1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	28,844		2.00
	TOTALS		0	31,441		
	E - RECLASS NURSING HOME ADMIN AND GEN					
1.00	SKILLED NURSING FACILITY	44.00	0	11,700		1.00
2.00	OTHER LONG TERM CARE	46.00	0	121,679		2.00
	TOTALS		0	133,379		
	G - RECLASS PHYSICIAN HOSPITAL MED DIRCT					
1.00	ADULTS & PEDIATRICS	30.00	11,102	1,110		1.00
	TOTALS		11,102	1,110		
	H - RECLASS NEW HOSPITAL DEPRECIATION					
1.00	NEW CAP REL COSTS-2007 HOSPITAL	1.02	0	1,350,336		1.00
	TOTALS		0	1,350,336		
	J - RECLASS NEW HOSPITAL MME DEPRECIATN					
1.00	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	0	977,357		1.00
	TOTALS		0	977,357		
	K - RECLASS INTEREST EXPENSE - NEW HOSP					
1.00	NEW CAP REL COSTS-2007 HOSPITAL	1.02	0	1,134,380		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	0	171,331		2.00
	TOTALS		0	1,305,711		
	M - RECLASS PHYSICIAN IP ROUND TIME					
1.00	ADULTS & PEDIATRICS	30.00	6,752	1,013		1.00
2.00		0.00	0	0		2.00
	TOTALS		6,752	1,013		
	P - RECLASS PHYSICIAN BENEFITS					
1.00	RURAL HEALTH CLINIC	88.00	0	106,457		1.00
2.00	RURAL HEALTH CLINIC II	88.01	0	31,382		2.00
	TOTALS		0	137,839		
	U - RECLASS COMMUNITY FITNESS CTR USE					
1.00	COMMUNITY FITNESS CENTER	194.05	8,118	629		1.00
2.00	OCCUPATIONAL THERAPY	67.00	19,842	1,437		2.00
	TOTALS		27,960	2,066		
	X - RECLASS SURGEON FEES					
1.00	OPERATING ROOM	50.00	0	84,460		1.00
	TOTALS		0	84,460		
	Y - RECLASS PROPERTY INSURANCE EXP					
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	61,292		1.00
	TOTALS		0	61,292		
	AA - RECLASS CLINIC MGR TIME TO HOSP/NH					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	19,877	0		1.00
2.00	RURAL HEALTH CLINIC II	88.01	4,839	0		2.00
3.00	ASSISTED LIVING UNITS	194.01	785	0		3.00
	TOTALS		25,501	0		
	BB - RECLASS SR CARE ADMINISTRATOR TIME					
1.00	ASSISTED LIVING UNITS	194.01	79,893	0		1.00
2.00	ADULT DAY CARE	194.02	18,199	0		2.00
	TOTALS		98,092	0		
	FF - RECLASS EXPENSES TO MATCH REVENUES					
1.00	SNF PHYSICAL THERAPY - SCC THERAPY	76.02	9,572	0		1.00
	TOTALS		9,572	0		
	HH - RECLASS HOSP MED DIRECTOR TIME					
1.00	ADULTS & PEDIATRICS	30.00	89,771	11,540		1.00
2.00	CARDIAC REHAB	66.01	35,908	4,616		2.00
	TOTALS		125,679	16,156		
	JJ - RECLASS CAP LEASE INTEREST EXPENSE					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	41,588		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	78		2.00
	TOTALS		0	41,666		

RECLASSIFICATIONS

Provider CCN: 14-1302

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

Worksheet A-6

Date/Time Prepared:
2/15/2022 11:13 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	MM - RECLASS CLINIC MD SALARY					
	ADULTS & PEDIATRICS	30.00	75,327	0		1.00
	TOTALS		75,327	0		
1.00	NN - ENT MD TIME IN OR					
	OPERATING ROOM	50.00	0	15,583		1.00
	TOTALS		0	15,583		
1.00	PP - RECLASS HOSPITAL BILLING EXPENSES					
	HOSPITAL BILLING	5.03	0	375,950		1.00
	TOTALS		0	375,950		
1.00	QQ - RECLASS CARDIAC REHAB EXP					
	CARDIAC REHAB	66.01	92,101	1,086		1.00
	TOTALS		92,101	1,086		
1.00	SS - RECLASS PHYSICIAN SURGERY TIME					
	OPERATING ROOM	50.00	5,878	1,848		1.00
	TOTALS		5,878	1,848		
1.00	TT - RECLASS SPECIALTY CLINIC EXPENSES					
	CLINIC	90.00	296,100	16,337		1.00
	CLINIC	90.00	0	10,632		2.00
500.00	TOTALS		296,100	26,969		
500.00	Grand Total: Increases		774,064	4,705,582		500.00

RECLASSIFICATIONS

Provider CCN: 14-1302

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

Worksheet A-6

Date/Time Prepared:
2/15/2022 11:13 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	ASSISTED LIVING UNITS		194.01	0	78,372	0	1.00
	TOTALS			0	78,372		
C - RECLASS ASSISTED LIVING BUILDING DEP							
1.00	NEW CAP REL COSTS-BLDG & FIXT		1.00	0	61,948	9	1.00
	TOTALS			0	61,948		
D - RECLASS PT/MOB SPACE DEPRECIATION							
1.00	PHYSICIANS' PRIVATE OFFICES		192.00	0	2,597	9	1.00
2.00	PHYSICIANS' PRIVATE OFFICES		192.00	0	28,844	9	2.00
	TOTALS			0	31,441		
E - RECLASS NURSING HOME ADMIN AND GEN							
1.00	OTHER ADMINISTRATIVE AND GENERAL		5.04	0	133,379	0	1.00
2.00			0.00	0	0	0	2.00
	TOTALS			0	133,379		
G - RECLASS PHYSICIAN HOSPITAL MED DIRCT							
1.00	RURAL HEALTH CLINIC		88.00	11,102	1,110	0	1.00
	TOTALS			11,102	1,110		
H - RECLASS NEW HOSPITAL DEPRECIATION							
1.00	NEW CAP REL COSTS-BLDG & FIXT		1.00	0	1,350,336	9	1.00
	TOTALS			0	1,350,336		
J - RECLASS NEW HOSPITAL MME DEPRECIATN							
1.00	NEW CAP REL COSTS-MVBLE EQUIP		2.00	0	977,357	9	1.00
	TOTALS			0	977,357		
K - RECLASS INTEREST EXPENSE - NEW HOSP							
1.00	INTEREST EXPENSE		113.00	0	1,305,711	11	1.00
2.00			0.00	0	0	11	2.00
	TOTALS			0	1,305,711		
M - RECLASS PHYSICIAN IP ROUND TIME							
1.00	RURAL HEALTH CLINIC		88.00	5,319	798	0	1.00
2.00	RURAL HEALTH CLINIC II		88.01	1,433	215	0	2.00
	TOTALS			6,752	1,013		
P - RECLASS PHYSICIAN BENEFITS							
1.00	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	137,839	0	1.00
2.00			0.00	0	0	0	2.00
	TOTALS			0	137,839		
U - RECLASS COMMUNITY FITNESS CTR USE							
1.00	PHYSICAL THERAPY		66.00	27,960	2,066	0	1.00
2.00			0.00	0	0	0	2.00
	TOTALS			27,960	2,066		
X - RECLASS SURGEON FEES							
1.00	CLINIC		90.00	0	84,460	0	1.00
	TOTALS			0	84,460		
Y - RECLASS PROPERTY INSURANCE EXP							
1.00	OTHER ADMINISTRATIVE AND GENERAL		5.04	0	61,292	12	1.00
	TOTALS			0	61,292		
AA - RECLASS CLINIC MGR TIME TO HOSP/NH							
1.00	RURAL HEALTH CLINIC		88.00	25,501	0	0	1.00
2.00			0.00	0	0	0	2.00
3.00			0.00	0	0	0	3.00
	TOTALS			25,501	0		
BB - RECLASS SR CARE ADMINISTRATOR TIME							
1.00	OTHER LONG TERM CARE		46.00	98,092	0	0	1.00
2.00			0.00	0	0	0	2.00
	TOTALS			98,092	0		
FF - RECLASS EXPENSES TO MATCH REVENUES							
1.00	OTHER LONG TERM CARE		46.00	9,572	0	0	1.00
	TOTALS			9,572	0		
HH - RECLASS HOSP MED DIRECTOR TIME							
1.00	RURAL HEALTH CLINIC		88.00	125,679	16,156	0	1.00
2.00			0.00	0	0	0	2.00
	TOTALS			125,679	16,156		
JJ - RECLASS CAP LEASE INTEREST EXPENSE							
1.00	INTEREST EXPENSE		113.00	0	41,666	0	1.00
2.00			0.00	0	0	0	2.00
	TOTALS			0	41,666		
MM - RECLASS CLINIC MD SALARY							
1.00	RURAL HEALTH CLINIC II		88.01	75,327	0	0	1.00
	TOTALS			75,327	0		

RECLASSIFICATIONS

Provider CCN: 14-1302

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

Worksheet A-6

Date/Time Prepared:
2/15/2022 11:13 am

Decreases						
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	NN - ENT MD TIME IN OR					
1.00	CLINIC	90.00	0	15,583	0	1.00
	TOTALS		0	15,583		
	PP - RECLASS HOSPITAL BILLING EXPENSES					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	375,950	0	1.00
	TOTALS		0	375,950		
	QQ - RECLASS CARDIAC REHAB EXP					
1.00	RESPIRATORY THERAPY	65.00	92,101	1,086	0	1.00
	TOTALS		92,101	1,086		
	SS - RECLASS PHYSICIAN SURGERY TIME					
1.00	RURAL HEALTH CLINIC	88.00	5,878	1,848	0	1.00
	TOTALS		5,878	1,848		
	TT - RECLASS SPECIALTY CLINIC EXPENSES					
1.00	SLEEP LAB	76.00	296,100	16,337	0	1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	10,632	0	2.00
	TOTALS		296,100	26,969		
500.00	Grand Total: Decreases		774,064	4,705,582		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1302

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part I
Date/Time Prepared:
2/15/2022 11:13 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	3,983,868	11,075	0	11,075	0	2.00	
3.00	Buildings and Fixtures	38,840,752	30,704	0	30,704	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	9,145,458	694,847	0	694,847	929,191	6.00	
7.00	HIT designated Assets	2,639,630	133,246	0	133,246	0	7.00	
8.00	Subtotal (sum of lines 1-7)	55,058,305	869,872	0	869,872	929,191	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	55,058,305	869,872	0	869,872	929,191	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	3,994,943	0				2.00	
3.00	Buildings and Fixtures	38,871,456	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	8,911,114	0				6.00	
7.00	HIT designated Assets	2,772,876	0				7.00	
8.00	Subtotal (sum of lines 1-7)	54,998,986	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	54,998,986	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1302

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part II
Date/Time Prepared:
2/15/2022 11:13 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,389,477	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	1,005,361	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)	2,394,838	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,389,477				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	1,005,361				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	2,394,838				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1302

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part III
Date/Time Prepared:
2/15/2022 11:13 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	4,951,263	0	4,951,263	0.090765	5,563	1.00	
1.01	NEW CAP REL COSTS-ALU BLDG	2,639,789	0	2,639,789	0.048392	2,966	1.01	
1.02	NEW CAP REL COSTS-2007 HOSPITAL	35,275,348	0	35,275,348	0.646655	39,635	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	1,067,252	0	1,067,252	0.019565	1,199	2.00	
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	10,616,738	0	10,616,738	0.194623	11,929	2.01	
3.00	Total (sum of lines 1-2)	54,550,390	0	54,550,390	1.000000	61,292	3.00	
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
		Taxes	Other Capital-Relat ed Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
		6.00	7.00	8.00	9.00	10.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	5,563	8,634	0	1.00	
1.01	NEW CAP REL COSTS-ALU BLDG	0	0	2,966	61,948	0	1.01	
1.02	NEW CAP REL COSTS-2007 HOSPITAL	0	0	39,635	1,350,336	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	1,199	28,004	0	2.00	
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	0	11,929	805,084	0	2.01	
3.00	Total (sum of lines 1-2)	0	0	61,292	2,254,006	0	3.00	
Cost Center Description		SUMMARY OF CAPITAL						
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
		11.00	12.00	13.00	14.00	15.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	5,563	0	0	14,197	1.00	
1.01	NEW CAP REL COSTS-ALU BLDG	0	2,966	0	0	64,914	1.01	
1.02	NEW CAP REL COSTS-2007 HOSPITAL	1,032,608	39,635	0	0	2,422,579	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	1,199	0	0	29,203	2.00	
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	152,324	11,929	0	0	969,337	2.01	
3.00	Total (sum of lines 1-2)	1,184,932	61,292	0	0	3,500,230	3.00	

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1302

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

Worksheet A-8

Date/Time Prepared:
2/15/2022 11:13 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				3.00	4.00		
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	-125,842	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	-19,007	0 NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	11	2.01
3.00	Investment income - other (chapter 2)	B	-4,614	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	-18,795	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	-1,674,687			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	-50,320	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	-4,008	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	0 RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	0 PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0 *** Cost Center Deleted ***	114.00		25.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1302

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

Worksheet A-8

Date/Time Prepared:
2/15/2022 11:13 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				3.00	4.00		
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-ALU BLDG			0 NEW CAP REL COSTS-ALU BLDG	1.01	0	26.01
26.02	Depreciation - NEW CAP REL COSTS-2007 HOSPITAL			0 NEW CAP REL COSTS-2007 HOSPITAL	1.02	0	26.02
26.03	Depreciation - NEW CAP REL COSTS-2007 MOB			0 NEW CAP REL COSTS-2007 MOB	1.03	0	26.03
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0 NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP NEW HO			0 NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	0	27.01
28.00	Non-physician Anesthetist			0 NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0 OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0 ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0 SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-172,273	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	-9	RURAL HEALTH CLINIC	88.00	0	33.01
33.05	PROVIDER RHC REVENUE	B	-5,022	RURAL HEALTH CLINIC	88.00	0	33.05
33.06	PART B BILLING COSTS	A	-48,848	HOSPITAL BILLING	5.03	0	33.06
33.07	SCHOOL ATHLETIC TRAINING REVENUE	B	-36,419	PHYSICAL THERAPY	66.00	0	33.07
33.08	HOSPITAL BED ASSESS (UP TO PAID AMT)	A	-319,316	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.08
33.09	MARKETING EXPENSES - NONALLOW	A	-89,628	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.09
34.00	LOBBYING EXPENSE ON DUES PAID	A	-24,196	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	34.00
35.00	COMMUNITY GRANTS / DONATIONS / PROM	A	-2,290	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	35.00
36.00	NH BED ASSESSMENT	A	-116,079	OTHER LONG TERM CARE	46.00	0	36.00
37.00	AR INSURANCE REVENUE	B	-7,756	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	-34,536	DIETARY-SCC	10.01	0	40.00
41.00	OFFSET INTERNAL ALLOCATION FOR ADC/A	B	-76,898	DIETARY-SCC	10.01	0	41.00
42.00	RHC PROVIDER OR TIME	A	-18,252	RURAL HEALTH CLINIC	88.00	0	42.00
43.00	SLEEP MISC REVENUE	B	0	OPERATION OF PLANT	7.00	0	43.00
43.01	PHARMACY CONTRACT PROG EXPENSE	A	-43,192	DRUGS CHARGED TO PATIENTS	73.00	0	43.01
43.02	NON-ALLOWABLE GOLF EXPENSES	A	-1,739	OTHER ADMINISTRATIVE AND GENERAL	5.04	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	NH MISC REVENUE	B	-35,000	OTHER LONG TERM CARE	46.00	0	43.04
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,907,156				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 10/01/2020
To 09/30/2021

Worksheet A-8-2

Date/Time Prepared:
2/15/2022 11:13 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	1,563,841	312,706	1,251,135	0	0	1.00
2.00	60.00	LABORATORY	11,762	0	11,762	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	465,102	465,102	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	6,117	6,117	0	0	0	4.00
5.00	50.00	OPERATING ROOM	105,922	105,922	0	0	0	5.00
6.00	90.00	CLINIC	784,840	784,840	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			2,937,584	1,674,687	1,262,897		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	312,706		1.00
2.00	60.00	LABORATORY	0	0	0	0		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	465,102		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	6,117		4.00
5.00	50.00	OPERATING ROOM	0	0	0	105,922		5.00
6.00	90.00	CLINIC	0	0	0	784,840		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	1,674,687		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1302		Period: From 10/01/2020 To 09/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/15/2022 11:13 am	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					6	1.00
2.00	Line 1 multiplied by 15 hours per week					90	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					17	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					5.60	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	100.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	84.42	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)	42.21	42.21	0.00			11.00
12.00	Number of travel hours (provider site)	0	24	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					8,484	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)					8,484	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)					8,484	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)					8,484	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)					718	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)					718	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)					95	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					813	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)					2,026	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)					2,026	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					813	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 10/01/2020 To 09/30/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/15/2022 11:13 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)	84.42	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)						8,484	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						813	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)						9,297	63.00
64.00	Total cost of outside supplier services (from your records)						8,466	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						718	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						95	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						813	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						95	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						2,026	101.01
101.02	Line 34 = sum of lines 27 and 31						2,121	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						2,026	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						2,026	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/15/2022 11:13 am

Cost Center Description			CAPITAL RELATED COSTS					
			Net Expenses for Cost Allocation (from Wkst A col. 7)	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	14,197	14,197				1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG	64,914	0	64,914			1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL	2,422,579	0	0	2,422,579		1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB	0	0	0	0	0	1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	29,203					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	969,337					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,646,923	0	0	0	0	4.00
5.01	00570	ADMITTING	370,730	0	0	35,014	0	5.01
5.02	00550	INFORMATION TECHNOLOGY	683,166	161	0	17,391	0	5.02
5.03	00590	HOSPITAL BILLING	327,102	0	0	0	0	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	1,595,206	2,350	19,517	210,130	0	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	672,577	0	0	162,951	0	7.00
7.01	00701	OPERATION OF PLANT-SCC	281,431	541	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	59,690	0	0	16,466	0	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	21,891	54	0	0	0	8.01
9.00	00900	HOUSEKEEPING	206,588	0	0	12,488	0	9.00
9.01	00901	HOUSEKEEPING-SCC	97,890	103	0	0	0	9.01
10.00	01000	DIETARY	342,776	0	0	148,289	0	10.00
10.01	01001	DIETARY-SCC	443,874	400	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	301,758	179	0	5,920	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	86,007	0	0	31,545	0	14.00
15.00	01500	PHARMACY	0	0	0	35,754	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	206,276	0	0	31,776	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	1,199,803	0	0	409,347	0	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	11,700	469	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	1,746,321	4,882	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,100,730	0	0	249,029	0	50.00
53.00	05300	ANESTHESIOLOGY	288,707	0	0	2,498	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	800,289	0	0	167,947	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	1,040,737	0	0	49,769	0	60.00
64.00	06400	INTRAVENOUS THERAPY	32,695	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	40,193	0	0	8,696	0	65.00
66.00	06600	PHYSICAL THERAPY	1,242,871	0	0	200,047	0	66.00
66.01	06601	CARDIAC REHAB	133,711	0	0	13,876	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	109,503	0	0	17,206	0	67.00
68.00	06800	SPEECH PATHOLOGY	76,933	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	180,998	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	1,103,728	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	9,572	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,828,322	0	0	265,172	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	531,809	0	0	0	0	88.01
90.00	09000	CLINIC	335,791	0	0	46,254	0	90.00
91.00	09100	EMERGENCY	1,938,977	0	0	256,291	0	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)	25,597,505	9,139	19,517	2,393,856	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	13,737	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,620	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	412,108	0	41,998	0	0	194.01

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
From 10/01/2020
To 09/30/2021Worksheet 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	18,245	0	3,399	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	5,058	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	8,747	0	0	14,986	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)	26,041,225	14,197	64,914	2,422,579	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2020
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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				
			2.00	2.01	4.00	5.01	5.02	
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	29,203					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	969,337				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	2,646,923			4.00
5.01	00570	ADMITTING	0	0	98,281	504,025		5.01
5.02	00550	INFORMATION TECHNOLOGY	0	56,646	86,517	0	843,881	5.02
5.03	00590	HOSPITAL BILLING	0	0	0	0	0	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	1,153	120,534	204,652	0	50,836	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	27,064	33,554	0	25,418	7.00
7.01	00701	OPERATION OF PLANT-SCC	232	0	24,885	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	551	0	0	0	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	0	0	0	0	8.01
9.00	00900	HOUSEKEEPING	0	320	50,924	0	0	9.00
9.01	00901	HOUSEKEEPING-SCC	0	0	21,873	0	0	9.01
10.00	01000	DIETARY	0	45,556	63,803	0	15,251	10.00
10.01	01001	DIETARY-SCC	0	0	71,252	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	0	80,986	0	5,084	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	22,812	0	0	14.00
15.00	01500	PHARMACY	0	3,515	0	0	15,251	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	250	54,873	0	20,334	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	36,871	240,318	52,126	96,589	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	16,916	0	399,101	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	244,424	102,650	71,246	81,338	50.00
53.00	05300	ANESTHESIOLOGY	0	11,639	0	13,678	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	310,952	103,931	101,406	50,836	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	11,121	86,227	67,973	25,418	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	12,597	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,586	0	2,768	0	65.00
66.00	06600	PHYSICAL THERAPY	49	12,365	323,320	60,380	162,675	66.00
66.01	06601	CARDIAC REHAB	0	7,317	34,698	4,694	5,084	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	26,868	6,379	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	20,526	3,948	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	18,947	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	51,981	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	2,595	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	47	19,519	185,375	0	137,258	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	51,834	0	45,753	88.01
90.00	09000	CLINIC	0	10,248	24,782	0	50,836	90.00
91.00	09100	EMERGENCY	44	31,010	113,918	35,902	55,920	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)	18,441	954,488	2,530,555	504,025	843,881	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	9,558	12,689	109,235	0	0	194.01
194.02	07952	ADULT DAY CARE	1,196	0	4,933	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	8	1,953	2,200	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)	29,203	969,337	2,646,923	504,025	843,881	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	327,102					5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	0	2,204,378	2,204,378			5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0		6.00
7.00	00700	OPERATION OF PLANT	0	921,564	101,171	0	1,022,735	7.00
7.01	00701	OPERATION OF PLANT-SCC	0	307,089	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	76,707	8,421	0	8,433	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	21,945	0	0	0	8.01
9.00	00900	HOUSEKEEPING	0	270,320	29,676	0	6,395	9.00
9.01	00901	HOUSEKEEPING-SCC	0	119,866	0	0	0	9.01
10.00	01000	DIETARY	0	615,675	67,590	0	75,941	10.00
10.01	01001	DIETARY-SCC	0	515,526	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	393,927	43,246	0	3,032	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	140,364	15,409	0	16,155	14.00
15.00	01500	PHARMACY	0	54,520	5,985	0	18,310	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	313,509	34,418	0	16,273	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	31,493	2,066,547	226,870	0	209,628	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	12,169	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	2,167,220	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	43,044	1,892,461	207,758	0	127,531	50.00
53.00	05300	ANESTHESIOLOGY	8,264	324,786	35,656	0	1,279	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	61,284	1,596,645	175,283	0	86,008	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	41,067	1,322,312	145,166	0	25,487	60.00
64.00	06400	INTRAVENOUS THERAPY	7,611	52,903	5,808	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,672	57,915	6,358	0	4,453	65.00
66.00	06600	PHYSICAL THERAPY	36,479	2,038,186	223,756	0	110,737	66.00
66.01	06601	CARDIAC REHAB	2,836	202,216	22,200	0	7,106	66.01
67.00	06700	OCCUPATIONAL THERAPY	3,854	163,810	17,983	0	8,812	67.00
68.00	06800	SPEECH PATHOLOGY	2,385	103,792	11,394	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,447	211,392	23,207	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	31,405	1,187,114	130,324	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	12,167	1,336	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	16,694	2,452,387	269,228	0	135,798	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,565	633,961	69,598	0	0	88.01
90.00	09000	CLINIC	1,311	469,222	51,512	0	15,397	90.00
91.00	09100	EMERGENCY	21,691	2,453,753	269,370	0	131,250	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)	327,102	25,376,348	2,198,723	0	1,008,025	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,944	1,531	0	7,035	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,620	507	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	585,588	0	0	0	194.01
194.02	07952	ADULT DAY CARE	0	27,773	0	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	5,058	555	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	27,894	3,062	0	7,675	194.05

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		HOSPITAL BILLING	Subtotal	OTHER ADMINISTRATIV E AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
		5.03	5A.03	5.04	6.00	7.00	
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)	327,102	26,041,225	2,204,378	0	1,022,735	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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To 09/30/2021Worksheet B
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Cost Center Description			OPERATION OF PLANT-SCC	LAUNDRY & LINEN SERVICE	LAUNDRY & LINEN SERVICE-SCC	HOUSEKEEPING	HOUSEKEEPING- SCC	
			7.01	8.00	8.01	9.00	9.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING						5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-SCC	307,089					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	93,561				8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	968	0	22,913			8.01
9.00	00900	HOUSEKEEPING	0	0	0	306,391		9.00
9.01	00901	HOUSEKEEPING-SCC	1,842	0	0	0	121,708	9.01
10.00	01000	DIETARY	0	0	0	25,291	0	10.00
10.01	01001	DIETARY-SCC	7,157	0	0	0	4,158	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	3,209	0	0	1,010	1,865	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	5,380	0	14.00
15.00	01500	PHARMACY	0	0	0	6,098	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	5,419	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	93,561	0	69,814	0	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	8,400	0	0	0	4,880	44.00
46.00	04600	OTHER LONG TERM CARE	87,382	0	22,913	0	50,771	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	42,472	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	426	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	28,643	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	8,488	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,483	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	13,442	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	1,380	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,065	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	46,606	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	4,733	0	90.00
91.00	09100	EMERGENCY	0	0	0	43,710	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)	108,958	93,561	22,913	305,460	61,674	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	95,587	0	0	0	55,539	194.01
194.02	07952	ADULT DAY CARE	7,736	0	0	0	4,495	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	94,808	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	931	0	194.05

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

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

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Cost Center Description		OPERATION OF PLANT-SCC	LAUNDRY & LINEN SERVICE	LAUNDRY & LINEN SERVICE-SCC	HOUSEKEEPING	HOUSEKEEPING- SCC	
		7.01	8.00	8.01	9.00	9.01	
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)	307,089	93,561	22,913	306,391	121,708	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	784,497					10.00
10.01	01001	DIETARY-SCC	0	526,841				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	446,289	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	784,497	0	0	0	357,157	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	334,855	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	44,566	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	44,566	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)	784,497	334,855	0	0	446,289	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	16,714	0	0	0	194.01
194.02	07952	ADULT DAY CARE	0	175,272	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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

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From 10/01/2020
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Cost Center Description		DIETARY	DIETARY-SCC	CAFETERIA	CAFETERIA-SCC	NURSING ADMINISTRATIO N	
		10.00	10.01	11.00	11.01	13.00	
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)	784,497	526,841	0	0	446,289	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2020
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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	177,308					14.00
15.00	01500	PHARMACY	0	84,913				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	640	0	370,259			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,671	0	35,650	0	3,855,395	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	25,449	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	2,663,141	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	86,273	0	48,727	0	2,449,788	50.00
53.00	05300	ANESTHESIOLOGY	1,231	0	9,355	0	372,733	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,141	0	69,349	0	1,964,069	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	46,488	0	1,547,941	60.00
64.00	06400	INTRAVENOUS THERAPY	4,766	0	8,615	0	72,092	64.00
65.00	06500	RESPIRATORY THERAPY	4,506	0	1,893	0	76,608	65.00
66.00	06600	PHYSICAL THERAPY	9,061	0	41,295	0	2,436,477	66.00
66.01	06601	CARDIAC REHAB	0	0	3,210	0	236,112	66.01
67.00	06700	OCCUPATIONAL THERAPY	307	0	4,363	0	196,340	67.00
68.00	06800	SPEECH PATHOLOGY	36	0	2,700	0	117,922	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	26,394	0	12,959	0	273,952	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	84,913	35,551	0	1,437,902	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	13,503	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	8,126	0	18,898	0	2,931,043	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,900	0	5,168	0	714,627	88.01
90.00	09000	CLINIC	2,425	0	1,484	0	544,773	90.00
91.00	09100	EMERGENCY	7,831	0	24,554	0	2,975,034	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)	177,308	84,913	370,259	0	24,904,901	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	22,510	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	5,127	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	753,428	194.01
194.02	07952	ADULT DAY CARE	0	0	0	0	215,276	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	0	100,421	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	0	39,562	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)	177,308	84,913	370,259	0	26,041,225	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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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	3,855,395	30.00
42.00	04200	SUBPROVIDER	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	25,449	44.00
46.00	04600	OTHER LONG TERM CARE	0	2,663,141	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,449,788	50.00
53.00	05300	ANESTHESIOLOGY	0	372,733	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,964,069	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	1,547,941	60.00
64.00	06400	INTRAVENOUS THERAPY	0	72,092	64.00
65.00	06500	RESPIRATORY THERAPY	0	76,608	65.00
66.00	06600	PHYSICAL THERAPY	0	2,436,477	66.00
66.01	06601	CARDIAC REHAB	0	236,112	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	196,340	67.00
68.00	06800	SPEECH PATHOLOGY	0	117,922	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	273,952	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,437,902	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	13,503	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	2,931,043	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	714,627	88.01
90.00	09000	CLINIC	0	544,773	90.00
91.00	09100	EMERGENCY	0	2,975,034	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	24,904,901	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22,510	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,127	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	753,428	194.01
194.02	07952	ADULT DAY CARE	0	215,276	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	194.03

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

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

 Worksheet B
 Part I
 Date/Time Prepared:
 2/15/2022 11:13 am

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
194.04	07954	IDLE SPACE	0	100,421	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	39,562	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	26,041,225	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/15/2022 11:13 am

Cost Center Description			CAPITAL RELATED COSTS					
			Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW ALU BLDG	NEW 2007 HOSPITAL		NEW 2007 MOB
			0	1.00	1.01	1.02	1.03	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00570	ADMITTING	0	0	0	35,014	0	5.01
5.02	00550	INFORMATION TECHNOLOGY	0	161	0	17,391	0	5.02
5.03	00590	HOSPITAL BILLING	0	0	0	0	0	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	0	2,350	19,517	210,130	0	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	162,951	0	7.00
7.01	00701	OPERATION OF PLANT-SCC	0	541	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	16,466	0	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	54	0	0	0	8.01
9.00	00900	HOUSEKEEPING	0	0	0	12,488	0	9.00
9.01	00901	HOUSEKEEPING-SCC	0	103	0	0	0	9.01
10.00	01000	DIETARY	0	0	0	148,289	0	10.00
10.01	01001	DIETARY-SCC	0	400	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	179	0	5,920	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	31,545	0	14.00
15.00	01500	PHARMACY	0	0	0	35,754	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	31,776	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	409,347	0	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	469	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	4,882	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	249,029	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,498	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,045	0	0	167,947	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	49,769	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,696	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	200,047	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	13,876	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	17,206	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	265,172	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	46,254	0	90.00
91.00	09100	EMERGENCY	0	0	0	256,291	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)	16,045	9,139	19,517	2,393,856	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	13,737	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	41,998	0	0	194.01
194.02	07952	ADULT DAY CARE	0	0	3,399	0	0	194.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/15/2022 11:13 am

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	5,058	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	14,986	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)	16,045	14,197	64,914	2,422,579	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/15/2022 11:13 am

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	35,014	0	35,014	5.01
5.02	00550	INFORMATION TECHNOLOGY	0	56,646	74,198	0	0	5.02
5.03	00590	HOSPITAL BILLING	0	0	0	0	0	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	1,153	120,534	353,684	0	0	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	27,064	190,015	0	0	7.00
7.01	00701	OPERATION OF PLANT-SCC	232	0	773	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	551	17,017	0	0	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	0	54	0	0	8.01
9.00	00900	HOUSEKEEPING	0	320	12,808	0	0	9.00
9.01	00901	HOUSEKEEPING-SCC	0	0	103	0	0	9.01
10.00	01000	DIETARY	0	45,556	193,845	0	0	10.00
10.01	01001	DIETARY-SCC	0	0	400	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	0	6,099	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	31,545	0	0	14.00
15.00	01500	PHARMACY	0	3,515	39,269	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	250	32,026	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	36,871	446,218	0	3,622	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	469	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	16,916	0	21,798	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	244,424	493,453	0	4,950	50.00
53.00	05300	ANESTHESIOLOGY	0	11,639	14,137	0	950	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	310,952	494,944	0	7,040	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	11,121	60,890	0	4,723	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	875	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,586	13,282	0	192	65.00
66.00	06600	PHYSICAL THERAPY	49	12,365	212,461	0	4,195	66.00
66.01	06601	CARDIAC REHAB	0	7,317	21,193	0	326	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	17,206	0	443	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	274	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	1,317	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	3,612	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	47	19,519	284,738	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	10,248	56,502	0	0	90.00
91.00	09100	EMERGENCY	44	31,010	287,345	0	2,495	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)	18,441	954,488	3,411,486	0	35,014	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	207	13,944	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	9,558	12,689	64,245	0	0	194.01
194.02	07952	ADULT DAY CARE	1,196	0	4,595	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:
 From 10/01/2020
 To 09/30/2021

 Worksheet B
 Part II
 Date/Time Prepared:
 2/15/2022 11:13 am

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	5,058	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	8	1,953	16,947	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)	29,203	969,337	3,516,275	0	35,014	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/15/2022 11:13 am

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	74,198					5.02
5.03	00590	HOSPITAL BILLING	0	0				5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	4,470	0	358,154			5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0		6.00
7.00	00700	OPERATION OF PLANT	2,235		16,438	0	208,688	7.00
7.01	00701	OPERATION OF PLANT-SCC	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,368	0	1,721	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	0	0	0	0	8.01
9.00	00900	HOUSEKEEPING	0	0	4,822	0	1,305	9.00
9.01	00901	HOUSEKEEPING-SCC	0	0	0	0	0	9.01
10.00	01000	DIETARY	1,341	0	10,982	0	15,496	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	447	0	7,026	0	619	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	2,504	0	3,296	14.00
15.00	01500	PHARMACY	1,341	0	972	0	3,736	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,788	0	5,592	0	3,320	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,493	0	36,861	0	42,774	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	7,152	0	33,756	0	26,023	50.00
53.00	05300	ANESTHESIOLOGY	0	0	5,793	0	261	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,470	0	28,479	0	17,550	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	2,235	0	23,586	0	5,201	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	944	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,033	0	909	65.00
66.00	06600	PHYSICAL THERAPY	14,301	0	36,355	0	22,596	66.00
66.01	06601	CARDIAC REHAB	447	0	3,607	0	1,450	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,922	0	1,798	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,851	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	3,771	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	21,175	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	217	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	12,068	0	43,743	0	27,709	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,023	0	11,308	0	0	88.01
90.00	09000	CLINIC	4,470	0	8,370	0	3,142	90.00
91.00	09100	EMERGENCY	4,917	0	43,760	0	26,781	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)	74,198	0	357,235	0	205,687	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	249	0	1,435	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	82	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	90	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	498	0	1,566	194.05

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
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Cost Center Description		INFORMATION TECHNOLOGY	HOSPITAL BILLING	OTHER ADMINISTRATIV E AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
		5.02	5.03	5.04	6.00	7.00	
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)	74,198	0	358,154	0	208,688	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- SCC	
			7.01	8.00	8.01	9.00	9.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING						5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-SCC	773					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	20,106				8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	2	0	56			8.01
9.00	00900	HOUSEKEEPING	0	0	0	18,935		9.00
9.01	00901	HOUSEKEEPING-SCC	5	0	0	0	108	9.01
10.00	01000	DIETARY	0	0	0	1,563	0	10.00
10.01	01001	DIETARY-SCC	18	0	0	0	4	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	8	0	0	62	2	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	332	0	14.00
15.00	01500	PHARMACY	0	0	0	377	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	335	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	20,106	0	4,314	0	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	21	0	0	0	4	44.00
46.00	04600	OTHER LONG TERM CARE	220	0	56	0	45	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	2,625	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	26	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,770	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	525	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	92	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	831	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	85	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	66	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	2,880	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	293	0	90.00
91.00	09100	EMERGENCY	0	0	0	2,701	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)	274	20,106	56	18,877	55	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	241	0	0	0	49	194.01
194.02	07952	ADULT DAY CARE	19	0	0	0	4	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	239	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	58	0	194.05

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- SCC	
		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)	773	20,106	56	18,935	108	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	223,227					10.00
10.01	01001	DIETARY-SCC	0	422				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	14,263	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	223,227	0	0	0	11,415	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	269	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	1,424	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	1,424	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)	223,227	269	0	0	14,263	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	13	0	0	0	194.01
194.02	07952	ADULT DAY CARE	0	140	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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

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Cost Center Description		DIETARY	DIETARY-SCC	CAFETERIA	CAFETERIA-SCC	NURSING ADMINISTRATIO N	
		10.00	10.01	11.00	11.01	13.00	
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)	223,227	422	0	0	14,263	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	37,677					14.00
15.00	01500	PHARMACY	0	45,695				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	136	0	43,197			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,480	0	4,158		803,668	30.00
42.00	04200	SUBPROVIDER	0	0	0		0	42.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		494	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0		22,388	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	18,332	0	5,682		593,397	50.00
53.00	05300	ANESTHESIOLOGY	261	0	1,091		22,519	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,730	0	8,104		564,087	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	5,421		102,581	60.00
64.00	06400	INTRAVENOUS THERAPY	1,013	0	1,005		3,837	64.00
65.00	06500	RESPIRATORY THERAPY	958	0	221		16,687	65.00
66.00	06600	PHYSICAL THERAPY	1,925	0	4,816		297,480	66.00
66.01	06601	CARDIAC REHAB	0	0	374		27,482	66.01
67.00	06700	OCCUPATIONAL THERAPY	65	0	509		23,009	67.00
68.00	06800	SPEECH PATHOLOGY	8	0	315		2,448	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,609	0	1,511		12,208	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	45,695	4,146		74,628	73.00
76.00	03020	SLEEP LAB	0	0	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	0	0		217	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,727	0	2,204		375,069	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,254	0	603		17,188	88.01
90.00	09000	CLINIC	515	0	173		73,465	90.00
91.00	09100	EMERGENCY	1,664	0	2,864		373,951	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)	37,677	45,695	43,197	0	3,406,803	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		15,628	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		82	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		64,548	194.01
194.02	07952	ADULT DAY CARE	0	0	0		4,758	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0		0	194.03
194.04	07954	IDLE SPACE	0	0	0		5,387	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0		19,069	194.05

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
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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)	37,677	45,695	43,197	0	3,516,275	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

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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	803,668	30.00
42.00	04200	SUBPROVIDER	0	42.00
44.00	04400	SKILLED NURSING FACILITY	494	44.00
46.00	04600	OTHER LONG TERM CARE	22,388	46.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	593,397	50.00
53.00	05300	ANESTHESIOLOGY	22,519	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	564,087	54.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
60.00	06000	LABORATORY	102,581	60.00
64.00	06400	INTRAVENOUS THERAPY	3,837	64.00
65.00	06500	RESPIRATORY THERAPY	16,687	65.00
66.00	06600	PHYSICAL THERAPY	297,480	66.00
66.01	06601	CARDIAC REHAB	27,482	66.01
67.00	06700	OCCUPATIONAL THERAPY	23,009	67.00
68.00	06800	SPEECH PATHOLOGY	2,448	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,208	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	74,628	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	217	76.02
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	375,069	88.00
88.01	08801	RURAL HEALTH CLINIC II	17,188	88.01
90.00	09000	CLINIC	73,465	90.00
91.00	09100	EMERGENCY	373,951	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)	3,406,803	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,628	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	82	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	64,548	194.01
194.02	07952	ADULT DAY CARE	4,758	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	194.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

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

 Worksheet B
 Part II
 Date/Time Prepared:
 2/15/2022 11:13 am

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
194.04	07954	IDLE SPACE	0	5,387	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	19,069	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	3,516,275	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

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

Worksheet B-1

Date/Time Prepared:
2/15/2022 11:13 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					99,352	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	8,429	8,900	4,543	0	3,921	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	788	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	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	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	57,552	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	168	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	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	5,733	0	160	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	1,000	0	0	90.00
91.00	09100	EMERGENCY	0	0	5,541	0	149	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)	32,778	8,900	51,755	0	62,738	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	32,519	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 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/15/2022 11:13 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	18,136	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	324	0	27	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)	14,197	64,914	2,422,579	0	29,203	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.278843	2.192892	46.253609	0.000000	0.293935	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 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/15/2022 11:13 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	1,000,841				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,765,108			4.00
5.01	00570	ADMITTING	0	362,583	32,368,252		5.01
5.02	00550	INFORMATION TECHNOLOGY	58,487	319,183	0	166	5.02
5.03	00590	HOSPITAL BILLING	0	0	0	0	5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL	124,451	755,010	0	10	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	27,944	123,790	0	5	7.00
7.01	00701	OPERATION OF PLANT-SCC	0	91,807	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	569	0	0	0	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	0	0	0	0	8.01
9.00	00900	HOUSEKEEPING	330	187,871	0	0	9.00
9.01	00901	HOUSEKEEPING-SCC	0	80,693	0	0	9.01
10.00	01000	DIETARY	47,037	235,383	0	3	10.00
10.01	01001	DIETARY-SCC	0	262,865	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	0	298,775	0	1	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	84,160	0	0	14.00
15.00	01500	PHARMACY	3,629	0	0	3	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	258	202,438	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	38,069	886,589	3,347,428	19	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	1,472,371	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	252,368	378,699	4,575,274	16	50.00
53.00	05300	ANESTHESIOLOGY	12,017	0	878,381	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	321,060	383,424	6,512,826	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	11,482	318,113	4,365,078	5	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	808,955	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,735	0	177,753	0	65.00
66.00	06600	PHYSICAL THERAPY	12,767	1,192,802	3,877,496	32	66.00
66.01	06601	CARDIAC REHAB	7,555	128,009	301,423	1	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	99,124	409,675	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	75,725	253,530	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,216,766	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	3,338,090	0	73.00
76.00	03020	SLEEP LAB	0	0	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	9,572	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	20,153	683,890	0	27	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	191,227	0	9	88.01
90.00	09000	CLINIC	10,581	91,425	0	10	90.00
91.00	09100	EMERGENCY	32,018	420,271	2,305,577	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)	985,510	9,335,799	32,368,252	166	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEN	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	13,101	402,992	0	0	194.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

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

Worksheet B-1

Date/Time Prepared:
2/15/2022 11:13 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	18,199	0	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	2,016	8,118	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)	969,337	2,646,923	504,025	843,881	327,102	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.968522	0.271059	0.015572	5,083.620482	0.009408	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		0	35,014	74,198	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000000	0.001082	446.975904	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 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:

2/15/2022 11:13 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	-2,204,378	20,079,671			5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0		6.00
7.00	00700	OPERATION OF PLANT	0	921,564	0	43,177	7.00
7.01	00701	OPERATION OF PLANT-SCC	-307,089	0	0	61,529	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	76,707	0	356	8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	-21,945	0	0	194	8.01
9.00	00900	HOUSEKEEPING	0	270,320	0	270	9.00
9.01	00901	HOUSEKEEPING-SCC	-119,866	0	0	369	9.01
10.00	01000	DIETARY	0	615,675	0	3,206	10.00
10.01	01001	DIETARY-SCC	-515,526	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	393,927	0	128	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	140,364	0	682	14.00
15.00	01500	PHARMACY	0	54,520	0	773	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	313,509	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	2,066,547	0	8,850	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	-12,169	0	0	1,683	44.00
46.00	04600	OTHER LONG TERM CARE	-2,167,220	0	0	17,508	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,892,461	0	5,384	50.00
53.00	05300	ANESTHESIOLOGY	0	324,786	0	54	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,596,645	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	1,322,312	0	1,076	60.00
64.00	06400	INTRAVENOUS THERAPY	0	52,903	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	57,915	0	188	65.00
66.00	06600	PHYSICAL THERAPY	0	2,038,186	0	4,675	66.00
66.01	06601	CARDIAC REHAB	0	202,216	0	300	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	163,810	0	372	67.00
68.00	06800	SPEECH PATHOLOGY	0	103,792	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	211,392	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	1,187,114	0	0	73.00
76.00	03020	SLEEP LAB	0	0	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	12,167	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,452,387	0	5,733	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	633,961	0	0	88.01
90.00	09000	CLINIC	0	469,222	0	650	90.00
91.00	09100	EMERGENCY	0	2,453,753	0	5,541	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,348,193	20,028,155	0	42,556	21,831
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,944	0	297	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,620	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	-585,588	0	0	19,152	194.01
194.02	07952	ADULT DAY CARE	-27,773	0	0	1,550	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	5,058	0	0	18,996

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

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

Worksheet B-1

Date/Time Prepared:
2/15/2022 11:13 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	
194.05	07955	COMMUNITY FITNESS CENTER	0	27,894	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)		2,204,378	0	1,022,735	307,089	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.109782	0.000000	23.687032	4.990964	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		358,154	0	208,688	773	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.017837	0.000000	4.833314	0.012563	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 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/15/2022 11:13 am

Cost Center Description			LAUNDRY & LINEN SERVICE (PATIENT DAYS)	LAUNDRY & LINEN SERVICE-SCC (PATIENT DAYS SCC)	HOUSEKEEPING (SQUARE FT)	HOUSEKEEPING-SCC (SQUARE FT SCC)	DIETARY (PATIENT DAYS)	
			8.00	8.01	9.00	9.01	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING						5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-SCC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE	2,417					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 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			LAUNDRY & LINEN SERVICE (PATIENT DAYS)	LAUNDRY & LINEN SERVICE-SCC (PATIENT DAYS SCC)	HOUSEKEEPING (SQUARE FT)	HOUSEKEEPING- SCC (SQUARE FT SCC)	DIETARY (PATIENT DAYS)	
			8.00	8.01	9.00	9.01	10.00	
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)	93,561	22,913	306,391	121,708	784,497	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	38.709557	1.558177	7.888543	2.899881	324.574679	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	20,106	56	18,935	108	223,227	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	8.318577	0.003808	0.487513	0.002573	92.357054	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 10/01/2020
To 09/30/2021

Worksheet B-1

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Cost Center Description			DIETARY-SCC (PATIENT DAYS SCC)	CAFETERIA (FTE)	CAFETERIA-SCC (FTE'S -SCC)	NURSING ADMINISTRATIO N (HOURS OF SERVICE)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	
			10.01	11.00	11.01	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00550	INFORMATION TECHNOLOGY						5.02
5.03	00590	HOSPITAL BILLING						5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-SCC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC						8.01
9.00	00900	HOUSEKEEPING						9.00
9.01	00901	HOUSEKEEPING-SCC						9.01
10.00	01000	DIETARY						10.00
10.01	01001	DIETARY-SCC	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	2,143		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	1,216,255	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	4,393	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	1,715	80,058	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	214	591,788	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	8,441	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	55,841	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	32,695	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	30,910	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	62,155	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	2,108	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	248	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	181,052	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	55,740	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	40,473	88.01
90.00	09000	CLINIC	0	0	0	0	16,635	90.00
91.00	09100	EMERGENCY	0	0	0	214	53,718	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)	14,705	0	0	2,143	1,216,255	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 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			DIETARY-SCC (PATIENT DAYS SCC)	CAFETERIA (FTE)	CAFETERIA-SCC (FTE'S -SCC)	NURSING ADMINISTRATIO N (HOURS OF SERVICE)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	
			10.01	11.00	11.01	13.00	14.00	
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)	526,841	0	0	446,289	177,308	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.771482	0.000000	0.000000	208.254316	0.145782	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	422	0	0	14,263	37,677	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.018240	0.000000	0.000000	6.655623	0.030978	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 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			PHARMACY (GROSS CHARGES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES HOSP BILLING)	NONPHYSICIAN ANESTHETISTS (TIME SPENT)	
			15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-ALU BLDG				1.01
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL				1.02
1.03	00103	NEW CAP REL COSTS-2007 MOB				1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00570	ADMITTING				5.01
5.02	00550	INFORMATION TECHNOLOGY				5.02
5.03	00590	HOSPITAL BILLING				5.03
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL				5.04
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT-SCC				7.01
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
8.01	00801	LAUNDRY & LINEN SERVICE-SCC				8.01
9.00	00900	HOUSEKEEPING				9.00
9.01	00901	HOUSEKEEPING-SCC				9.01
10.00	01000	DIETARY				10.00
10.01	01001	DIETARY-SCC				10.01
11.00	01100	CAFETERIA				11.00
11.01	01101	CAFETERIA-SCC				11.01
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY				14.00
15.00	01500	PHARMACY	3,338,090			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	34,767,337		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,347,428	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	4,575,274	0	50.00
53.00	05300	ANESTHESIOLOGY	0	878,381	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,512,826	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	4,365,078	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	808,955	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	177,753	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,877,496	0	66.00
66.01	06601	CARDIAC REHAB	0	301,423	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	409,675	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	253,530	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,216,766	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,338,090	3,338,090	0	73.00
76.00	03020	SLEEP LAB	0	0	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	1,774,465	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	485,276	0	88.01
90.00	09000	CLINIC	0	139,344	0	90.00
91.00	09100	EMERGENCY	0	2,305,577	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,338,090	34,767,337	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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

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

Worksheet B-1

Date/Time Prepared:
2/15/2022 11:13 am

Cost Center Description		PHARMACY (GROSS CHARGES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES HOSP BILLING)	NONPHYSICIAN ANESTHETISTS (TIME SPENT)		
		15.00	16.00	19.00		
194.03	07953 GRANT FUNDED PROGRAMS	0	0	0		194.03
194.04	07954 IDLE SPACE	0	0	0		194.04
194.05	07955 COMMUNITY FITNESS CENTER	0	0	0		194.05
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	84,913	370,259	0		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.025438	0.010650	0.000000		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	45,695	43,197	0		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.013689	0.001242	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 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/15/2022 11:13 am

				Title XVIII	Hospital	Cost		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance		Total Costs
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,855,395		3,855,395	0	3,855,395	30.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	25,449		25,449	0	25,449	44.00
46.00	04600	OTHER LONG TERM CARE	2,663,141		2,663,141	0	2,663,141	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,449,788		2,449,788	0	2,449,788	50.00
53.00	05300	ANESTHESIOLOGY	372,733		372,733	0	372,733	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,964,069		1,964,069	0	1,964,069	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	1,547,941		1,547,941	0	1,547,941	60.00
64.00	06400	INTRAVENOUS THERAPY	72,092		72,092	0	72,092	64.00
65.00	06500	RESPIRATORY THERAPY	76,608	0	76,608	0	76,608	65.00
66.00	06600	PHYSICAL THERAPY	2,436,477	0	2,436,477	0	2,436,477	66.00
66.01	06601	CARDIAC REHAB	236,112	0	236,112	0	236,112	66.01
67.00	06700	OCCUPATIONAL THERAPY	196,340	0	196,340	0	196,340	67.00
68.00	06800	SPEECH PATHOLOGY	117,922	0	117,922	0	117,922	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	273,952		273,952	0	273,952	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,437,902		1,437,902	0	1,437,902	73.00
76.00	03020	SLEEP LAB	0		0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0		0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	13,503		13,503	0	13,503	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,931,043		2,931,043	0	2,931,043	88.00
88.01	08801	RURAL HEALTH CLINIC II	714,627		714,627	0	714,627	88.01
90.00	09000	CLINIC	544,773		544,773	0	544,773	90.00
91.00	09100	EMERGENCY	2,975,034		2,975,034	0	2,975,034	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	279,337		279,337	0	279,337	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)	25,184,238	0	25,184,238	0	25,184,238	200.00
201.00		Less Observation Beds	279,337		279,337		279,337	201.00
202.00		Total (see instructions)	24,904,901	0	24,904,901	0	24,904,901	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1302

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/15/2022 11:13 am

			Title XVIII		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,086,564		3,086,564		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	3,223,578		3,223,578		46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,043,884	3,531,391	4,575,275	0.535441	50.00
53.00	05300	ANESTHESIOLOGY	33,304	845,077	878,381	0.424341	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	266,544	6,246,282	6,512,826	0.301569	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	315,127	4,049,951	4,365,078	0.354619	60.00
64.00	06400	INTRAVENOUS THERAPY	28,116	780,839	808,955	0.089117	64.00
65.00	06500	RESPIRATORY THERAPY	131,434	46,319	177,753	0.430980	65.00
66.00	06600	PHYSICAL THERAPY	652,674	3,224,821	3,877,495	0.628364	66.00
66.01	06601	CARDIAC REHAB	0	301,423	301,423	0.783324	66.01
67.00	06700	OCCUPATIONAL THERAPY	251,711	157,964	409,675	0.479258	67.00
68.00	06800	SPEECH PATHOLOGY	111,041	142,489	253,530	0.465120	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	542,286	674,480	1,216,766	0.225148	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,095,906	2,242,184	3,338,090	0.430756	73.00
76.00	03020	SLEEP LAB	0	0	0	0.000000	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	1,774,465	1,774,465		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	485,276	485,276		88.01
90.00	09000	CLINIC	0	139,344	139,344	3.909555	90.00
91.00	09100	EMERGENCY	40,776	2,264,801	2,305,577	1.290364	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	6,883	253,981	260,864	1.070815	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)	10,829,828	27,161,087	37,990,915		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	10,829,828	27,161,087	37,990,915		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-1302	Period: From 10/01/2020 To 09/30/2021	Worksheet C Part I Date/Time Prepared: 2/15/2022 11:13 am
			Title XVIII	Hospital	Cost
Cost Center Description			PPS Inpatient Ratio		
			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	0.535441		50.00
53.00	05300	ANESTHESIOLOGY	0.424341		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.301569		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	0.354619		60.00
64.00	06400	INTRAVENOUS THERAPY	0.089117		64.00
65.00	06500	RESPIRATORY THERAPY	0.430980		65.00
66.00	06600	PHYSICAL THERAPY	0.628364		66.00
66.01	06601	CARDIAC REHAB	0.783324		66.01
67.00	06700	OCCUPATIONAL THERAPY	0.479258		67.00
68.00	06800	SPEECH PATHOLOGY	0.465120		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.225148		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.430756		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			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
90.00	09000	CLINIC	3.909555		90.00
91.00	09100	EMERGENCY	1.290364		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.070815		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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1302

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/15/2022 11:13 am

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE		Total Costs
						Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,855,395		3,855,395	0	3,855,395	30.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	25,449		25,449	0	25,449	44.00
46.00	04600	OTHER LONG TERM CARE	2,663,141		2,663,141	0	2,663,141	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,449,788		2,449,788	0	2,449,788	50.00
53.00	05300	ANESTHESIOLOGY	372,733		372,733	0	372,733	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,964,069		1,964,069	0	1,964,069	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	1,547,941		1,547,941	0	1,547,941	60.00
64.00	06400	INTRAVENOUS THERAPY	72,092		72,092	0	72,092	64.00
65.00	06500	RESPIRATORY THERAPY	76,608	0	76,608	0	76,608	65.00
66.00	06600	PHYSICAL THERAPY	2,436,477	0	2,436,477	0	2,436,477	66.00
66.01	06601	CARDIAC REHAB	236,112	0	236,112	0	236,112	66.01
67.00	06700	OCCUPATIONAL THERAPY	196,340	0	196,340	0	196,340	67.00
68.00	06800	SPEECH PATHOLOGY	117,922	0	117,922	0	117,922	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	273,952		273,952	0	273,952	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,437,902		1,437,902	0	1,437,902	73.00
76.00	03020	SLEEP LAB	0		0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0		0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	13,503		13,503	0	13,503	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,931,043		2,931,043	0	2,931,043	88.00
88.01	08801	RURAL HEALTH CLINIC II	714,627		714,627	0	714,627	88.01
90.00	09000	CLINIC	544,773		544,773	0	544,773	90.00
91.00	09100	EMERGENCY	2,975,034		2,975,034	0	2,975,034	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	279,337		279,337	0	279,337	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)	25,184,238	0	25,184,238	0	25,184,238	200.00
201.00		Less Observation Beds	279,337		279,337		279,337	201.00
202.00		Total (see instructions)	24,904,901	0	24,904,901	0	24,904,901	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1302

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/15/2022 11:13 am

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,086,564		3,086,564		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	3,223,578		3,223,578		46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,043,884	3,531,391	4,575,275	0.535441	50.00
53.00	05300	ANESTHESIOLOGY	33,304	845,077	878,381	0.424341	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	266,544	6,246,282	6,512,826	0.301569	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	315,127	4,049,951	4,365,078	0.354619	60.00
64.00	06400	INTRAVENOUS THERAPY	28,116	780,839	808,955	0.089117	64.00
65.00	06500	RESPIRATORY THERAPY	131,434	46,319	177,753	0.430980	65.00
66.00	06600	PHYSICAL THERAPY	652,674	3,224,821	3,877,495	0.628364	66.00
66.01	06601	CARDIAC REHAB	0	301,423	301,423	0.783324	66.01
67.00	06700	OCCUPATIONAL THERAPY	251,711	157,964	409,675	0.479258	67.00
68.00	06800	SPEECH PATHOLOGY	111,041	142,489	253,530	0.465120	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	542,286	674,480	1,216,766	0.225148	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,095,906	2,242,184	3,338,090	0.430756	73.00
76.00	03020	SLEEP LAB	0	0	0	0.000000	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	1,774,465	1,774,465	1.651790	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	485,276	485,276	1.472620	88.01
90.00	09000	CLINIC	0	139,344	139,344	3.909555	90.00
91.00	09100	EMERGENCY	40,776	2,264,801	2,305,577	1.290364	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	6,883	253,981	260,864	1.070815	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)	10,829,828	27,161,087	37,990,915		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	10,829,828	27,161,087	37,990,915		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1302

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/15/2022 11:13 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 10/01/2020 To 09/30/2021		Worksheet D Part II Date/Time Prepared: 2/15/2022 11:13 am		
				Title XVIII		Hospital		Cost		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)			
								1.00	2.00	3.00
	ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	593,397	4,575,275	0.129696	520,785	67,544	50.00		
53.00	05300	ANESTHESIOLOGY	22,519	878,381	0.025637	15,619	400	53.00		
54.00	05400	RADIOLOGY-DIAGNOSTIC	564,087	6,512,826	0.086612	85,715	7,424	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	102,581	4,365,078	0.023500	103,753	2,438	60.00		
64.00	06400	INTRAVENOUS THERAPY	3,837	808,955	0.004743	2,649	13	64.00		
65.00	06500	RESPIRATORY THERAPY	16,687	177,753	0.093877	50,341	4,726	65.00		
66.00	06600	PHYSICAL THERAPY	297,480	3,877,495	0.076720	64,693	4,963	66.00		
66.01	06601	CARDIAC REHAB	27,482	301,423	0.091174	0	0	66.01		
67.00	06700	OCCUPATIONAL THERAPY	23,009	409,675	0.056164	18,911	1,062	67.00		
68.00	06800	SPEECH PATHOLOGY	2,448	253,530	0.009656	7,330	71	68.00		
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00		
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,208	1,216,766	0.010033	279,833	2,808	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	74,628	3,338,090	0.022356	285,347	6,379	73.00		
76.00	03020	SLEEP LAB	0	0	0.000000	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	217	0	0.000000	0	0	76.02		
	OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	375,069	1,774,465	0.211370	0	0	88.00		
88.01	08801	RURAL HEALTH CLINIC II	17,188	485,276	0.035419	0	0	88.01		
90.00	09000	CLINIC	73,465	139,344	0.527220	0	0	90.00		
91.00	09100	EMERGENCY	373,951	2,305,577	0.162194	4,692	761	91.00		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	58,229	260,864	0.223216	0	0	92.00		
93.00	04040	FAMILY PRACTICE	0	0	0.000000	0	0	93.00		
200.00		Total (lines 50 through 199)	2,638,482	31,680,773		1,439,668	98,589	200.00		

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1302

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/15/2022 11:13 am

			Title XVIII		Hospital		Cost	
Cost Center Description			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/15/2022 11:13 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	4,575,275	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	878,381	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,512,826	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	4,365,078	0.000000
64.00	06400	INTRAVENOUS THERAPY	0	0	0	808,955	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	177,753	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	3,877,495	0.000000
66.01	06601	CARDIAC REHAB	0	0	0	301,423	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	409,675	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	253,530	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,216,766	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	3,338,090	0.000000
76.00	03020	SLEEP LAB	0	0	0	0	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	1,774,465	0.000000
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	485,276	0.000000
90.00	09000	CLINIC	0	0	0	139,344	0.000000
91.00	09100	EMERGENCY	0	0	0	2,305,577	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	260,864	0.000000
93.00	04040	FAMILY PRACTICE	0	0	0	0	0.000000
200.00		Total (lines 50 through 199)	0	0	0	31,680,773	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1302

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/15/2022 11:13 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	520,785	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	15,619	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	85,715	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	103,753	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	2,649	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	50,341	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	64,693	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	18,911	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	7,330	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	279,833	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	285,347	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	4,692	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)		1,439,668	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1302

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part V
Date/Time Prepared:
2/15/2022 11:13 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	0.535441	0	956,751	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.424341	0	182,703	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.301569	0	2,189,925	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	0.354619	0	1,371,701	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.089117	0	266,845	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.430980	0	6,294	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.628364	0	1,417,891	0	0	66.00
66.01	06601	CARDIAC REHAB	0.783324	0	205,188	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.479258	0	72,888	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.465120	0	116,255	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.225148	0	119,543	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	0.430756	0	757,431	2,487	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						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
90.00	09000	CLINIC	3.909555	0	30,134	0	0	90.00
91.00	09100	EMERGENCY	1.290364	0	833,176	6,260	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.070815	0	118,522	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	0	0	0	93.00
200.00		Subtotal (see instructions)		0	8,645,247	8,747	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	8,645,247	8,747	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN:14-1302		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part V Date/Time Prepared: 2/15/2022 11:13 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	512,284	0				50.00	
53.00	05300	ANESTHESIOLOGY	77,528	0				53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	660,413	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	486,431	0				60.00	
64.00	06400	INTRAVENOUS THERAPY	23,780	0				64.00	
65.00	06500	RESPIRATORY THERAPY	2,713	0				65.00	
66.00	06600	PHYSICAL THERAPY	890,952	0				66.00	
66.01	06601	CARDIAC REHAB	160,729	0				66.01	
67.00	06700	OCCUPATIONAL THERAPY	34,932	0				67.00	
68.00	06800	SPEECH PATHOLOGY	54,073	0				68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0				69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	26,915	0				71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	326,268	1,071				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	117,811	0				90.00	
91.00	09100	EMERGENCY	1,075,100	8,078				91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	126,915	0				92.00	
93.00	04040	FAMILY PRACTICE	0	0				93.00	
200.00		Subtotal (see instructions)	4,576,844	9,149				200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0					201.00	
202.00		Net Charges (line 200 - line 201)	4,576,844	9,149				202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1302

Period:

Worksheet D

Component CCN:14-Z302

From 10/01/2020

Part V

To 09/30/2021

Date/Time Prepared:

2/15/2022 11:13 am

			Title XVIII	Swing Beds - SNF		Cost		
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.535441	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.424341	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.301569	0	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.354619	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.089117	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.430980	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.628364	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0.783324	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.479258	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.465120	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.225148	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.430756	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0.000000	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0.000000	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0.000000	0	0	0	0	76.02
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
90.00	09000	CLINIC	3.909555	0	0	0	0	90.00
91.00	09100	EMERGENCY	1.290364	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.070815	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	0	0	0	93.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1302

Period:

Worksheet D

Component CCN:14-Z302

From 10/01/2020
To 09/30/2021Part V
Date/Time Prepared:
2/15/2022 11:13 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 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/15/2022 11:13 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	0	93.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1302 Component CCN: 14-6140		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/15/2022 11:13 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	4,575,275	0.000000	50.00
53.00	05300	ANESTHESIOLOGY		0	0	0	878,381	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	6,512,826	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	4,365,078	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	808,955	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	177,753	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	3,877,495	0.000000	66.00
66.01	06601	CARDIAC REHAB		0	0	0	301,423	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	409,675	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	253,530	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	1,216,766	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	3,338,090	0.000000	73.00
76.00	03020	SLEEP LAB		0	0	0	0	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	1,774,465	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II		0	0	0	485,276	0.000000	88.01
90.00	09000	CLINIC		0	0	0	139,344	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	2,305,577	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	260,864	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	31,680,773		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1302 Component CCN: 14-6140		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/15/2022 11:13 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 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/15/2022 11:13 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)			2,611	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			913	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)			731	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			383	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)			1,206	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			33	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)			76	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			443	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)			383	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)			912	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)			3,855,395	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)			4,620	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)			10,640	25.00
26.00	Total swing-bed cost (see instructions)			2,454,105	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,401,290	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)			1,401,290	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)			1,534.83	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			679,930	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)			679,930	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1302

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

Worksheet D-1

Date/Time Prepared:
2/15/2022 11:13 am

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					615,148	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,295,078	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)					587,840	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					1,399,765	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,987,605	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)					182	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,534.82	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					279,337	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1302		Period: From 10/01/2020 To 09/30/2021		Worksheet D-1 Date/Time Prepared: 2/15/2022 11:13 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	803,668	3,855,395	0.208453	279,337	58,229	90.00
91.00	Nursing Program cost	0	3,855,395	0.000000	279,337	0	91.00
92.00	Allied health cost	0	3,855,395	0.000000	279,337	0	92.00
93.00	All other Medical Education	0	3,855,395	0.000000	279,337	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1302 Component CCN: 14-6140	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/15/2022 11:13 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)		25,449	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)		25,449	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)		25,449	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	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1
				Component CCN:14-6140		Date/Time Prepared: 2/15/2022 11:13 am
				Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT						43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges						54.00
55.00 Target amount per discharge						55.00
56.00 Target amount (line 54 x line 55)						56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00 Bonus payment (see instructions)						58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00 Relief payment (see instructions)						62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					25,449	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					0.00	71.00
72.00 Program routine service cost (line 9 x line 71)					0	72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					0	74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00 Program capital-related costs (line 9 x line 76)					0	77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00 Inpatient routine service cost per diem limitation					0.00	81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00 Reasonable inpatient routine service costs (see instructions)					0	83.00
84.00 Program inpatient ancillary services (see instructions)					0	84.00
85.00 Utilization review - physician compensation (see instructions)					0	85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					0	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-1302 Component CCN: 14-6140		Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/15/2022 11:13 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 Program 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 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/15/2022 11:13 am	
Cost Center Description		Title XVIII	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		850,955		30.00
42.00	04200 SUBPROVIDER		0		42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.535441	520,785	278,850	50.00
53.00	05300 ANESTHESIOLOGY	0.424341	15,619	6,628	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.301569	85,715	25,849	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	0.354619	103,753	36,793	60.00
64.00	06400 INTRAVENOUS THERAPY	0.089117	2,649	236	64.00
65.00	06500 RESPIRATORY THERAPY	0.430980	50,341	21,696	65.00
66.00	06600 PHYSICAL THERAPY	0.628364	64,693	40,651	66.00
66.01	06601 CARDIAC REHAB	0.783324	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.479258	18,911	9,063	67.00
68.00	06800 SPEECH PATHOLOGY	0.465120	7,330	3,409	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.225148	279,833	63,004	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.430756	285,347	122,915	73.00
76.00	03020 SLEEP LAB	0.000000	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	3.909555	0	0	90.00
91.00	09100 EMERGENCY	1.290364	4,692	6,054	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.070815	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)		1,439,668	615,148	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)		1,439,668		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1302	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/15/2022 11:13 am	
		Component CCN: 14-Z302			
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
42.00	04200 SUBPROVIDER				42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.535441	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.424341	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.301569	53,773	16,216	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	0.354619	118,538	42,036	60.00
64.00	06400 INTRAVENOUS THERAPY	0.089117	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.430980	30,324	13,069	65.00
66.00	06600 PHYSICAL THERAPY	0.628364	412,547	259,230	66.00
66.01	06601 CARDIAC REHAB	0.783324	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.479258	166,315	79,708	67.00
68.00	06800 SPEECH PATHOLOGY	0.465120	80,629	37,502	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.225148	10,798	2,431	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.430756	440,642	189,809	73.00
76.00	03020 SLEEP LAB	0.000000	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	3.909555	0	0	90.00
91.00	09100 EMERGENCY	1.290364	3,334	4,302	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.070815	552	591	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)		1,317,452	644,894	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)		1,317,452		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1302 Component CCN: 14-6140	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/15/2022 11:13 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				30.00
42.00	04200 SUBPROVIDER				42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.535441	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.424341	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.301569	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	0.354619	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.089117	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.430980	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.628364	0	0	66.00
66.01	06601 CARDIAC REHAB	0.783324	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.479258	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.465120	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.225148	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	0.430756	0	0	73.00
76.00	03020 SLEEP LAB	0.000000	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	3.909555	0	0	90.00
91.00	09100 EMERGENCY	1.290364	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.070815	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 10/01/2020 To 09/30/2021	Worksheet E Part B Date/Time Prepared: 2/15/2022 11:13 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			4,585,993 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)			4,585,993 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 chargebasis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			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)			4,631,853 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)			23,627 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			1,428,764 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)			3,179,462 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)			3,179,462 30.00
31.00	Primary payer payments			6,951 31.00
32.00	Subtotal (line 30 minus line 31)			3,172,511 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)			97,012 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			63,058 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			69,602 36.00
37.00	Subtotal (see instructions)			3,235,569 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.97	Demonstration payment adjustment amount before sequestration			0 39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			3,235,569 40.00
40.01	Sequestration adjustment (see instructions)			0 40.01
40.02	Demonstration payment adjustment amount after sequestration			0 40.02
40.03	Sequestration adjustment-PARHM pass-throughs			0 40.03
41.00	Interim payments			3,827,018 41.00
41.01	Interim payments-PARHM			0 41.01
42.00	Tentative settlement (for contractors use only)			0 42.00
42.01	Tentative settlement-PARHM (for contractor use only)			0 42.01
43.00	Balance due provider/program (see instructions)			-591,449 43.00
43.01	Balance due provider/program-PARHM (see instructions)			0 43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1302 Component CCN: 14-6140	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part B Date/Time Prepared: 2/15/2022 11:13 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)		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)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		0	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		0	37.00
38.00	MSP-LCC reconciliation amount from PS&R			38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		0	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
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 10/01/2020
To 09/30/2021Worksheet E-1
Part I
Date/Time Prepared:
2/15/2022 11:13 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		1,151,617		4,371,847	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	06/23/2021	13,390	06/23/2021	430,596	3.50	
3.51		09/01/2021	2,869	09/01/2021	114,233	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)		-16,259		-544,829	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)		1,135,358		3,827,018	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		18,190		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		591,449	6.02	
7.00	Total Medicare program liability (see instructions)		1,153,548		3,235,569	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 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/15/2022 11:13 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		2,560,707		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	09/01/2021	13,560		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)		-13,560		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)		2,547,147		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		70,591		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,617,738		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 10/01/2020 To 09/30/2021		Worksheet E-1 Part I Date/Time Prepared: 2/15/2022 11:13 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 10/01/2020
To 09/30/2021Worksheet E-1
Part II
Date/Time Prepared:
2/15/2022 11:13 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 through 12, and 32.			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8, sum of lines 1, 8 through 12, and 32.			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1302	Period: From 10/01/2020 To 09/30/2021	Worksheet E-2	
		Component CCN: 14-Z302		Date/Time Prepared: 2/15/2022 11:13 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)		2,007,481	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)		651,343	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		1,295	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)		2,658,824	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		2,658,824	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)		2,658,824	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		41,086	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		2,617,738	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)		2,617,738	0	19.00
19.01	Sequestration adjustment (see instructions)		0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
19.25	Sequestration for non-claims based amounts (see instructions)		0	0	19.25
20.00	Interim payments		2,547,147	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, 19.02, 19.25, 20, and 21)		70,591	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 10/01/2020 To 09/30/2021	Worksheet E-3 Part V Date/Time Prepared: 2/15/2022 11:13 am
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,295,078	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)		1,295,078	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,308,029	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)		1,308,029	19.00
20.00	Deductibles (exclude professional component)		164,156	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,143,873	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,143,873	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		14,884	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		9,675	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		11,568	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,153,548	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.98	Recovery of accelerated depreciation.		0	29.98
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		1,153,548	30.00
30.01	Sequestration adjustment (see instructions)		0	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		1,135,358	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)		18,190	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 10/01/2020 To 09/30/2021	Worksheet E-3 Part VI Date/Time Prepared: 2/15/2022 11:13 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
14.98	Recovery of accelerated depreciation.		0	14.98
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 10/01/2020
To 09/30/2021

Worksheet G

Date/Time Prepared:
2/15/2022 11:13 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	5,130,329	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,391,881	0	0	0	4.00
5.00	Other receivable	350,119	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,825,530	0	0	0	6.00
7.00	Inventory	476,463	0	0	0	7.00
8.00	Prepaid expenses	208,734	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)	10,731,996	0	0	0	11.00
FIXED ASSETS						
12.00	Land	448,597	0	0	0	12.00
13.00	Land improvements	3,994,943	0	0	0	13.00
14.00	Accumulated depreciation	-2,835,137	0	0	0	14.00
15.00	Buildings	38,745,867	0	0	0	15.00
16.00	Accumulated depreciation	-22,796,086	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	8,909,614	0	0	0	23.00
24.00	Accumulated depreciation	-6,224,629	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	2,772,876	0	0	0	27.00
28.00	Accumulated depreciation	-2,639,491	0	0	0	28.00
29.00	Minor equipment-nondepreciable	227,699	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	20,604,253	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	9,756,891	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	1,579,632	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	11,336,523	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	42,672,772	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	929,468	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,092,760	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,119,416	0	0	0	40.00
41.00	Deferred income	95,786	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	550,000	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,787,430	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	34,199,131	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	828,646	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	35,027,777	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	38,815,207	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	3,857,565				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	3,857,565	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	42,672,772	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1302

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

Worksheet G-1

Date/Time Prepared:
2/15/2022 11:13 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		-1,652,386		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,486,438				2.00
3.00	Total (sum of line 1 and line 2)		3,834,052		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	CHANGE IN NET DEFICIT	23,513		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)		23,513		0		10.00
11.00	Subtotal (line 3 plus line 10)		3,857,565		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)		3,857,565		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 10/01/2020
To 09/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
2/15/2022 11:13 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,086,564		3,086,564	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	3,223,578		3,223,578	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	6,310,142		6,310,142	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)	6,310,142		6,310,142	17.00
18.00	Ancillary services	4,519,687	0	4,519,687	18.00
19.00	Outpatient services	0	24,901,343	24,901,343	19.00
20.00	RURAL HEALTH CLINIC	0	1,774,465	1,774,465	20.00
20.01	RURAL HEALTH CLINIC II	0	485,276	485,276	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	5,056,178	5,056,178	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	10,829,829	32,217,262	43,047,091	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		28,948,381		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	PROVISION FOR BAD DEBTS	455,595			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)		455,595		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)		29,403,976		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1302

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

Worksheet G-3

Date/Time Prepared:
2/15/2022 11:13 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	43,047,091	1.00
2.00	Less contractual allowances and discounts on patients' accounts	14,536,890	2.00
3.00	Net patient revenues (line 1 minus line 2)	28,510,201	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	29,403,976	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-893,775	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	76,452	6.00
7.00	Income from investments	224,731	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	161,754	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	4,008	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	18,795	22.00
23.00	Governmental appropriations	0	23.00
24.00	340B REVENUE	997,757	24.00
24.01	ASSISTED LIVING UNITS	734,321	24.01
24.02	ADULT DAY CARE PROGRAM	20,000	24.02
24.03	FITNESS CENTER REVENUE	109,956	24.03
24.04	GRANT REVENUE	136,833	24.04
24.05	MISCELLANEOUS REVENUE	107,302	24.05
24.06	GAIN ON FORGIVENESS OF DEBT	2,398,100	24.06
24.50	COVID-19 PHE Funding	1,428,168	24.50
25.00	Total other income (sum of lines 6-24)	6,418,177	25.00
26.00	Total (line 5 plus line 25)	5,524,402	26.00
27.00	LOSS ON SALE OF EQUIPMENT	37,964	27.00
27.01	OTHER EXPENSES (SPECIFY)	0	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	37,964	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,486,438	29.00

Health Financial Systems		MIDWEST MEDICAL CENTER			In Lieu of Form CMS-2552-10		
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CCN: 14-1302		Period:	Worksheet M-1		
		Component CCN: 14-8511		From 10/01/2020 To 09/30/2021	Date/Time Prepared: 2/15/2022 11:13 am		
		RHC I		Cost			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,084,295	0	1,084,295	-66,202	1,018,093	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	98,019	0	98,019	4,769	102,788	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	384,153	0	384,153	0	384,153	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	25,714	0	25,714	0	25,714	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	30,956	30,956	-25,501	5,455	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,592,181	30,956	1,623,137	-86,934	1,536,203	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	17,870	17,870	0	17,870	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	17,870	17,870	0	17,870	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,592,181	48,826	1,641,007	-86,934	1,554,073	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	176,004	121,450	297,454	78	297,532	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	176,004	121,450	297,454	78	297,532	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,768,185	170,276	1,938,461	-86,856	1,851,605	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1302

Period:

Worksheet M-1

Component CCN: 14-8511

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/15/2022 11:13 am

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-23,274	994,819	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	102,788	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	384,153	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	25,714	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	5,455	9.00
10.00	Subtotal (sum of lines 1 through 9)	-23,274	1,512,929	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	17,870	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	17,870	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-23,274	1,530,799	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	0	29.00
30.00	Administrative Costs	-9	297,523	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-9	297,523	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-23,283	1,828,322	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1302

Period:

Worksheet M-1

Component CCN: 14-8557

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/15/2022 11:13 am

		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	295,005	0	295,005	-45,593	249,412
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	25,243	0	25,243	0	25,243
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	128,043	0	128,043	0	128,043
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	21,932	21,932	0	21,932
10.00	Subtotal (sum of lines 1 through 9)	448,291	21,932	470,223	-45,593	424,630
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	25,701	25,701	0	25,701
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	25,701	25,701	0	25,701
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	448,291	47,633	495,924	-45,593	450,331
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	4,839	4,839	0	4,839
30.00	Administrative Costs	42,646	31,654	74,300	4,839	79,139
31.00	Total Facility Overhead (sum of lines 29 and 30)	42,646	36,493	79,139	4,839	83,978
32.00	Total facility costs (sum of lines 22, 28 and 31)	490,937	84,126	575,063	-40,754	534,309

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1302

Period:

Worksheet M-1

Component CCN: 14-8557

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/15/2022 11:13 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	249,412	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	25,243	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	128,043	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	21,932	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	424,630	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	25,701	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	25,701	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	450,331	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	4,839	29.00
30.00	Administrative Costs	-2,500	76,639	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-2,500	81,478	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-2,500	531,809	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1302

Period:

Worksheet M-2

Component CCN: 14-8511

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/15/2022 11:13 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	2.65	7,382	2,478	6,567		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.79	1,147	1,050	830		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.44	8,529		7,397	8,529	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	0.38	520			520	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)	3.82	9,049			9,049	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)					1,530,799	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)					1,530,799	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)					297,523	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,102,721	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,400,244	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,400,244	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,400,244	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,931,043	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1302

Period:

Worksheet M-2

Component CCN: 14-8557

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/15/2022 11:13 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	0.58	2,092	3,402	1,973		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.26	382	1,134	295		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.84	2,474		2,268	2,474	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)	0.84	2,474			2,474	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)					450,331	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)					450,331	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)					81,478	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					182,818	15.00
16.00	Total overhead (sum of lines 14 and 15)					264,296	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					264,296	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					264,296	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					714,627	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1302 Component CCN: 14-8511	Period: From 10/01/2020 To 09/30/2021	Worksheet M-3 Date/Time Prepared: 2/15/2022 11:13 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)			2,931,043	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			103,874	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,827,169	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			9,049	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)			9,049	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			312.43	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	344.33	344.33	349.15	8.00
9.00	Rate for Program covered visits (see instructions)	312.43	312.43	312.43	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	593	580	1,180	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	185,271	181,209	368,667	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	735,147		16.00
16.01	Total program charges (see instructions)(from contractor's records)		446,916		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		22,504		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		37,018		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.)		519,559		16.04
16.05	Total program cost (see instructions)	0	556,577		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		48,680		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		75,147		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		556,577		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		24,808		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		581,385		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)		581,385		26.00
26.01	Sequestration adjustment (see instructions)		0		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		604,913		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		-23,528		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1302 Component CCN: 14-8557	Period: From 10/01/2020 To 09/30/2021	Worksheet M-3 Date/Time Prepared: 2/15/2022 11:13 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)			714,627	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			21,312	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			693,315	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,474	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)			2,474	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			280.24	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	261.44	261.44	265.10	8.00
9.00	Rate for Program covered visits (see instructions)	280.24	280.24	265.10	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	136	133	270	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	38,113	37,272	71,577	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	146,962		16.00
16.01	Total program charges (see instructions)(from contractor's records)		94,702		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		8,488		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		13,172		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.)		98,406		16.04
16.05	Total program cost (see instructions)	0	111,578		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		10,782		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		15,087		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		111,578		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		4,283		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		115,861		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)		115,861		26.00
26.01	Sequestration adjustment (see instructions)		0		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		104,450		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		11,411		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 VACCINE COST

Provider CCN: 14-1302

Period:

Worksheet M-4

Component CCN: 14-8511

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/15/2022 11:13 am

		Title XVIII		RHC I	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,512,929	1,512,929	1,512,929	1,512,929	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000422	0.002864	0.000003	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	638	4,333	5	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	15,975	33,224	75	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	16,613	37,557	80	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,530,799	1,530,799	1,530,799	1,530,799	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,400,244	1,400,244	1,400,244	1,400,244	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.010853	0.024534	0.000052	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	15,197	34,354	73	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	31,810	71,911	153	0	10.00
11.00	Total number of injections/infusions (from your records)	129	875	1	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	246.59	82.18	153.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	27	219	1	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	6,658	17,997	153	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		103,874			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		24,808			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1302

Period:

Worksheet M-4

Component CCN: 14-8557

From 10/01/2020
To 09/30/2021Date/Time Prepared:
2/15/2022 11:13 am

		Title XVIII		RHC II	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	424,630	424,630	424,630	424,630	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000421	0.002106	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	179	894	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	5,074	7,283	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	5,253	8,177	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	450,331	450,331	450,331	450,331	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	264,296	264,296	264,296	264,296	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.011665	0.018158	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	3,083	4,799	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	8,336	12,976	0	0	10.00
11.00	Total number of injections/infusions (from your records)	37	185	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	225.30	70.14	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	5	45	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	1,127	3,156	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		21,312			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		4,283			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 10/01/2020 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 2/15/2022 11:13 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		490,380	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		06/23/2021	91,372	3.01	
3.02		09/01/2021	23,161	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)		114,533	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		604,913	4.00	
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00	
Program to Provider					
5.01			0	5.01	
5.02			0	5.02	
5.03			0	5.03	
Provider to Program					
5.50			0	5.50	
5.51			0	5.51	
5.52			0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00	
6.01	SETTLEMENT TO PROVIDER		0	6.01	
6.02	SETTLEMENT TO PROGRAM		23,528	6.02	
7.00	Total Medicare program liability (see instructions)		581,385	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 10/01/2020 To 09/30/2021	Worksheet M-5 Date/Time Prepared: 2/15/2022 11:13 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		90,022	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		09/01/2021	14,428	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)		14,428	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		104,450	4.00	
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00	
Program to Provider					
5.01			0	5.01	
5.02			0	5.02	
5.03			0	5.03	
Provider to Program					
5.50			0	5.50	
5.51			0	5.51	
5.52			0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00	
6.01	SETTLEMENT TO PROVIDER		11,411	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		115,861	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00 2.00		
8.00	Name of Contractor				8.00