

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

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

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

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet S
Parts I-III
Date/Time Prepared:
2/5/2017 2:42 pm

PART I - COST REPORT STATUS

Provider use only 1. Electronically filed cost report Date: 2/5/2017 Time: 2:42 pm
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only 5. Cost Report Status 6. Date Received:
 (1) As Submitted 7. Contractor No. 10. NPR Date:
 (2) Settled without Audit 8. Initial Report for this Provider CCN 11. Contractor's Vendor Code: 4
 (3) Settled with Audit 9. Final Report for this Provider CCN 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.
 (4) Reopened
 (5) Amended

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MIDWEST MEDICAL CENTER (14-1302) for the cost reporting period beginning 10/01/2015 and ending 09/30/2016 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.

Encryption Information

ECR: Date: 2/5/2017 Time: 2:42 pm
 Ton2i5uckzdlVLAhA2gMosp4V0tCr0
 QGJat0Fn2MiajsRyUormMw.0DZFCnq
 cOsD1SONZN0Jn:UR

(Signed)

Officer or Administrator of Provider(s)

PI: Date: 2/5/2017 Time: 2:42 pm
 wQ5u0ka0rkyjvXskd1LK0mk1JAK.A0
 z1Q1g0b.R2Nye1fJyv01xOGKPOfcwc
 e9SN0oeKHX0FVjQL

Title

Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	47,600	-317,923	1	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	350,614	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	-1	0		0	7.00
10.00 RURAL HEALTH CLINIC I	0		36,574		0	10.00
10.01 RURAL HEALTH CLINIC II	0		7,474		0	10.01
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00 Total	0	398,213	-273,875	1	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.



Accountant's Compilation Report

Board of Directors
Midwest Medical Center
Galena, Illinois

Management is responsible for the accompanying Medicare Cost Report of Midwest Medical Center, included in the accompanying prescribed form as of and for the year ended September 30, 2016. We have performed a compilation engagement in accordance with *Statements on Standards for Accounting and Review Services* promulgated by the Accounting and Review Services Committee of the AICPA. We did not audit or review the Medicare Cost Report included in the accompanying prescribed form nor were we required to perform any procedures to verify the accuracy or completeness of the information provided by management. Accordingly, we do not express an opinion, a conclusion, nor provide any form of assurance on this Medicare Cost Report.

Other Matter

The Medicare Cost Report included in the accompanying prescribed form is intended to comply with the requirements of the Centers for Medicare and Medicaid Services and is not intended to be a presentation in accordance with accounting principles generally accepted in the United States.

Restriction on Use

Our report and the prescribed form are intended solely for the information and use of Midwest Medical Center and the Centers for Medicare and Medicaid Services and is not intended to be, and should not be, used by anyone other than these specified parties.

A handwritten signature in cursive script that reads "Wipfli LLP".

Wipfli LLP

February 5, 2017
Eau Claire, Wisconsin

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1302	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part I Date/Time Prepared: 2/5/2017 2:36 pm
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		1.00	2.00	3.00	4.00						
Hospital and Hospital Health Care Complex Address:											
1.00	Street: I 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)			
				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
17.10	Hospital-Based (CORF) I										17.10
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)	10/01/2015	09/30/2016	20.00
21.00	Type of Control (see instructions)	2		21.00

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			22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.								2	N	23.00

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1302		Period: From 10/01/2015 To 09/30/2016		Worksheet S-2 Part I Date/Time Prepared: 2/5/2017 2:36 pm			
		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		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00	
						Urban/Rural S	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)					N		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)(ii)? 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)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00	
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete wkst. L, Pt. III and wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR 412.300 PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)					N			60.00
		Y/N	IME	Direct GME	IME	Direct GME			
		1.00	2.00	3.00	4.00	5.00			
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N				0.00	0.00	61.00	
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)		0.00	0.00				61.01	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet S-2
Part I
Date/Time Prepared:
2/5/2017 2:36 pm

	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
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)	0.00	0.00			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)	0.00	0.00			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).	0.00	0.00			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)	0.00	0.00			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)	0.00	0.00			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 and enter in column 4, 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 and enter in column 4, 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 64-67. (see instructions)				N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00
		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

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
						1.00 2.00 3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00
71.00	If line 70 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
75.00	Inpatient Rehabilitation Facility PPS 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 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1302	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part I Date/Time Prepared: 2/5/2017 2:36 pm
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			1.00			
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00		
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00		
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00		
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00		
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.	N		87.00		
			V 1.00	XIX 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		
Rural Providers						
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y		105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00		
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete wkst. D-2, Pt. II.	N		107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00		
			Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	Y	Y	N	109.00
			1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.		N			110.00
			1.00	2.00	3.00	
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2			118.00
			Premiums 1.00	Losses 2.00	Insurance 3.00	
118.01	List amounts of malpractice premiums and paid losses:		156,033	0		0118.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1302	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part I Date/Time Prepared: 2/5/2017 2:36 pm
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			1.00	2.00			
118.00	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			118.00		
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 state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the worksheet A line number where these taxes are included.	Y		5.04	122.00		
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00		
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00		
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00		
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00		
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00		
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00		
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00		
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00		
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00		
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00		
All Providers							
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.	N			145.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	Y		07/27/2016	146.00		
			1.00				
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			Y	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 1.00	Part B 2.00	Title V 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	N	155.00
156.00	Subprovider - IPF	N		N	N	N	156.00
157.00	Subprovider - IRF	N		N	N	N	157.00
158.00	SUBPROVIDER						158.00
159.00	SNF	N		N	N	N	159.00
160.00	HOME HEALTH AGENCY	N		N	N	N	160.00
161.00	CMHC			N	N	N	161.00
161.10	CORF			N	N	N	161.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1302		Period: From 10/01/2015 To 09/30/2016		Worksheet S-2 Part I Date/Time Prepared: 2/5/2017 2:36 pm		
							1.00	
Multicampus								
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00
		Beginning		Ending				
		1.00		2.00				
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				10/01/2015	09/30/2016	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 10/01/2015 To 09/30/2016		Worksheet S-2 Part II Date/Time Prepared: 2/5/2017 2:36 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date			V/I	
		1.00	2.00			3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "v" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type			Date	
		1.00	2.00			3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		01/24/2017		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	Attachment A				5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on worksheet A? If yes, see instructions.	N					11.00
		Y/N			Legal Oper.		
		1.00			2.00		
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	01/20/2017	Y	01/20/2017		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

		Description	Y/N	Y/N	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	0	1.00 N	3.00 N	20.00
		Y/N	Date	Y/N	Date
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	1.00 N	3.00 N	4.00 21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			Y <i>Attachments F-G</i>	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 <i>Attachment H</i>	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			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.	PAUL		TRACZEK	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.	7158586619		PTRACZEK@WIPFLI.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet S-2
Part II
Date/Time Prepared:
2/5/2017 2:36 pm

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

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	6,739.20	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	6,739.20	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,150	6,739.20	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY	44.00	5	1,830		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	46.00	52	19,032			21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		82				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

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)	221	12	319		1.00
2.00 HMO and other (see instructions)	35	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	1,228	0	1,384		5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	270		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,449	12	1,973		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)	1,449	12	1,973	0.00	93.38
15.00 CAH visits	5,642	0	23,247		15.00
16.00 SUBPROVIDER - IPF					16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00
18.00 SUBPROVIDER		0	0	0.00	0.00
19.00 SKILLED NURSING FACILITY	39	0	41	0.00	3.06
20.00 NURSING FACILITY					20.00
21.00 OTHER LONG TERM CARE			18,362	0.00	48.23
22.00 HOME HEALTH AGENCY					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00 HOSPICE					24.00
24.10 HOSPICE (non-distinct part)	0	0	0		24.10
25.00 CMHC - CMHC					25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00
26.00 RURAL HEALTH CLINIC	2,454	0	9,621	0.00	15.99
26.01 RURAL HEALTH CLINIC II	47	0	555	0.00	0.91
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00 Total (sum of lines 14-26)				0.00	161.57
28.00 Observation Bed Days		0	79		28.00
29.00 Ambulance Trips	0				29.00
30.00 Employee discount days (see instruction)			0		30.00
31.00 Employee discount days - IRF			0		31.00
32.00 Labor & delivery days (see instructions)	0	0	0		32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0		32.01
33.00 LTCH non-covered days	0				33.00

Component	Full Time Equivalents	Discharges				Total All Patients	
		Nonpaid workers	Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00	14.00		
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	76	6	104	1.00
2.00 HMO and other (see instructions)				12	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		76	6	104	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF	0.00	0		0	0	0	17.00
18.00 SUBPROVIDER	0.00	0			0	0	18.00
19.00 SKILLED NURSING FACILITY	0.00						19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE	0.00					33	21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
25.10 CMHC - CORF	0.00						25.10
26.00 RURAL HEALTH CLINIC	0.00						26.00
26.01 RURAL HEALTH CLINIC II	0.00						26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days							33.00

1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	1.00	N	2.00		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	1.00	Y	2.00	02/01/2000	2.00

	Group	SNF Days	Swing Bed Days	SNF Days	Total (sum of col. 2 + 3)	
	1.00	2.00	3.00	4.00		
3.00	RUX	0	0	0	0	3.00
4.00	RUL	0	0	0	0	4.00
5.00	RVX	0	0	0	0	5.00
6.00	RVL	0	0	0	0	6.00
7.00	RHX	0	0	0	0	7.00
8.00	RHL	0	0	0	0	8.00
9.00	RMX	0	0	0	0	9.00
10.00	RML	0	0	0	0	10.00
11.00	RLX	0	0	0	0	11.00
12.00	RUC	0	0	0	0	12.00
13.00	RUB	0	0	0	0	13.00
14.00	RUA	0	0	0	0	14.00
15.00	RVC	0	0	0	0	15.00
16.00	RVB	0	0	0	0	16.00
17.00	RVA	0	0	0	0	17.00
18.00	RHC	0	0	0	0	18.00
19.00	RHB	0	0	0	0	19.00
20.00	RHA	0	0	0	0	20.00
21.00	RMC	25	0	0	25	21.00
22.00	RMB	14	0	0	14	22.00
23.00	RMA	0	0	0	0	23.00
24.00	RLB	0	0	0	0	24.00
25.00	RLA	0	0	0	0	25.00
26.00	ES3	0	0	0	0	26.00
27.00	ES2	0	0	0	0	27.00
28.00	ES1	0	0	0	0	28.00
29.00	HE2	0	0	0	0	29.00
30.00	HE1	0	0	0	0	30.00
31.00	HD2	0	0	0	0	31.00
32.00	HD1	0	0	0	0	32.00
33.00	HC2	0	0	0	0	33.00
34.00	HC1	0	0	0	0	34.00
35.00	HB2	0	0	0	0	35.00
36.00	HB1	0	0	0	0	36.00
37.00	LE2	0	0	0	0	37.00
38.00	LE1	0	0	0	0	38.00
39.00	LD2	0	0	0	0	39.00
40.00	LD1	0	0	0	0	40.00
41.00	LC2	0	0	0	0	41.00
42.00	LC1	0	0	0	0	42.00
43.00	LB2	0	0	0	0	43.00
44.00	LB1	0	0	0	0	44.00
45.00	CE2	0	0	0	0	45.00
46.00	CE1	0	0	0	0	46.00
47.00	CD2	0	0	0	0	47.00
48.00	CD1	0	0	0	0	48.00
49.00	CC2	0	0	0	0	49.00
50.00	CC1	0	0	0	0	50.00
51.00	CB2	0	0	0	0	51.00
52.00	CB1	0	0	0	0	52.00
53.00	CA2	0	0	0	0	53.00
54.00	CA1	0	0	0	0	54.00
55.00	SE3	0	0	0	0	55.00
56.00	SE2	0	0	0	0	56.00
57.00	SE1	0	0	0	0	57.00
58.00	SSC	0	0	0	0	58.00
59.00	SSB	0	0	0	0	59.00
60.00	SSA	0	0	0	0	60.00
61.00	IB2	0	0	0	0	61.00
62.00	IB1	0	0	0	0	62.00
63.00	IA2	0	0	0	0	63.00
64.00	IA1	0	0	0	0	64.00
65.00	BB2	0	0	0	0	65.00
66.00	BB1	0	0	0	0	66.00
67.00	BA2	0	0	0	0	67.00
68.00	BA1	0	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet S-7

Date/Time Prepared:
2/5/2017 2:36 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		39	0	39	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
SNF SERVICES						
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).			99914	0	201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		1,204,040	4,411.37	Y	202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		27,294			207.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1302	Period: From 10/01/2015	worksheet S-8	
		Component CCN: 14-8511	To 09/30/2016	Date/Time Prepared: 2/5/2017 2:36 pm	
			RHC I	Cost	
			1.00		
1.00	Clinic Address and Identification	ONE MEDICAL CENTER DRIVE			1.00
	Street	City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	GALENA	IL	61036	2.00
			1.00		
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
			Grant Award	Date	
			1.00	2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)				4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00
7.00	Appalachian Regional Commission				7.00
8.00	Look-Alikes				8.00
9.00	OTHER (SPECIFY)				9.00
9.01					9.01
9.02					9.02
9.03					9.03
9.04					9.04
9.05					9.05
9.06					9.06
9.07					9.07
9.08					9.08
9.09					9.09
9.10					9.10
			1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N	0	10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
					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
		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
Component CCN: 14-8511

Period:
From 10/01/2015
To 09/30/2016

Worksheet S-8
Date/Time Prepared:
2/5/2017 2:36 pm

		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
		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	

		RHC II		Cost		
		1.00				
1.00	Clinic Address and Identification					
	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
11.00	Facility hours of operations (1)					
	Clinic	08:00		17:00		08:00
				1.00		2.00
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			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
11.00	Facility hours of operations (1)					
	Clinic	17:00	08:00	17:00	08:00	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
Component CCN: 14-8557

Period:
From 10/01/2015
To 09/30/2016

Worksheet S-8

Date/Time Prepared:
2/5/2017 2:36 pm

		RHC II		Cost			
		Friday		Saturday			
		from	to	from	to		
11.00	Facility hours of operations (1)	11.00	12.00	13.00	14.00		
	Clinic	08:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1302	Period: From 10/01/2015 To 09/30/2016	Worksheet S-10 Date/Time Prepared: 2/5/2017 2:36 pm
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				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)			0.762183	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			2,740,055	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 or supplemental payments from Medicaid?			Y	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			0	5.00	
6.00	Medicaid charges			6,018,015	6.00	
7.00	Medicaid cost (line 1 times line 6)			4,586,829	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			1,846,774	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	
Uncompensated care (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			1,846,774	19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				1.00	2.00	3.00
20.00	Charity care charges for the entire facility (see instructions)		119,655	0	119,655	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)		91,199	0	91,199	21.00
22.00	Partial payment by patients approved for charity care		0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)		91,199	0	91,199	23.00
				1.00		
24.00	Does the amount in 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," charges for patient days beyond an indigent care program's length of stay limit			0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)			798,009	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)			18,522	27.00	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			779,487	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			594,112	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			685,311	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			2,532,085	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 14-1302		Period: From 10/01/2015 To 09/30/2016		Worksheet A	
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (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		1,593,882	1,593,882	-1,493,579	100,303	1.00
1.01	00101		0	0	91,118	91,118	1.01
1.02	00102		0	0	4,039,614	4,039,614	1.02
1.03	00103		0	0	0	0	1.03
2.00	00200		833,266	833,266	-803,000	30,266	2.00
2.01	00201		0	0	1,202,757	1,202,757	2.01
3.00	00300		0	0	0	0	3.00
4.00	00400		2,110,207	2,110,207	-153,427	1,956,780	4.00
5.01	00570	240,799	6,577	247,376	0	247,376	5.01
5.02	00550	261,543	258,117	519,660	0	519,660	5.02
5.03	00590	0	0	0	213,396	213,396	5.03
5.04	00540	459,110	1,401,813	1,860,923	-345,132	1,515,791	5.04
6.00	00600	0	0	0	0	0	6.00
7.00	00700	55,662	480,137	535,799	0	535,799	7.00
7.01	00701	75,652	198,046	273,698	0	273,698	7.01
8.00	00800	0	67,692	67,692	-29,899	37,793	8.00
8.01	00801	0	33,028	33,028	29,899	62,927	8.01
9.00	00900	119,281	31,599	150,880	0	150,880	9.00
9.01	00901	84,281	16,338	100,619	0	100,619	9.01
10.00	01000	176,112	170,675	346,787	0	346,787	10.00
10.01	01001	213,504	226,451	439,955	104,235	544,190	10.01
11.00	01100	0	0	0	0	0	11.00
11.01	01101	0	0	0	0	0	11.01
13.00	01300	219,399	5,923	225,322	35,340	260,662	13.00
14.00	01400	70,185	3,784	73,969	0	73,969	14.00
15.00	01500	0	0	0	135,000	135,000	15.00
16.00	01600	140,342	12,712	153,054	0	153,054	16.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	686,377	80,764	767,141	79,125	846,266	30.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
44.00	04400	0	0	0	17,858	17,858	44.00
46.00	04600	1,210,490	320,149	1,530,639	116,349	1,646,988	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	205,188	151,550	356,738	22,288	379,026	50.00
53.00	05300	18,189	142,130	160,319	0	160,319	53.00
54.00	05400	295,813	773,657	1,069,470	13,461	1,082,931	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	301,845	407,067	708,912	0	708,912	60.00
60.01	06001	0	0	0	0	0	60.01
64.00	06400	0	20,393	20,393	0	20,393	64.00
65.00	06500	0	22,671	22,671	0	22,671	65.00
66.00	06600	863,085	123,996	987,081	-32,754	954,327	66.00
67.00	06700	0	85,491	85,491	17,992	103,483	67.00
68.00	06800	0	34,859	34,859	0	34,859	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	74,743	74,743	0	74,743	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	510,198	510,198	-127,515	382,683	73.00
76.00	03020	15,313	13,263	28,576	0	28,576	76.00
76.01	03950	0	0	0	0	0	76.01
76.02	03530	0	0	0	8,607	8,607	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	1,307,087	371,800	1,678,887	-99,025	1,579,862	88.00
88.01	08801	0	0	0	113,704	113,704	88.01
89.00	08900	0	0	0	0	0	89.00
90.00	09000	419,406	68,576	487,982	-28,779	459,203	90.00
91.00	09100	269,646	1,344,802	1,614,448	0	1,614,448	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300	0	3,004,461	3,004,461	-3,004,461	0	113.00
118.00		7,708,309	15,000,817	22,709,126	123,172	22,832,298	118.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 14-1302		Period: From 10/01/2015 To 09/30/2016		Worksheet A Date/Time Prepared: 2/5/2017 2:36 pm		
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
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	53,070	53,070	-42,619	10,451	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	229,109	114,180	343,289	-77,801	265,488	194.01
194.02	07952	ADULT DAY CARE	96,571	47,140	143,711	-17,514	126,197	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	14,762	14,762	194.05
200.00		TOTAL (SUM OF LINES 118-199)	8,033,989	15,215,207	23,249,196	0	23,249,196	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES	Provider CCN: 14-1302	Period: From 10/01/2015 To 09/30/2016	Worksheet A Date/Time Prepared: 2/5/2017 2:36 pm
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Cost Center Description		Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	0	100,303	1.00
1.01	00101 NEW CAP REL COSTS-ALU BLDG	0	91,118	1.01
1.02	00102 NEW CAP REL COSTS-2007 HOSPITAL	-5,033	4,034,581	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	30,266	2.00
2.01	00201 NEW CAP REL COSTS-MVBLE EQUIP NEW HO	-337,198	865,559	2.01
3.00	00300 OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	1,956,780	4.00
5.01	00570 ADMITTING	0	247,376	5.01
5.02	00550 INFORMATION TECHNOLOGY	0	519,660	5.02
5.03	00590 HOSPITAL BILLING	-25,229	188,167	5.03
5.04	00540 OTHER ADMINISTRATIVE AND GENERAL	-206,377	1,309,414	5.04
6.00	00600 MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700 OPERATION OF PLANT	-33,944	501,855	7.00
7.01	00701 OPERATION OF PLANT-SCC	0	273,698	7.01
8.00	00800 LAUNDRY & LINEN SERVICE	0	37,793	8.00
8.01	00801 LAUNDRY & LINEN SERVICE-SCC	0	62,927	8.01
9.00	00900 HOUSEKEEPING	0	150,880	9.00
9.01	00901 HOUSEKEEPING-SCC	0	100,619	9.01
10.00	01000 DIETARY	-76,475	270,312	10.00
10.01	01001 DIETARY-SCC	-282,168	262,022	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	260,662	13.00
14.00	01400 CENTRAL SERVICE & SUPPLY	0	73,969	14.00
15.00	01500 PHARMACY	0	135,000	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-5,156	147,898	16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-3,123	843,143	30.00
41.00	04100 SUBPROVIDER - IRF	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	42.00
44.00	04400 SKILLED NURSING FACILITY	0	17,858	44.00
46.00	04600 OTHER LONG TERM CARE	-128,038	1,518,950	46.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-22,287	356,739	50.00
53.00	05300 ANESTHESIOLOGY	0	160,319	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	-267,812	815,119	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	708,912	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	20,393	64.00
65.00	06500 RESPIRATORY THERAPY	0	22,671	65.00
66.00	06600 PHYSICAL THERAPY	-40,784	913,543	66.00
67.00	06700 OCCUPATIONAL THERAPY	-3,734	99,749	67.00
68.00	06800 SPEECH PATHOLOGY	0	34,859	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	74,743	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	-78,163	304,520	73.00
76.00	03020 SLEEP LAB	0	28,576	76.00
76.01	03950 PAIN CLINIC / SERVICE	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	8,607	76.02
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	-43,222	1,536,640	88.00
88.01	08801 RURAL HEALTH CLINIC II	-5,842	107,862	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000 CLINIC	-314,721	144,482	90.00
91.00	09100 EMERGENCY	-122,101	1,492,347	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	93.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910 CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS				
109.00	10900 PANCREAS ACQUISITION	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	111.00
113.00	11300 INTEREST EXPENSE	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-2,001,407	20,830,891	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet A
Date/Time Prepared:
2/5/2017 2:36 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,451	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	265,488	194.01
194.02	07952	ADULT DAY CARE	0	126,197	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	194.03
194.04	07954	IDLE SPACE	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	14,762	194.05
200.00		TOTAL (SUM OF LINES 118-199)	-2,001,407	21,247,789	200.00

		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	104,235	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	104,235	
C - RECLASS ASSISTED LIVING BUILDING DEP					
1.00	NEW CAP REL COSTS-ALU BLDG	1.01	0	89,269	1.00
	TOTALS		0	89,269	
D - RECLASS PT/MOB SPACE DEPRECIATION					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	5,247	1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	37,372	2.00
	TOTALS		0	42,619	
E - RECLASS NURSING HOME ADMIN AND GEN					
1.00	SKILLED NURSING FACILITY	44.00	0	13,967	1.00
2.00	OTHER LONG TERM CARE	46.00	0	145,252	2.00
	TOTALS		0	159,219	
F - RECLASS PHARMACIST EXPENSE					
1.00	PHARMACY	15.00	0	135,000	1.00
	TOTALS		0	135,000	
G - RECLASS PHYSICIAN HOSPITAL MED DIRCT					
1.00	ADULTS & PEDIATRICS	30.00	9,303	930	1.00
	TOTALS		9,303	930	
H - RECLASS NEW HOSPITAL DEPRECIATION					
1.00	NEW CAP REL COSTS-2007 HOSPITAL	1.02	0	1,391,715	1.00
	TOTALS		0	1,391,715	
I - RECLASS NEW HOSPITAL BOND AMORTIZATN					
1.00	NEW CAP REL COSTS-2007 HOSPITAL	1.02	0	25,000	1.00
	TOTALS		0	25,000	
J - RECLASS NEW HOSPITAL MME DEPRECIATN					
1.00	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	0	804,458	1.00
	TOTALS		0	804,458	
K - RECLASS INTEREST EXPENSE - NEW HOSP					
1.00	NEW CAP REL COSTS-2007 HOSPITAL	1.02	0	2,597,914	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	0	392,376	2.00
	TOTALS		0	2,990,290	
M - RECLASS PHYSICIAN IP ROUND TIME					
1.00	ADULTS & PEDIATRICS	30.00	3,241	486	1.00
2.00		0.00	0	0	2.00
	TOTALS		3,241	486	
P - RECLASS PHYSICIAN BENEFITS					
1.00	RURAL HEALTH CLINIC	88.00	0	128,931	1.00
2.00	CLINIC	90.00	0	24,496	2.00
	TOTALS		0	153,427	
U - RECLASS COMMUNITY FITNESS CTR USE					
1.00	COMMUNITY FITNESS CENTER	194.05	11,965	2,797	1.00
2.00	OCCUPATIONAL THERAPY	67.00	15,418	2,574	2.00
	TOTALS		27,383	5,371	
V - RECLASS MEDICARE CERTIFIED SNF UNIT					
1.00	SKILLED NURSING FACILITY	44.00	2,682	951	1.00
	TOTALS		2,682	951	
X - RECLASS SURGEON FEES					
1.00	OPERATING ROOM	50.00	0	18,000	1.00
	TOTALS		0	18,000	
Y - RECLASS PROPERTY INSURANCE EXP					
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	37,315	1.00
	TOTALS		0	37,315	
AA - RECLASS CLINIC MGR TIME TO HOSP/NH					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	18,694	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	13,647	0	2.00
	TOTALS		32,341	0	
BB - RECLASS SR CARE ADMINISTRATOR TIME					
1.00	SKILLED NURSING FACILITY	44.00	258	0	1.00
2.00	ASSISTED LIVING UNITS	194.01	6,664	0	2.00
3.00	ADULT DAY CARE	194.02	2,256	0	3.00
	TOTALS		9,178	0	

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
DD - RECLASS NURSE PRACTITIONER MGMT TIME						
1.00	NURSING ADMINISTRATION	13.00	33,326	2,014	1.00	
	TOTALS		33,326	2,014		
EE - RECLASS SENIOR CARE CAMPUS LAUNDRY						
1.00	LAUNDRY & LINEN SERVICE-SCC	8.01	0	29,899	1.00	
	TOTALS		0	29,899		
FF - RECLASS EXPENSES TO MATCH REVENUES						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	7,485	1.00	
2.00	SNF PHYSICAL THERAPY - SCC THERAPY	76.02	8,607	0	2.00	
	TOTALS		8,607	7,485		
HH - RECLASS HOSP MED DIRECTOR TIME						
1.00	ADULTS & PEDIATRICS	30.00	41,527	6,582	1.00	
	TOTALS		41,527	6,582		
JJ - RECLASS CAP LEASE INTEREST EXPENSE						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	13,461	1.00	
2.00	RURAL HEALTH CLINIC	88.00	0	710	2.00	
	TOTALS		0	14,171		
KK - RECLASS ELIZABETH CLINIC DEPR						
1.00	CLINIC	90.00	0	33,314	1.00	
	TOTALS		0	33,314		
MM - RECLASS CLINIC MD SALARY						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	46,104	0	1.00	
2.00	ADULTS & PEDIATRICS	30.00	3,409	0	2.00	
3.00	RURAL HEALTH CLINIC	88.00	2,480	0	3.00	
	TOTALS		51,993	0		
NN - ENT MD TIME IN OR						
1.00	OPERATING ROOM	50.00	0	4,288	1.00	
2.00	CLINIC	90.00	0	79,712	2.00	
	TOTALS		0	84,000		
OO - RECLASS CLINIC EXPENSES TO RHC						
1.00	RURAL HEALTH CLINIC II	88.01	87,376	26,328	1.00	
	TOTALS		87,376	26,328		
PP - RECLASS HOSPITAL BILLING EXPENSES						
1.00	HOSPITAL BILLING	5.03	0	213,396	1.00	
	TOTALS		0	213,396		
500.00	Grand Total: Increases		306,957	6,375,474	500.00	

		Decreases				
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - RECLASS ADC AND ALU DIETARY EXPENSE						
1.00	ADULT DAY CARE	194.02	0	19,770	0	1.00
2.00	ASSISTED LIVING UNITS	194.01	0	84,465	0	2.00
	TOTALS		0	104,235		
C - RECLASS ASSISTED LIVING BUILDING DEP						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	89,269	9	1.00
	TOTALS		0	89,269		
D - RECLASS PT/MOB SPACE DEPRECIATION						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	5,247	9	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	37,372	9	2.00
	TOTALS		0	42,619		
E - RECLASS NURSING HOME ADMIN AND GEN						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	159,219	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	159,219		
F - RECLASS PHARMACIST EXPENSE						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	135,000	0	1.00
	TOTALS		0	135,000		
G - RECLASS PHYSICIAN HOSPITAL MED DIRCT						
1.00	RURAL HEALTH CLINIC	88.00	9,303	930	0	1.00
	TOTALS		9,303	930		
H - RECLASS NEW HOSPITAL DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,391,715	9	1.00
	TOTALS		0	1,391,715		
I - RECLASS NEW HOSPITAL BOND AMORTIZATN						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	25,000	9	1.00
	TOTALS		0	25,000		
J - RECLASS NEW HOSPITAL MME DEPRECIATN						
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	804,458	9	1.00
	TOTALS		0	804,458		
K - RECLASS INTEREST EXPENSE - NEW HOSP						
1.00	INTEREST EXPENSE	113.00	0	2,990,290	11	1.00
2.00		0.00	0	0	11	2.00
	TOTALS		0	2,990,290		
M - RECLASS PHYSICIAN IP ROUND TIME						
1.00	RURAL HEALTH CLINIC	88.00	2,716	407	0	1.00
2.00	CLINIC	90.00	525	79	0	2.00
	TOTALS		3,241	486		
P - RECLASS PHYSICIAN BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	153,427	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	153,427		
U - RECLASS COMMUNITY FITNESS CTR USE						
1.00	PHYSICAL THERAPY	66.00	27,383	5,371	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		27,383	5,371		
V - RECLASS MEDICARE CERTIFIED SNF UNIT						
1.00	OTHER LONG TERM CARE	46.00	2,682	951	0	1.00
	TOTALS		2,682	951		
X - RECLASS SURGEON FEES						
1.00	RURAL HEALTH CLINIC	88.00	0	18,000	0	1.00
	TOTALS		0	18,000		
Y - RECLASS PROPERTY INSURANCE EXP						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	37,315	12	1.00
	TOTALS		0	37,315		
AA - RECLASS CLINIC MGR TIME TO HOSP/NH						
1.00	RURAL HEALTH CLINIC	88.00	32,341	0	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		32,341	0		
BB - RECLASS SR CARE ADMINISTRATOR TIME						
1.00	OTHER LONG TERM CARE	46.00	9,178	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		9,178	0		
DD - RECLASS NURSE PRACTITIONER MGMT TIME						
1.00	RURAL HEALTH CLINIC	88.00	33,326	2,014	0	1.00
	TOTALS		33,326	2,014		

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
EE - RECLASS SENIOR CARE CAMPUS LAUNDRY						
1.00	LAUNDRY & LINEN SERVICE	8.00	0	29,899	0	1.00
	TOTALS		0	29,899		
FF - RECLASS EXPENSES TO MATCH REVENUES						
1.00	OTHER LONG TERM CARE	46.00	8,607	7,485	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		8,607	7,485		
HH - RECLASS HOSP MED DIRECTOR TIME						
1.00	RURAL HEALTH CLINIC	88.00	41,527	6,582	0	1.00
	TOTALS		41,527	6,582		
JJ - RECLASS CAP LEASE INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	14,171	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	14,171		
KK - RECLASS ELIZABETH CLINIC DEPR						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	33,314	9	1.00
	TOTALS		0	33,314		
MM - RECLASS CLINIC MD SALARY						
1.00	CLINIC	90.00	51,993	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		51,993	0		
NN - ENT MD TIME IN OR						
1.00	RURAL HEALTH CLINIC	88.00	0	84,000	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	84,000		
OO - RECLASS CLINIC EXPENSES TO RHC						
1.00	CLINIC	90.00	87,376	26,328	0	1.00
	TOTALS		87,376	26,328		
PP - RECLASS HOSPITAL BILLING EXPENSES						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	213,396	0	1.00
	TOTALS		0	213,396		
500.00	Grand Total: Decreases		306,957	6,375,474		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet A-7
Part I
Date/Time Prepared:
2/5/2017 2:36 pm

	Beginning Balances	Acquisitions			Disposals and Retirements		
		Purchases	Donation	Total			
		1.00	2.00	3.00			4.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	559,916	0	0	0	111,319	1.00
2.00	Land Improvements	3,817,882	0	0	0	77,068	2.00
3.00	Buildings and Fixtures	38,783,468	15,528	0	15,528	511,525	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	8,899,495	264,467	0	264,467	1,356,686	6.00
7.00	HIT designated Assets	2,556,630	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	54,617,391	279,995	0	279,995	2,056,598	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	54,617,391	279,995	0	279,995	2,056,598	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	3,740,814	0				2.00
3.00	Buildings and Fixtures	38,287,471	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	7,807,276	0				6.00
7.00	HIT designated Assets	2,556,630	0				7.00
8.00	Subtotal (sum of lines 1-7)	52,840,788	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	52,840,788	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet A-7
Part II
Date/Time Prepared:
2/5/2017 2:36 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,593,882	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	833,266	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)	2,427,148	0	0	0	0	3.00

Cost Center Description		SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,593,882	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	833,266	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	2,427,148	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet A-7
Part III
Date/Time Prepared:
2/5/2017 2:36 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	4,352,910	0	4,352,910	0.083083	3,100	1.00
1.01	NEW CAP REL COSTS-ALU BLDG	2,596,083	0	2,596,083	0.049551	1,849	1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	35,079,292	0	35,079,292	0.669552	24,985	1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0	0	0.000000	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,047,530	0	2,047,530	0.039081	1,458	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	8,316,376	0	8,316,376	0.158733	5,923	2.01
3.00	Total (sum of lines 1-2)	52,392,191	0	52,392,191	1.000000	37,315	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	3,100	97,203	0	1.00
1.01	NEW CAP REL COSTS-ALU BLDG	0	0	1,849	89,269	0	1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	0	0	24,985	1,416,715	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	1,458	28,808	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	0	5,923	468,020	0	2.01
3.00	Total (sum of lines 1-2)	0	0	37,315	2,100,015	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	3,100	0	0	100,303	1.00
1.01	NEW CAP REL COSTS-ALU BLDG	0	1,849	0	0	91,118	1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	2,592,881	24,985	0	0	4,034,581	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	1,458	0	0	30,266	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	391,616	5,923	0	0	865,559	2.01
3.00	Total (sum of lines 1-2)	2,984,497	37,315	0	0	5,121,827	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	wkst. A-7	Ref.
			Cost Center	3.00			
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	-5,033	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	-760	0	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01		11 2.01
3.00 Investment income - other (chapter 2)	B	-26		RADIOLOGY-DIAGNOSTIC	54.00		0 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00		0 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00		0 5.00
6.00 Rental of provider space by suppliers (chapter 8)	B	-5,900		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	-707,817					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	-76,475		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	-5,156		MEDICAL RECORDS & LIBRARY	16.00		0 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00		0 19.00
20.00 Vending machines		0			0.00		0 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00		0 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00		0 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0		RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0		PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0		*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00		0 26.00
26.01 Depreciation - NEW CAP REL COSTS-ALU BLDG			0	NEW CAP REL COSTS-ALU BLDG	1.01		0 26.01
26.02 Depreciation - NEW CAP REL COSTS-2007 HOSPITAL			0	NEW CAP REL COSTS-2007 HOSPITAL	1.02		0 26.02

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	wkst. A-7	Ref.
	1.00	2.00	3.00	4.00	5.00	
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		0 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	-3,734	0 OCCUPATIONAL THERAPY	67.00		0 30.00
30.99 Hospice (non-distinct) (see instructions)			0 ADULTS & PEDIATRICS	30.00		0 30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0 SPEECH PATHOLOGY	68.00		0 31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-336,438	0 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	-1	1 RURAL HEALTH CLINIC	88.00		0 33.01
33.05 PROVIDER RHC REVENUE	B	-28,675	5 RURAL HEALTH CLINIC	88.00		0 33.05
33.06 PART B BILLING COSTS	A	-25,229	5 HOSPITAL BILLING	5.03		0 33.06
33.07 SCHOOL ATHLETIC TRAINING REVENUE	B	-40,784	4 PHYSICAL THERAPY	66.00		0 33.07
33.08 HOSPITAL BED ASSESS (UP TO PAID AMT)	A	-121,006	0 OTHER ADMINISTRATIVE AND GENERAL	5.04		0 33.08
33.09 MARKETING EXPENSES - NONALLOW	A	-68,452	0 OTHER ADMINISTRATIVE AND GENERAL	5.04		0 33.09
34.00 LOBBYING EXPENSE ON DUES PAID	A	-13,364	0 OTHER ADMINISTRATIVE AND GENERAL	5.04		0 34.00
35.00 COMMUNITY GRANTS / DONATIONS / PROM	A	-3,555	0 OTHER ADMINISTRATIVE AND GENERAL	5.04		0 35.00
36.00 NH BED ASSESSMENT	A	-128,038	0 OTHER LONG TERM CARE	46.00		0 36.00
37.00 MISC REVENUE - SCHOOL NURSE	B	-22,201	0 CLINIC	90.00		0 37.00
38.00 MISC REVENUE - SCHOOL NURSE	B	-5,842	0 RURAL HEALTH CLINIC II	88.01		0 38.00
40.00 SENIOR CARE CAMPUS CAFETERIA	B	-182,504	0 DIETARY-SCC	10.01		0 40.00
41.00 OFFSET INTERNAL ALLOCATION FOR ADC/A	B	-99,664	0 DIETARY-SCC	10.01		0 41.00
42.00 RHC PROVIDER OR TIME	A	-14,546	0 RURAL HEALTH CLINIC	88.00		0 42.00
43.00 SLEEP AREA MISC RENTAL INCOME	B	-28,044	0 OPERATION OF PLANT	7.00		0 43.00
43.01 PHARMACY CONTRACT PROG EXPENSE	A	-78,163	0 DRUGS CHARGED TO PATIENTS	73.00		0 43.01
43.02		0		0.00		0 43.02
43.03		0		0.00		0 43.03
43.04		0		0.00		0 43.04
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-2,001,407				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 10/01/2015
To 09/30/2016

Worksheet A-8-2

Date/Time Prepared:
2/5/2017 2:36 pm

	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
Wkst. A Line #	Cost Center/Physician Identifier		Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
1.00	91.00	EMERGENCY	1,137,940	122,101	1,015,839	0	0	1.00
2.00	60.00	LABORATORY	13,633	0	13,633	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	267,787	267,786	1	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	3,124	3,123	1	0	0	4.00
5.00	50.00	OPERATING ROOM	22,288	22,287	1	0	0	5.00
6.00	90.00	CLINIC	292,521	292,520	1	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,737,293	707,817	1,029,476		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	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	91.00	EMERGENCY	0	0	0	122,101		1.00
2.00	60.00	LABORATORY	0	0	0	0		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	267,786		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	3,123		4.00
5.00	50.00	OPERATING ROOM	0	0	0	22,287		5.00
6.00	90.00	CLINIC	0	0	0	292,520		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	707,817		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1302		Period: From 10/01/2015 To 09/30/2016		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/5/2017 2:36 pm	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					49	1.00
2.00	Line 1 multiplied by 15 hours per week					735	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					148	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.55	7.00
8.00	Optional travel expense rate per mile					0.56	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	885.00	34.25	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	74.81	56.11	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)	37.41	37.41	28.06			11.00
12.00	Number of travel hours (provider site)	0	260	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	8,079	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)					66,207	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					1,922	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					68,129	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					68,129	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					68,129	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)					5,537	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)					5,537	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)					821	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					6,358	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)					19,451	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)					19,451	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)					4,524	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					6,358	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 10/01/2015 To 09/30/2016		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/5/2017 2:36 pm	
		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	0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	74.81	56.11	0.00	0.00	0.00	52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0	54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0	55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					68,129	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					6,358	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)					74,487	63.00
64.00	Total cost of outside supplier services (from your records)					78,221	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					3,734	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					5,537	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					821	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					6,358	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					821	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					19,451	101.01
101.02	Line 34 = sum of lines 27 and 31					20,272	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					19,451	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					4,524	102.01
102.02	Line 35 = sum of lines 31 and 32					23,975	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1302		Period: From 10/01/2015 To 09/30/2016		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/5/2017 2:36 pm	
		Speech Pathology				Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					38	1.00
2.00	Line 1 multiplied by 15 hours per week					570	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					114	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.55	7.00
8.00	Optional travel expense rate per mile					0.56	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	684.12	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	71.89	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)	35.95	35.95	0.00			11.00
12.00	Number of travel hours (provider site)	0	59	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	3,511	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)					49,181	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)					49,181	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)					49,181	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)					49,181	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					4,098	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					4,098	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)					633	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					4,731	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)					4,242	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)					4,242	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)					1,966	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					4,731	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1302				Period: From 10/01/2015 To 09/30/2016	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/5/2017 2:36 pm
						Speech Pathology	Cost
							1.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					Total	0 46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	71.89	0.00	0.00	0.00	0.00	52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0	54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0	55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					49,181	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					4,731	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)					53,912	63.00
64.00	Total cost of outside supplier services (from your records)					48,638	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					4,098	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					633	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					4,731	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					633	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					4,242	101.01
101.02	Line 34 = sum of lines 27 and 31					4,875	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					4,242	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					1,966	102.01
102.02	Line 35 = sum of lines 31 and 32					6,208	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet B
Part I
Date/Time Prepared:
2/5/2017 2:36 pm

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS				
		NEW BLDG & FIXT	NEW ALU BLDG	NEW 2007 HOSPITAL	NEW 2007 MOB	
	0	1.00	1.01	1.02	1.03	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	100,303	100,303				1.00
1.01 00101 NEW CAP REL COSTS-ALU BLDG	91,118	0	91,118			1.01
1.02 00102 NEW CAP REL COSTS-2007 HOSPITAL	4,034,581	0	0	4,034,581		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	30,266					2.00
2.01 00201 NEW CAP REL COSTS-MVBLE EQUIP NEW HO	865,559					2.01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	1,956,780	0	0	0	0	4.00
5.01 00570 ADMITTING	247,376	0	0	58,313	0	5.01
5.02 00550 INFORMATION TECHNOLOGY	519,660	1,139	0	28,964	0	5.02
5.03 00590 HOSPITAL BILLING	188,167	0	0	0	0	5.03
5.04 00540 OTHER ADMINISTRATIVE AND GENERAL	1,309,414	14,911	27,395	349,952	0	5.04
6.00 00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 00700 OPERATION OF PLANT	501,855	0	0	271,381	0	7.00
7.01 00701 OPERATION OF PLANT-SCC	273,698	3,822	0	0	0	7.01
8.00 00800 LAUNDRY & LINEN SERVICE	37,793	0	0	27,423	0	8.00
8.01 00801 LAUNDRY & LINEN SERVICE-SCC	62,927	382	0	0	0	8.01
9.00 00900 HOUSEKEEPING	150,880	0	0	20,798	0	9.00
9.01 00901 HOUSEKEEPING-SCC	100,619	727	0	0	0	9.01
10.00 01000 DIETARY	270,312	0	0	246,962	0	10.00
10.01 01001 DIETARY-SCC	262,022	2,825	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	260,662	1,267	0	9,860	0	13.00
14.00 01400 CENTRAL SERVICE & SUPPLY	73,969	0	0	52,535	0	14.00
15.00 01500 PHARMACY	135,000	0	0	59,545	0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	147,898	0	0	52,920	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	843,143	0	0	681,726	0	30.00
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00
44.00 04400 SKILLED NURSING FACILITY	17,858	3,316	0	0	0	44.00
46.00 04600 OTHER LONG TERM CARE	1,518,950	34,492	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	356,739	0	0	414,735	0	50.00
53.00 05300 ANESTHESIOLOGY	160,319	0	0	4,160	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	815,119	0	0	279,700	0	54.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	708,912	0	0	82,885	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 06400 INTRAVENOUS THERAPY	20,393	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	22,671	0	0	14,482	0	65.00
66.00 06600 PHYSICAL THERAPY	913,543	0	0	360,120	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	99,749	0	0	28,656	0	67.00
68.00 06800 SPEECH PATHOLOGY	34,859	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	74,743	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	304,520	0	0	0	0	73.00
76.00 03020 SLEEP LAB	28,576	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	8,607	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	1,536,640	0	0	514,799	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	107,862	0	0	0	0	88.01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC	144,482	0	0	0	0	90.00
91.00 09100 EMERGENCY	1,492,347	0	0	426,829	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04040 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet B
Part I
Date/Time Prepared:
2/5/2017 2:36 pm

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	
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,830,891	62,881	27,395	3,986,745	0 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	22,878	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,451	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	265,488	0	58,952	0	0 194.01
194.02	07952	ADULT DAY CARE	126,197	0	4,771	0	0 194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0 194.03
194.04	07954	IDLE SPACE	0	37,422	0	0	0 194.04
194.05	07955	COMMUNITY FITNESS CENTER	14,762	0	0	24,958	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 118-201)	21,247,789	100,303	91,118	4,034,581	0 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet B
Part I
Date/Time Prepared:
2/5/2017 2:36 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	INFORMATION TECHNOLOGY	
	NEW MVBLE EQUIP	NEW MVBLE EQUIP NEW HO				
	2.00	2.01				
GENERAL SERVICE COST CENTERS						
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	30,266					2.00
2.01 00201 NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	865,559				2.01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	1,956,780			4.00
5.01 00570 ADMITTING	0	0	70,787	376,476		5.01
5.02 00550 INFORMATION TECHNOLOGY	0	35,006	76,885	0	661,654	5.02
5.03 00590 HOSPITAL BILLING	0	0	0	0	0	5.03
5.04 00540 OTHER ADMINISTRATIVE AND GENERAL	557	177,712	154,011	0	34,150	5.04
6.00 00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 00700 OPERATION OF PLANT	0	38,416	16,363	0	21,344	7.00
7.01 00701 OPERATION OF PLANT-SCC	5,303	0	22,239	0	0	7.01
8.00 00800 LAUNDRY & LINEN SERVICE	0	1,747	0	0	0	8.00
8.01 00801 LAUNDRY & LINEN SERVICE-SCC	0	0	0	0	0	8.01
9.00 00900 HOUSEKEEPING	0	1,819	35,065	0	0	9.00
9.01 00901 HOUSEKEEPING-SCC	0	0	24,776	0	0	9.01
10.00 01000 DIETARY	0	60,870	51,771	0	12,806	10.00
10.01 01001 DIETARY-SCC	737	0	62,763	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	64,496	0	4,269	13.00
14.00 01400 CENTRAL SERVICE & SUPPLY	0	0	20,632	0	0	14.00
15.00 01500 PHARMACY	0	6,361	0	0	8,537	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	1,011	41,256	0	21,344	16.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	8,598	105,858	201,772	34,251	76,837	30.00
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00
44.00 04400 SKILLED NURSING FACILITY	22	0	919	0	0	44.00
46.00 04600 OTHER LONG TERM CARE	9,700	0	349,024	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	167,048	60,318	34,876	55,494	50.00
53.00 05300 ANESTHESIOLOGY	0	13,561	0	7,975	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	56	171,012	86,959	102,533	55,494	54.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	150	6,849	88,732	63,577	21,344	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 06400 INTRAVENOUS THERAPY	0	0	0	7,264	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	704	0	1,951	0	65.00
66.00 06600 PHYSICAL THERAPY	533	16,514	245,668	47,925	106,718	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	4,532	3,801	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	1,373	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	7,243	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	25,196	0	73.00
76.00 03020 SLEEP LAB	0	12,806	4,502	827	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	2,530	168	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	168	29,661	66,792	0	149,405	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0	7,819	0	8,537	88.01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC	0	0	14,275	0	38,419	90.00
91.00 09100 EMERGENCY	1,823	16,730	79,267	37,516	46,956	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04040 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	27,647	863,864	1,854,153	376,476	661,654	118.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

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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				
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	325	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	2,465	0	69,935	0	0 194.01
194.02 07952	ADULT DAY CARE	120	316	29,175	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	34	1,054	3,517	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 118-201)	30,266	865,559	1,956,780	376,476	661,654 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet B
Part I
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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	188,167					5.03
5.04	00540 OTHER ADMINISTRATIVE AND GENERAL	0	2,068,102	2,068,102			5.04
6.00	00600 MAINTENANCE & REPAIRS	0	0	0	0		6.00
7.00	00700 OPERATION OF PLANT	0	849,359	95,690	0	945,049	7.00
7.01	00701 OPERATION OF PLANT-SCC	0	305,062	0	0	0	7.01
8.00	00800 LAUNDRY & LINEN SERVICE	0	66,963	7,544	0	7,792	8.00
8.01	00801 LAUNDRY & LINEN SERVICE-SCC	0	63,309	0	0	0	8.01
9.00	00900 HOUSEKEEPING	0	208,562	23,497	0	5,910	9.00
9.01	00901 HOUSEKEEPING-SCC	0	126,122	0	0	0	9.01
10.00	01000 DIETARY	0	642,721	72,410	0	70,172	10.00
10.01	01001 DIETARY-SCC	0	328,347	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	340,733	38,387	0	2,802	13.00
14.00	01400 CENTRAL SERVICE & SUPPLY	0	147,136	16,576	0	14,927	14.00
15.00	01500 PHARMACY	0	209,443	23,596	0	16,919	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	264,429	29,791	0	15,037	16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	15,307	1,967,492	221,660	0	193,707	30.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400 SKILLED NURSING FACILITY	0	22,115	2,491	0	0	44.00
46.00	04600 OTHER LONG TERM CARE	0	1,912,166	215,427	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	15,586	1,104,796	124,467	0	117,844	50.00
53.00	05300 ANESTHESIOLOGY	3,564	189,579	21,358	0	1,182	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	45,821	1,556,694	175,379	0	79,475	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	28,413	1,000,862	112,758	0	23,551	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	3,246	30,903	3,482	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	872	40,680	4,583	0	4,115	65.00
66.00	06600 PHYSICAL THERAPY	21,418	1,712,439	192,925	0	102,325	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,699	138,437	15,596	0	8,142	67.00
68.00	06800 SPEECH PATHOLOGY	614	36,846	4,151	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,237	85,223	9,601	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	11,260	340,976	38,415	0	0	73.00
76.00	03020 SLEEP LAB	370	47,081	5,304	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	75	11,380	1,282	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	18,431	2,315,896	260,913	0	146,276	88.00
88.01	08801 RURAL HEALTH CLINIC II	1,101	125,319	14,119	0	0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	387	197,563	22,258	0	0	90.00
91.00	09100 EMERGENCY	16,766	2,118,234	238,642	0	121,280	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	188,167	20,574,969	1,992,302	0	931,456	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23,203	2,614	0	6,501	190.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

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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	
192.00	19200	0	10,451	1,177	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	396,840	44,708	0	0	194.01
194.02	07952	0	160,579	18,091	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	37,422	4,216	0	0	194.04
194.05	07955	0	44,325	4,994	0	7,092	194.05
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	188,167	21,247,789	2,068,102	0	945,049	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2015
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Cost Center Description		OPERATION OF PLANT-SCC	LAUNDRY & LINEN SERVICE	LAUNDRY & LINEN SERVICE-SCC	HOUSEKEEPING	HOUSEKEEPING-S CC		
		7.01	8.00	8.01	9.00	9.01		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	NEW CAP REL COSTS-ALU BLDG					1.01	
1.02	00102	NEW CAP REL COSTS-2007 HOSPITAL					1.02	
1.03	00103	NEW CAP REL COSTS-2007 MOB					1.03	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00	
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP NEW HO					2.01	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01	00570	ADMITTING					5.01	
5.02	00550	INFORMATION TECHNOLOGY					5.02	
5.03	00590	HOSPITAL BILLING					5.03	
5.04	00540	OTHER ADMINISTRATIVE AND GENERAL					5.04	
6.00	00600	MAINTENANCE & REPAIRS					6.00	
7.00	00700	OPERATION OF PLANT					7.00	
7.01	00701	OPERATION OF PLANT-SCC	305,062				7.01	
8.00	00800	LAUNDRY & LINEN SERVICE	0	82,299			8.00	
8.01	00801	LAUNDRY & LINEN SERVICE-SCC	962	0	64,271		8.01	
9.00	00900	HOUSEKEEPING	0	0	0	237,969	9.00	
9.01	00901	HOUSEKEEPING-SCC	1,830	0	0	0	127,952	9.01
10.00	01000	DIETARY	0	0	0	19,643	0	10.00
10.01	01001	DIETARY-SCC	7,110	0	0	0	4,372	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	3,188	0	0	784	1,960	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	4,179	0	14.00
15.00	01500	PHARMACY	0	0	0	4,736	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	4,209	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	82,299	0	54,223	0	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400	SKILLED NURSING FACILITY	8,344	0	143	0	5,131	44.00
46.00	04600	OTHER LONG TERM CARE	86,805	0	64,128	0	53,376	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	32,987	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	331	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	22,247	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	6,593	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,152	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	10,440	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	827	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	40,946	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	33,949	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	108,239	82,299	64,271	237,246	64,839	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			OPERATION OF PLANT-SCC	LAUNDRY & LINEN SERVICE	LAUNDRY & LINEN SERVICE-SCC	HOUSEKEEPING	HOUSEKEEPING-S	CC
			7.01	8.00	8.01	9.00	9.01	
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	94,955	0	0	0	58,388	194.01
194.02	07952	ADULT DAY CARE	7,685	0	0	0	4,725	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	94,183	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	723	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 118-201)	305,062	82,299	64,271	237,969	127,952	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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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	804,946					10.00
10.01	01001 DIETARY-SCC	0	339,829				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	387,854	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	804,946	0	0	0	310,210	30.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400 SKILLED NURSING FACILITY	0	473	0	0	0	44.00
46.00	04600 OTHER LONG TERM CARE	0	211,696	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	38,822	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020 SLEEP LAB	0	0	0	0	0	76.00
76.01	03950 PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	38,822	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	804,946	212,169	0	0	387,854	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

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		
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	28,384	0	0	0	194.01
194.02	07952	ADULT DAY CARE	0	99,276	0	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	804,946	339,829	0	0	387,854	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

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From 10/01/2015
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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						1.00
1.01	00101						1.01
1.02	00102						1.02
1.03	00103						1.03
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.01	00570						5.01
5.02	00550						5.02
5.03	00590						5.03
5.04	00540						5.04
6.00	00600						6.00
7.00	00700						7.00
7.01	00701						7.01
8.00	00800						8.00
8.01	00801						8.01
9.00	00900						9.00
9.01	00901						9.01
10.00	01000						10.00
10.01	01001						10.01
11.00	01100						11.00
11.01	01101						11.01
13.00	01300						13.00
14.00	01400	182,818					14.00
15.00	01500	0	254,694				15.00
16.00	01600	2,908	0	316,374			16.00
19.00	01900	0	0	0	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	20,748	0	25,735	0	3,681,020	30.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
44.00	04400	0	0	0	0	38,697	44.00
46.00	04600	0	0	0	0	2,543,598	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	36,554	0	26,205	0	1,481,675	50.00
53.00	05300	1,112	0	5,993	0	219,555	53.00
54.00	05400	19,656	0	77,049	0	1,930,500	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	47,771	0	1,191,535	60.00
60.01	06001	0	0	0	0	0	60.01
64.00	06400	7,331	0	5,458	0	47,174	64.00
65.00	06500	8,150	0	1,466	0	60,146	65.00
66.00	06600	29,159	0	36,010	0	2,083,298	66.00
67.00	06700	7,755	0	2,856	0	173,613	67.00
68.00	06800	0	0	1,032	0	42,029	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	774	0	5,442	0	101,040	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	61	254,694	18,932	0	653,078	73.00
76.00	03020	0	0	622	0	53,007	76.00
76.01	03950	0	0	0	0	0	76.01
76.02	03530	0	0	126	0	12,788	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	20,500	0	30,987	0	2,815,518	88.00
88.01	08801	1,528	0	1,851	0	142,817	88.01
89.00	08900	0	0	0	0	0	89.00
90.00	09000	5,805	0	650	0	226,276	90.00
91.00	09100	20,777	0	28,189	0	2,599,893	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300	0	0	0	0	0	113.00
118.00		182,818	254,694	316,374	0	20,097,257	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	32,318	190.00

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	
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	11,628	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	623,275	194.01
194.02	07952 ADULT DAY CARE	0	0	0	0	290,356	194.02
194.03	07953 GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954 IDLE SPACE	0	0	0	0	135,821	194.04
194.05	07955 COMMUNITY FITNESS CENTER	0	0	0	0	57,134	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 118-201)	182,818	254,694	316,374	0	21,247,789	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1302

Period:
From 10/01/2015
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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	3,681,020	30.00
41.00	04100 SUBPROVIDER - IRF	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	42.00
44.00	04400 SKILLED NURSING FACILITY	0	38,697	44.00
46.00	04600 OTHER LONG TERM CARE	0	2,543,598	46.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	1,481,675	50.00
53.00	05300 ANESTHESIOLOGY	0	219,555	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	1,930,500	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	1,191,535	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	47,174	64.00
65.00	06500 RESPIRATORY THERAPY	0	60,146	65.00
66.00	06600 PHYSICAL THERAPY	0	2,083,298	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	173,613	67.00
68.00	06800 SPEECH PATHOLOGY	0	42,029	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	101,040	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	653,078	73.00
76.00	03020 SLEEP LAB	0	53,007	76.00
76.01	03950 PAIN CLINIC / SERVICE	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	12,788	76.02
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	2,815,518	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	142,817	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000 CLINIC	0	226,276	90.00
91.00	09100 EMERGENCY	0	2,599,893	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	93.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910 CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS				
109.00	10900 PANCREAS ACQUISITION	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	111.00
113.00	11300 INTEREST EXPENSE	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	20,097,257	118.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	32,318	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	11,628	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	623,275	194.01
194.02	07952 ADULT DAY CARE	0	290,356	194.02
194.03	07953 GRANT FUNDED PROGRAMS	0	0	194.03
194.04	07954 IDLE SPACE	0	135,821	194.04
194.05	07955 COMMUNITY FITNESS CENTER	0	57,134	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 118-201)	0	21,247,789	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
		NEW BLDG & FIXT	NEW ALU BLDG	NEW 2007 HOSPITAL	NEW 2007 MOB	
		0	1.00	1.01	1.02	1.03
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	0	58,313	5.01
5.02 00550	INFORMATION TECHNOLOGY	0	1,139	0	28,964	5.02
5.03 00590	HOSPITAL BILLING	0	0	0	0	5.03
5.04 00540	OTHER ADMINISTRATIVE AND GENERAL	0	14,911	27,395	349,952	5.04
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	0	0	0	271,381	7.00
7.01 00701	OPERATION OF PLANT-SCC	0	3,822	0	0	7.01
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	27,423	8.00
8.01 00801	LAUNDRY & LINEN SERVICE-SCC	0	382	0	0	8.01
9.00 00900	HOUSEKEEPING	0	0	0	20,798	9.00
9.01 00901	HOUSEKEEPING-SCC	0	727	0	0	9.01
10.00 01000	DIETARY	0	0	0	246,962	10.00
10.01 01001	DIETARY-SCC	0	2,825	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	1,267	0	9,860	13.00
14.00 01400	CENTRAL SERVICE & SUPPLY	0	0	0	52,535	14.00
15.00 01500	PHARMACY	0	0	0	59,545	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	52,920	16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	0	0	681,726	30.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
44.00 04400	SKILLED NURSING FACILITY	0	3,316	0	0	44.00
46.00 04600	OTHER LONG TERM CARE	0	34,492	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	414,735	50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	4,160	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	14,171	0	0	279,700	54.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	0	0	0	82,885	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	14,482	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	360,120	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	28,656	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	8,740	0	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	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	514,799	88.00
88.01 08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	426,829	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00 04040	FAMILY PRACTICE	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
		NEW BLDG & FIXT	NEW ALU BLDG	NEW 2007 HOSPITAL	NEW 2007 MOB	
	0	1.00	1.01	1.02	1.03	
118.00	SUBTOTALS (SUM OF LINES 1-117)	22,911	62,881	27,395	3,986,745	0 118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	22,878	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	58,952	0	0 194.01
194.02	07952 ADULT DAY CARE	0	0	4,771	0	0 194.02
194.03	07953 GRANT FUNDED PROGRAMS	0	0	0	0	0 194.03
194.04	07954 IDLE SPACE	0	37,422	0	0	0 194.04
194.05	07955 COMMUNITY FITNESS CENTER	0	0	0	24,958	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 118-201)	22,911	100,303	91,118	4,034,581	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
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Cost Center Description		CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
		NEW MVBLE EQUIP	NEW MVBLE EQUIP NEW HO				
		2.00	2.01				
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
1.03	00103						1.03
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.01	00570						4.00
5.02	00550			58,313		58,313	5.01
5.02	00550		35,006	65,109			5.02
5.03	00590						5.03
5.04	00540	557	177,712	570,527			5.04
6.00	00600						6.00
7.00	00700						7.00
7.01	00701						7.01
8.00	00800						8.00
8.01	00801						8.01
9.00	00900						9.00
9.01	00901						9.01
10.00	01000						10.00
10.01	01001	737		3,562			10.01
11.00	01100						11.00
11.01	01101						11.01
13.00	01300		179	11,306			13.00
14.00	01400			52,535			14.00
15.00	01500		6,361	65,906			15.00
16.00	01600		1,011	53,931			16.00
19.00	01900						19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	8,598	105,858	796,182		5,305	30.00
41.00	04100						41.00
42.00	04200						42.00
44.00	04400	22		3,338			44.00
46.00	04600	9,700		44,192			46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000		167,048	581,783		5,402	50.00
53.00	05300		13,561	17,721		1,235	53.00
54.00	05400	56	171,012	464,939		15,881	54.00
57.00	05700						57.00
58.00	05800						58.00
59.00	05900						59.00
60.00	06000	150	6,849	89,884		9,848	60.00
60.01	06001						60.01
64.00	06400					1,125	64.00
65.00	06500		704	15,186		302	65.00
66.00	06600	533	16,514	377,167		7,423	66.00
67.00	06700			28,656		589	67.00
68.00	06800					213	68.00
69.00	06900						69.00
71.00	07100					1,122	71.00
72.00	07200						72.00
73.00	07300			8,740		3,903	73.00
76.00	03020		12,806	12,806		128	76.00
76.01	03950						76.01
76.02	03530					26	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	168	29,661	544,628			88.00
88.01	08801						88.01
89.00	08900						89.00
90.00	09000						90.00
91.00	09100	1,823	16,730	445,382		5,811	91.00
92.00	09200						92.00
93.00	04040						93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910						99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900						109.00
110.00	11000						110.00
111.00	11100						111.00
113.00	11300						113.00
118.00		27,647	863,864	4,991,443		58,313	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet B
Part II
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Cost Center Description	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
	NEW MVBLE EQUIP	NEW MVBLE EQUIP NEW HO				
	2.00	2.01				
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	325	23,203	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	2,465	0	61,417	0	0	194.01
194.02 07952 ADULT DAY CARE	120	316	5,207	0	0	194.02
194.03 07953 GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04 07954 IDLE SPACE	0	0	37,422	0	0	194.04
194.05 07955 COMMUNITY FITNESS CENTER	34	1,054	26,046	0	0	194.05
200.00 Cross Foot Adjustments	0	0	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	30,266	865,559	5,144,738	0	58,313	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet B
Part II
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Cost Center Description	INFORMATION TECHNOLOGY	HOSPITAL BILLING	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
	5.02	5.03	5.04	6.00	7.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101 NEW CAP REL COSTS-ALU BLDG						1.01
1.02 00102 NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03 00103 NEW CAP REL COSTS-2007 MOB						1.03
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01 00201 NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 00570 ADMITTING						5.01
5.02 00550 INFORMATION TECHNOLOGY	65,109					5.02
5.03 00590 HOSPITAL BILLING	0	0				5.03
5.04 00540 OTHER ADMINISTRATIVE AND GENERAL	3,360	0	573,887			5.04
6.00 00600 MAINTENANCE & REPAIRS	0	0	0	0		6.00
7.00 00700 OPERATION OF PLANT	2,100	0	26,554	0	338,451	7.00
7.01 00701 OPERATION OF PLANT-SCC	0	0	0	0	0	7.01
8.00 00800 LAUNDRY & LINEN SERVICE	0	0	2,093	0	2,791	8.00
8.01 00801 LAUNDRY & LINEN SERVICE-SCC	0	0	0	0	0	8.01
9.00 00900 HOUSEKEEPING	0	0	6,520	0	2,116	9.00
9.01 00901 HOUSEKEEPING-SCC	0	0	0	0	0	9.01
10.00 01000 DIETARY	1,260	0	20,093	0	25,131	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	420	0	10,652	0	1,003	13.00
14.00 01400 CENTRAL SERVICE & SUPPLY	0	0	4,600	0	5,346	14.00
15.00 01500 PHARMACY	840	0	6,548	0	6,059	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	2,100	0	8,267	0	5,385	16.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	7,561	0	61,510	0	69,374	30.00
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00
44.00 04400 SKILLED NURSING FACILITY	0	0	691	0	0	44.00
46.00 04600 OTHER LONG TERM CARE	0	0	59,780	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	5,461	0	34,539	0	42,203	50.00
53.00 05300 ANESTHESIOLOGY	0	0	5,927	0	423	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	5,461	0	48,667	0	28,462	54.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	2,100	0	31,290	0	8,434	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 06400 INTRAVENOUS THERAPY	0	0	966	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	1,272	0	1,474	65.00
66.00 06600 PHYSICAL THERAPY	10,501	0	53,536	0	36,646	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	4,328	0	2,916	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	1,152	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,664	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	10,660	0	0	73.00
76.00 03020 SLEEP LAB	0	0	1,472	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	356	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	14,703	0	72,400	0	52,386	88.00
88.01 08801 RURAL HEALTH CLINIC II	840	0	3,918	0	0	88.01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC	3,781	0	6,176	0	0	90.00
91.00 09100 EMERGENCY	4,621	0	66,222	0	43,434	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04040 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	65,109	0	552,853	0	333,583	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	725	0	2,328	190.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

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Cost Center Description		INFORMATION TECHNOLOGY	HOSPITAL BILLING	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
		5.02	5.03	5.04	6.00	7.00	
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	327	0	0	0 192.00
192.01	19201 MIDWEST MEDICAL CLINIC	0	0	0	0	0	0 192.01
194.00	07950 OTHER NONREIMBURSABLE	0	0	0	0	0	0 194.00
194.01	07951 ASSISTED LIVING UNITS	0	0	12,406	0	0	0 194.01
194.02	07952 ADULT DAY CARE	0	0	5,020	0	0	0 194.02
194.03	07953 GRANT FUNDED PROGRAMS	0	0	0	0	0	0 194.03
194.04	07954 IDLE SPACE	0	0	1,170	0	0	0 194.04
194.05	07955 COMMUNITY FITNESS CENTER	0	0	1,386	0	2,540	0 194.05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	65,109	0	573,887	0	338,451	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description	OPERATION OF PLANT-SCC	LAUNDRY & LINEN SERVICE	LAUNDRY & LINEN SERVICE-SCC	HOUSEKEEPING	HOUSEKEEPING-S CC	
	7.01	8.00	8.01	9.00	9.01	
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	9,125					7.01
8.00 00800 LAUNDRY & LINEN SERVICE	0	34,054				8.00
8.01 00801 LAUNDRY & LINEN SERVICE-SCC	29	0	411			8.01
9.00 00900 HOUSEKEEPING	0	0	0	31,253		9.00
9.01 00901 HOUSEKEEPING-SCC	55	0	0	0	782	9.01
10.00 01000 DIETARY	0	0	0	2,580	0	10.00
10.01 01001 DIETARY-SCC	213	0	0	0	27	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	95	0	0	103	12	13.00
14.00 01400 CENTRAL SERVICE & SUPPLY	0	0	0	549	0	14.00
15.00 01500 PHARMACY	0	0	0	622	0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	553	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	34,054	0	7,120	0	30.00
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00
44.00 04400 SKILLED NURSING FACILITY	250	0	1	0	31	44.00
46.00 04600 OTHER LONG TERM CARE	2,597	0	410	0	326	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	4,332	0	50.00
53.00 05300 ANESTHESIOLOGY	0	0	0	43	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	2,922	0	54.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	866	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	151	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	1,371	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	109	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	5,378	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	4,459	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04040 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	3,239	34,054	411	31,158	396	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

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Cost Center Description			OPERATION OF PLANT-SCC	LAUNDRY & LINEN SERVICE	LAUNDRY & LINEN SERVICE-SCC	HOUSEKEEPING	HOUSEKEEPING-S	CC
			7.01	8.00	8.01	9.00	9.01	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	0 192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	0 192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	0 194.00
194.01	07951	ASSISTED LIVING UNITS	2,839	0	0	0	357	194.01
194.02	07952	ADULT DAY CARE	230	0	0	0	29	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	0 194.03
194.04	07954	IDLE SPACE	2,817	0	0	0	0	0 194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	95	0	0 194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118-201)	9,125	34,054	411	31,253	782	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	356,896					10.00
10.01	01001 DIETARY-SCC	0	3,802				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	23,591	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	356,896	0	0	0	18,869	30.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400 SKILLED NURSING FACILITY	0	5	0	0	0	44.00
46.00	04600 OTHER LONG TERM CARE	0	2,368	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	2,361	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020 SLEEP LAB	0	0	0	0	0	76.00
76.01	03950 PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	2,361	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	356,896	2,373	0	0	23,591	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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet B
Part II
Date/Time Prepared:
2/5/2017 2:36 pm

Cost Center Description			DIETARY	DIETARY-SCC	CAFETERIA	CAFETERIA-SCC	NURSING	
			10.00	10.01	11.00	11.01	ADMINISTRATION	
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	0	0	0 192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	0 194.00
194.01	07951	ASSISTED LIVING UNITS	0	318	0	0	0	0 194.01
194.02	07952	ADULT DAY CARE	0	1,111	0	0	0	0 194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0	0 194.03
194.04	07954	IDLE SPACE	0	0	0	0	0	0 194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	0	0	0 194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118-201)	356,896	3,802	0	0	23,591	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
		14.00	15.00	16.00	19.00	24.00	
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	63,030					14.00
15.00	01500 PHARMACY	0	79,975				15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	1,003	0	71,239			16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	7,153	0	5,795		1,369,819	30.00
41.00	04100 SUBPROVIDER - IRF	0	0	0		0	41.00
42.00	04200 SUBPROVIDER	0	0	0		0	42.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0		4,316	44.00
46.00	04600 OTHER LONG TERM CARE	0	0	0		109,673	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	12,601	0	5,901		694,583	50.00
53.00	05300 ANESTHESIOLOGY	383	0	1,349		27,081	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	6,777	0	17,349		590,458	54.00
57.00	05700 CT SCAN	0	0	0		0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		0	59.00
60.00	06000 LABORATORY	0	0	10,757		153,179	60.00
60.01	06001 BLOOD LABORATORY	0	0	0		0	60.01
64.00	06400 INTRAVENOUS THERAPY	2,528	0	1,229		5,848	64.00
65.00	06500 RESPIRATORY THERAPY	2,810	0	330		21,525	65.00
66.00	06600 PHYSICAL THERAPY	10,053	0	8,109		504,806	66.00
67.00	06700 OCCUPATIONAL THERAPY	2,674	0	643		39,915	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	232		1,597	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	267	0	1,225		5,278	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	21	79,975	4,263		107,562	73.00
76.00	03020 SLEEP LAB	0	0	140		14,546	76.00
76.01	03950 PAIN CLINIC / SERVICE	0	0	0		0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	28		410	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	7,068	0	6,978		703,541	88.00
88.01	08801 RURAL HEALTH CLINIC II	527	0	417		5,702	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0	89.00
90.00	09000 CLINIC	2,002	0	146		12,105	90.00
91.00	09100 EMERGENCY	7,163	0	6,348		585,801	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040 FAMILY PRACTICE	0	0	0		0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0	0	0		0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900 PANCREAS ACQUISITION	0	0	0		0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0		0	110.00
111.00	11100 ISLET ACQUISITION	0	0	0		0	111.00
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	63,030	79,975	71,239	0	4,957,745	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		26,256	190.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet B
Part II
Date/Time Prepared:
2/5/2017 2:36 pm

Cost Center Description		CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
		14.00	15.00	16.00	19.00	24.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	327	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	77,337	194.01
194.02	07952	ADULT DAY CARE	0	0	0	11,597	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	41,409	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	30,067	194.05
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	63,030	79,975	71,239	0	5,144,738

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet B
Part II
Date/Time Prepared:
2/5/2017 2:36 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101 NEW CAP REL COSTS-ALU BLDG			1.01
1.02	00102 NEW CAP REL COSTS-2007 HOSPITAL			1.02
1.03	00103 NEW CAP REL COSTS-2007 MOB			1.03
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP			2.00
2.01	00201 NEW CAP REL COSTS-MVBLE EQUIP NEW HO			2.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00570 ADMITTING			5.01
5.02	00550 INFORMATION TECHNOLOGY			5.02
5.03	00590 HOSPITAL BILLING			5.03
5.04	00540 OTHER ADMINISTRATIVE AND GENERAL			5.04
6.00	00600 MAINTENANCE & REPAIRS			6.00
7.00	00700 OPERATION OF PLANT			7.00
7.01	00701 OPERATION OF PLANT-SCC			7.01
8.00	00800 LAUNDRY & LINEN SERVICE			8.00
8.01	00801 LAUNDRY & LINEN SERVICE-SCC			8.01
9.00	00900 HOUSEKEEPING			9.00
9.01	00901 HOUSEKEEPING-SCC			9.01
10.00	01000 DIETARY			10.00
10.01	01001 DIETARY-SCC			10.01
11.00	01100 CAFETERIA			11.00
11.01	01101 CAFETERIA-SCC			11.01
13.00	01300 NURSING ADMINISTRATION			13.00
14.00	01400 CENTRAL SERVICE & SUPPLY			14.00
15.00	01500 PHARMACY			15.00
16.00	01600 MEDICAL RECORDS & LIBRARY			16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS			19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	0	1,369,819	30.00
41.00	04100 SUBPROVIDER - IRF	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	42.00
44.00	04400 SKILLED NURSING FACILITY	0	4,316	44.00
46.00	04600 OTHER LONG TERM CARE	0	109,673	46.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	694,583	50.00
53.00	05300 ANESTHESIOLOGY	0	27,081	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	590,458	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	153,179	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	5,848	64.00
65.00	06500 RESPIRATORY THERAPY	0	21,525	65.00
66.00	06600 PHYSICAL THERAPY	0	504,806	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	39,915	67.00
68.00	06800 SPEECH PATHOLOGY	0	1,597	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,278	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	107,562	73.00
76.00	03020 SLEEP LAB	0	14,546	76.00
76.01	03950 PAIN CLINIC / SERVICE	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	410	76.02
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	703,541	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	5,702	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000 CLINIC	0	12,105	90.00
91.00	09100 EMERGENCY	0	585,801	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	93.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910 CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS				
109.00	10900 PANCREAS ACQUISITION	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	111.00
113.00	11300 INTEREST EXPENSE	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	4,957,745	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet B
Part II
Date/Time Prepared:
2/5/2017 2:36 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total		
		25.00	26.00		
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26,256	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	327	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	77,337	194.01
194.02	07952	ADULT DAY CARE	0	11,597	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	194.03
194.04	07954	IDLE SPACE	0	41,409	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	30,067	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 118-201)	0	5,144,738	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet B-1

Date/Time Prepared:
2/5/2017 2:36 pm

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					28,807
2.01	00201 NEW CAP REL COSTS-MVBLE EQUIP NEW HO					0
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0
5.01	00570 ADMITTING	0	0	757	0	0
5.02	00550 INFORMATION TECHNOLOGY	578	0	376	0	0
5.03	00590 HOSPITAL BILLING	0	0	0	0	0
5.04	00540 OTHER ADMINISTRATIVE AND GENERAL	7,569	8,900	4,543	0	530
6.00	00600 MAINTENANCE & REPAIRS	0	0	0	0	0
7.00	00700 OPERATION OF PLANT	0	0	3,523	0	0
7.01	00701 OPERATION OF PLANT-SCC	1,940	0	0	0	5,047
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	356	0	0
8.01	00801 LAUNDRY & LINEN SERVICE-SCC	194	0	0	0	0
9.00	00900 HOUSEKEEPING	0	0	270	0	0
9.01	00901 HOUSEKEEPING-SCC	369	0	0	0	0
10.00	01000 DIETARY	0	0	3,206	0	0
10.01	01001 DIETARY-SCC	1,434	0	0	0	701
11.00	01100 CAFETERIA	0	0	0	0	0
11.01	01101 CAFETERIA-SCC	0	0	0	0	0
13.00	01300 NURSING ADMINISTRATION	643	0	128	0	0
14.00	01400 CENTRAL SERVICE & SUPPLY	0	0	682	0	0
15.00	01500 PHARMACY	0	0	773	0	0
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	687	0	0
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	0	8,850	0	8,184
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200 SUBPROVIDER	0	0	0	0	0
44.00	04400 SKILLED NURSING FACILITY	1,683	0	0	0	21
46.00	04600 OTHER LONG TERM CARE	17,508	0	0	0	9,234
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	5,384	0	0
53.00	05300 ANESTHESIOLOGY	0	0	54	0	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	3,631	0	53
57.00	05700 CT SCAN	0	0	0	0	0
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000 LABORATORY	0	0	1,076	0	143
60.01	06001 BLOOD LABORATORY	0	0	0	0	0
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500 RESPIRATORY THERAPY	0	0	188	0	0
66.00	06600 PHYSICAL THERAPY	0	0	4,675	0	507
67.00	06700 OCCUPATIONAL THERAPY	0	0	372	0	0
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03020 SLEEP LAB	0	0	0	0	0
76.01	03950 PAIN CLINIC / SERVICE	0	0	0	0	0
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	6,683	0	160
88.01	08801 RURAL HEALTH CLINIC II	0	0	0	0	0
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000 CLINIC	0	0	0	0	0
91.00	09100 EMERGENCY	0	0	5,541	0	1,735
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04040 FAMILY PRACTICE	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
99.10	09910 CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100 ISLET ACQUISITION	0	0	0	0	0
113.00	11300 INTEREST EXPENSE	0	0	0	0	0

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	
118.00	SUBTOTALS (SUM OF LINES 1-117)	31,918	8,900	51,755	0	26,315	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	2,346	194.01
194.02	07952 ADULT DAY CARE	0	1,550	0	0	114	194.02
194.03	07953 GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	07954 IDLE SPACE	18,996	0	0	0	0	194.04
194.05	07955 COMMUNITY FITNESS CENTER	0	0	324	0	32	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)	100,303	91,118	4,034,581	0	30,266	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1.970048	3.078103	77.031102	0.000000	1.050647	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)						204.00
205.00	Unit cost multiplier (Wkst. B, Part II)						205.00

Cost 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					
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	860,394						2.01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	6,656,473					4.00
5.01 00570 ADMITTING	0	240,799	19,801,383				5.01
5.02 00550 INFORMATION TECHNOLOGY	34,797	261,543	0		155		5.02
5.03 00590 HOSPITAL BILLING	0	0	0		0	22,145,520	5.03
5.04 00540 OTHER ADMINISTRATIVE AND GENERAL	176,651	523,908	0		8	0	5.04
6.00 00600 MAINTENANCE & REPAIRS	0	0	0		0	0	6.00
7.00 00700 OPERATION OF PLANT	38,187	55,662	0		5	0	7.00
7.01 00701 OPERATION OF PLANT-SCC	0	75,652	0		0	0	7.01
8.00 00800 LAUNDRY & LINEN SERVICE	1,737	0	0		0	0	8.00
8.01 00801 LAUNDRY & LINEN SERVICE-SCC	0	0	0		0	0	8.01
9.00 00900 HOUSEKEEPING	1,808	119,281	0		0	0	9.00
9.01 00901 HOUSEKEEPING-SCC	0	84,281	0		0	0	9.01
10.00 01000 DIETARY	60,507	176,112	0		3	0	10.00
10.01 01001 DIETARY-SCC	0	213,504	0		0	0	10.01
11.00 01100 CAFETERIA	0	0	0		0	0	11.00
11.01 01101 CAFETERIA-SCC	0	0	0		0	0	11.01
13.00 01300 NURSING ADMINISTRATION	178	219,399	0		1	0	13.00
14.00 01400 CENTRAL SERVICE & SUPPLY	0	70,185	0		0	0	14.00
15.00 01500 PHARMACY	6,323	0	0		2	0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	1,005	140,342	0		5	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	105,226	686,377	1,801,427		18	1,801,427	30.00
41.00 04100 SUBPROVIDER - IRF	0	0	0		0	0	41.00
42.00 04200 SUBPROVIDER	0	0	0		0	0	42.00
44.00 04400 SKILLED NURSING FACILITY	0	3,127	0		0	0	44.00
46.00 04600 OTHER LONG TERM CARE	0	1,187,287	0		0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	166,051	205,188	1,834,323		13	1,834,323	50.00
53.00 05300 ANESTHESIOLOGY	13,480	0	419,467		0	419,467	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	169,992	295,813	5,393,153		13	5,393,153	54.00
57.00 05700 CT SCAN	0	0	0		0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0		0	0	59.00
60.00 06000 LABORATORY	6,808	301,845	3,343,888		5	3,343,888	60.00
60.01 06001 BLOOD LABORATORY	0	0	0		0	0	60.01
64.00 06400 INTRAVENOUS THERAPY	0	0	382,047		0	382,047	64.00
65.00 06500 RESPIRATORY THERAPY	700	0	102,616		0	102,616	65.00
66.00 06600 PHYSICAL THERAPY	16,415	835,702	2,520,641		25	2,520,641	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	15,418	199,906		0	199,906	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	72,238		0	72,238	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0		0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	380,939		0	380,939	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	1,325,222		0	1,325,222	73.00
76.00 03020 SLEEP LAB	12,730	15,313	43,521		0	43,521	76.00
76.01 03950 PAIN CLINIC / SERVICE	0	0	0		0	0	76.01
76.02 03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	8,607	8,814		0	8,814	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	29,484	227,211	0		35	2,169,074	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	26,598	0		2	129,542	88.01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0	0	89.00
90.00 09000 CLINIC	0	48,559	0		9	45,521	90.00
91.00 09100 EMERGENCY	16,630	269,646	1,973,181		11	1,973,181	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		0	0	92.00
93.00 04040 FAMILY PRACTICE	0	0	0		0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10 09910 CORF	0	0	0		0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00 10900 PANCREAS ACQUISITION	0	0	0		0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0		0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0		0	0	111.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet B-1

Date/Time Prepared:
2/5/2017 2:36 pm

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					
113.00 11300 INTEREST EXPENSE				5.01	5.02	5.03	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	858,709		6,307,359	19,801,383	155	22,145,520	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	323		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		237,902	0	0		0 194.01
194.02 07952 ADULT DAY CARE	314		99,247	0	0		0 194.02
194.03 07953 GRANT FUNDED PROGRAMS	0		0	0	0		0 194.03
194.04 07954 IDLE SPACE	0		0	0	0		0 194.04
194.05 07955 COMMUNITY FITNESS CENTER	1,048		11,965	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)	865,559		1,956,780	376,476	661,654	188,167	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	1.006003		0.293966	0.019013	4,268.735484	0.008497	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			0	58,313	65,109	0	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.000000	0.002945	420.058065	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet B-1

Date/Time Prepared:
2/5/2017 2:36 pm

Cost Center Description	Reconciliation	OTHER	MAINTENANCE &	OPERATION OF	OPERATION OF	
		ADMINISTRATIVE AND GENERAL (ACCUM COST)	REPAIRS (SQUARE FEET)	PLANT (SQUARE FT)	PLANT-SCC (SQUARE FT SCC)	
	5A.04	5.04	6.00	7.00	7.01	
GENERAL SERVICE COST CENTERS						
1.00 00100						1.00
1.01 00101						1.01
1.02 00102						1.02
1.03 00103						1.03
2.00 00200						2.00
2.01 00201						2.01
4.00 00400						4.00
5.01 00570						5.01
5.02 00550						5.02
5.03 00590						5.03
5.04 00540	-2,068,102	18,356,847				5.04
6.00 00600	0	0	0			6.00
7.00 00700	0	849,359	0	43,177		7.00
7.01 00701	-305,062	0	0	0	61,529	7.01
8.00 00800	0	66,963	0	356	0	8.00
8.01 00801	-63,309	0	0	0	194	8.01
9.00 00900	0	208,562	0	270	0	9.00
9.01 00901	-126,122	0	0	0	369	9.01
10.00 01000	0	642,721	0	3,206	0	10.00
10.01 01001	-328,347	0	0	0	1,434	10.01
11.00 01100	0	0	0	0	0	11.00
11.01 01101	0	0	0	0	0	11.01
13.00 01300	0	340,733	0	128	643	13.00
14.00 01400	0	147,136	0	682	0	14.00
15.00 01500	0	209,443	0	773	0	15.00
16.00 01600	0	264,429	0	687	0	16.00
19.00 01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	0	1,967,492	0	8,850	0	30.00
41.00 04100	0	0	0	0	0	41.00
42.00 04200	0	0	0	0	0	42.00
44.00 04400	0	22,115	0	0	1,683	44.00
46.00 04600	0	1,912,166	0	0	17,508	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	0	1,104,796	0	5,384	0	50.00
53.00 05300	0	189,579	0	54	0	53.00
54.00 05400	0	1,556,694	0	3,631	0	54.00
57.00 05700	0	0	0	0	0	57.00
58.00 05800	0	0	0	0	0	58.00
59.00 05900	0	0	0	0	0	59.00
60.00 06000	0	1,000,862	0	1,076	0	60.00
60.01 06001	0	0	0	0	0	60.01
64.00 06400	0	30,903	0	0	0	64.00
65.00 06500	0	40,680	0	188	0	65.00
66.00 06600	0	1,712,439	0	4,675	0	66.00
67.00 06700	0	138,437	0	372	0	67.00
68.00 06800	0	36,846	0	0	0	68.00
69.00 06900	0	0	0	0	0	69.00
71.00 07100	0	85,223	0	0	0	71.00
72.00 07200	0	0	0	0	0	72.00
73.00 07300	0	340,976	0	0	0	73.00
76.00 03020	0	47,081	0	0	0	76.00
76.01 03950	0	0	0	0	0	76.01
76.02 03530	0	11,380	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	0	2,315,896	0	6,683	0	88.00
88.01 08801	0	125,319	0	0	0	88.01
89.00 08900	0	0	0	0	0	89.00
90.00 09000	0	197,563	0	0	0	90.00
91.00 09100	0	2,118,234	0	5,541	0	91.00
92.00 09200	0	0	0	0	0	92.00
93.00 04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 10900	0	0	0	0	0	109.00
110.00 11000	0	0	0	0	0	110.00
111.00 11100	0	0	0	0	0	111.00
113.00 11300	0	0	0	0	0	113.00
118.00	-2,890,942	17,684,027	0	42,556	21,831	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet B-1

Date/Time Prepared:
2/5/2017 2:36 pm

Cost Center Description		Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FT)	OPERATION OF PLANT-SCC (SQUARE FT SCC)	
		5A.04	5.04	6.00	7.00	7.01	
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23,203	0	297	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,451	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	396,840	0	0	19,152 194.01
194.02	07952	ADULT DAY CARE	0	160,579	0	0	1,550 194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0 194.03
194.04	07954	IDLE SPACE	0	37,422	0	0	18,996 194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	44,325	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)		2,068,102	0	945,049	305,062 202.00
203.00		Unit cost multiplier (wkst. B, Part I)		0.112661	0.000000	21.887787	4.958020 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		573,887	0	338,451	9,125 204.00
205.00		Unit cost multiplier (wkst. B, Part II)		0.031263	0.000000	7.838687	0.148304 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet B-1

Date/Time Prepared:
2/5/2017 2:36 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (PATIENT DAYS)	LAUNDRY & LINEN SERVICE-SCC (PATIENT DAYS SCC)	HOUSEKEEPING (SQARE FT)	HOUSEKEEPING-SCC (SQARE 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	2,052					8.00
8.01	00801 LAUNDRY & LINEN SERVICE-SCC	0	18,403				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	2,052	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	2,052	0	8,850	0	2,052	30.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400 SKILLED NURSING FACILITY	0	41	0	1,683	0	44.00
46.00	04600 OTHER LONG TERM CARE	0	18,362	0	17,508	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	5,384	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	54	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	3,631	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	1,076	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	188	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	1,704	0	0	66.00
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	6,683	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	5,541	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,052	18,403	38,722	21,268	2,052	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet B-1

Date/Time Prepared:
2/5/2017 2:36 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (PATIENT DAYS)	LAUNDRY & LINEN SERVICE-SCC (PATIENT DAYS SCC)	HOUSEKEEPING (SQARE FT)	HOUSEKEEPING-S CC (SQARE FT SCC)	DIETARY (PATIENT DAYS)	
		8.00	8.01	9.00	9.01	10.00	
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
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	19,152	194.01
194.02	07952	ADULT DAY CARE	0	0	0	1,550	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	118	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)	82,299	64,271	237,969	127,952	804,946
203.00		Unit cost multiplier (Wkst. B, Part I)	40.106725	3.492420	6.126905	3.048654	392.273879
204.00		Cost to be allocated (per Wkst. B, Part II)	34,054	411	31,253	782	356,896
205.00		Unit cost multiplier (Wkst. B, Part II)	16.595517	0.022333	0.804660	0.018632	173.925926

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet B-1

Date/Time Prepared:
2/5/2017 2:36 pm

Cost Center Description		DIETARY-SCC (PATIENT DAYS SCC)	CAFETERIA (FTE)	CAFETERIA-SCC (FTE'S -SCC)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	
		10.01	11.00	11.01	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 NEW CAP REL COSTS-ALU BLDG						1.01
1.02	00102 NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	00103 NEW CAP REL COSTS-2007 MOB						1.03
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201 NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570 ADMITTING						5.01
5.02	00550 INFORMATION TECHNOLOGY						5.02
5.03	00590 HOSPITAL BILLING						5.03
5.04	00540 OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00	00700 OPERATION OF PLANT						7.00
7.01	00701 OPERATION OF PLANT-SCC						7.01
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
8.01	00801 LAUNDRY & LINEN SERVICE-SCC						8.01
9.00	00900 HOUSEKEEPING						9.00
9.01	00901 HOUSEKEEPING-SCC						9.01
10.00	01000 DIETARY						10.00
10.01	01001 DIETARY-SCC	29,476					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	2,128		13.00
14.00	01400 CENTRAL SERVICE & SUPPLY	0	0	0	0	508,550	14.00
15.00	01500 PHARMACY	0	0	0	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	8,089	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	1,702	57,715	30.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
44.00	04400 SKILLED NURSING FACILITY	41	0	0	0	0	44.00
46.00	04600 OTHER LONG TERM CARE	18,362	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	213	101,683	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	3,094	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	54,677	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	20,393	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	22,671	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	81,113	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	21,573	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	2,153	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	169	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	57,025	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	0	0	4,250	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	16,149	90.00
91.00	09100 EMERGENCY	0	0	0	213	57,796	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	18,403	0	0	2,128	508,550	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

worksheet B-1

Date/Time Prepared:
2/5/2017 2:36 pm

Cost Center Description		DIETARY-SCC (PATIENT DAYS SCC)	CAFETERIA (FTE)	CAFETERIA-SCC (FTE'S -SCC)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	
		10.01	11.00	11.01	13.00	14.00	
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	2,462	0	0	0	0 194.01
194.02	07952	ADULT DAY CARE	8,611	0	0	0	0 194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	0	0 194.03
194.04	07954	IDLE SPACE	0	0	0	0	0 194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	0	0 194.05
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per wkst. B, Part I)	339,829	0	0	387,854	182,818 202.00
203.00		Unit cost multiplier (wkst. B, Part I)	11.529007	0.000000	0.000000	182.262218	0.359489 203.00
204.00		Cost to be allocated (per wkst. B, Part II)	3,802	0	0	23,591	63,030 204.00
205.00		Unit cost multiplier (wkst. B, Part II)	0.128986	0.000000	0.000000	11.085996	0.123941 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet B-1

Date/Time Prepared:
2/5/2017 2:36 pm

Cost Center Description		PHARMACY (GROSS CHARGES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES HOSP BILLING)	NONPHYSICIAN ANESTHETISTS (TIME SPENT)	
		15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101 NEW CAP REL COSTS-ALU BLDG				1.01
1.02	00102 NEW CAP REL COSTS-2007 HOSPITAL				1.02
1.03	00103 NEW CAP REL COSTS-2007 MOB				1.03
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201 NEW CAP REL COSTS-MVBLE EQUIP NEW HO				2.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00570 ADMITTING				5.01
5.02	00550 INFORMATION TECHNOLOGY				5.02
5.03	00590 HOSPITAL BILLING				5.03
5.04	00540 OTHER ADMINISTRATIVE AND GENERAL				5.04
6.00	00600 MAINTENANCE & REPAIRS				6.00
7.00	00700 OPERATION OF PLANT				7.00
7.01	00701 OPERATION OF PLANT-SCC				7.01
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
8.01	00801 LAUNDRY & LINEN SERVICE-SCC				8.01
9.00	00900 HOUSEKEEPING				9.00
9.01	00901 HOUSEKEEPING-SCC				9.01
10.00	01000 DIETARY				10.00
10.01	01001 DIETARY-SCC				10.01
11.00	01100 CAFETERIA				11.00
11.01	01101 CAFETERIA-SCC				11.01
13.00	01300 NURSING ADMINISTRATION				13.00
14.00	01400 CENTRAL SERVICE & SUPPLY				14.00
15.00	01500 PHARMACY	1,325,222			15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	22,145,520		16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	0	1,801,427	0	30.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	42.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	44.00
46.00	04600 OTHER LONG TERM CARE	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	1,834,323	0	50.00
53.00	05300 ANESTHESIOLOGY	0	419,467	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	5,393,153	0	54.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	3,343,888	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	382,047	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	102,616	0	65.00
66.00	06600 PHYSICAL THERAPY	0	2,520,641	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	199,906	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	72,238	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	380,939	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,325,222	1,325,222	0	73.00
76.00	03020 SLEEP LAB	0	43,521	0	76.00
76.01	03950 PAIN CLINIC / SERVICE	0	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	8,814	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	2,169,074	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	129,542	0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000 CLINIC	0	45,521	0	90.00
91.00	09100 EMERGENCY	0	1,973,181	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910 CORF	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900 PANCREAS ACQUISITION	0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	0	111.00
113.00	11300 INTEREST EXPENSE	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,325,222	22,145,520	0	118.00

Cost Center Description		PHARMACY (GROSS CHARGES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES HOSP BILLING)	NONPHYSICIAN ANESTHETISTS (TIME SPENT)		
		15.00	16.00	19.00		
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
192.01	19201	MIDWEST MEDICAL CLINIC	0	0	0	192.01
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	194.00
194.01	07951	ASSISTED LIVING UNITS	0	0	0	194.01
194.02	07952	ADULT DAY CARE	0	0	0	194.02
194.03	07953	GRANT FUNDED PROGRAMS	0	0	0	194.03
194.04	07954	IDLE SPACE	0	0	0	194.04
194.05	07955	COMMUNITY FITNESS CENTER	0	0	0	194.05
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	254,694	316,374	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.192190	0.014286	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	79,975	71,239	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.060348	0.003217	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet C
Part I
Date/Time Prepared:
2/5/2017 2:36 pm

Cost Center Description	Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII		Hospital		Cost
			Total Costs	RCE Disallowance	Total Costs		
							3.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	3,681,020		3,681,020	0	3,681,020		30.00
41.00 04100 SUBPROVIDER - IRF	0		0	0	0		41.00
42.00 04200 SUBPROVIDER	0		0	0	0		42.00
44.00 04400 SKILLED NURSING FACILITY	38,697		38,697	0	38,697		44.00
46.00 04600 OTHER LONG TERM CARE	2,543,598		2,543,598	0	2,543,598		46.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	1,481,675		1,481,675	0	1,481,675		50.00
53.00 05300 ANESTHESIOLOGY	219,555		219,555	0	219,555		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,930,500		1,930,500	0	1,930,500		54.00
57.00 05700 CT SCAN	0		0	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0		0	0	0		59.00
60.00 06000 LABORATORY	1,191,535		1,191,535	0	1,191,535		60.00
60.01 06001 BLOOD LABORATORY	0		0	0	0		60.01
64.00 06400 INTRAVENOUS THERAPY	47,174		47,174	0	47,174		64.00
65.00 06500 RESPIRATORY THERAPY	60,146	0	60,146	0	60,146		65.00
66.00 06600 PHYSICAL THERAPY	2,083,298	0	2,083,298	0	2,083,298		66.00
67.00 06700 OCCUPATIONAL THERAPY	173,613	0	173,613	0	173,613		67.00
68.00 06800 SPEECH PATHOLOGY	42,029	0	42,029	0	42,029		68.00
69.00 06900 ELECTROCARDIOLOGY	0		0	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	101,040		101,040	0	101,040		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	653,078		653,078	0	653,078		73.00
76.00 03020 SLEEP LAB	53,007		53,007	0	53,007		76.00
76.01 03950 PAIN CLINIC / SERVICE	0		0	0	0		76.01
76.02 03530 SNF PHYSICAL THERAPY - SCC THERAPY	12,788		12,788	0	12,788		76.02
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	2,815,518		2,815,518	0	2,815,518		88.00
88.01 08801 RURAL HEALTH CLINIC II	142,817		142,817	0	142,817		88.01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0		89.00
90.00 09000 CLINIC	226,276		226,276	0	226,276		90.00
91.00 09100 EMERGENCY	2,599,893		2,599,893	0	2,599,893		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	161,511		161,511	0	161,511		92.00
93.00 04040 FAMILY PRACTICE	0		0	0	0		93.00
OTHER REIMBURSABLE COST CENTERS							
99.10 09910 CORF	0		0		0		99.10
SPECIAL PURPOSE COST CENTERS							
109.00 10900 PANCREAS ACQUISITION	0		0		0		109.00
110.00 11000 INTESTINAL ACQUISITION	0		0		0		110.00
111.00 11100 ISLET ACQUISITION	0		0		0		111.00
113.00 11300 INTEREST EXPENSE	0		0		0		113.00
200.00 Subtotal (see instructions)	20,258,768	0	20,258,768	0	20,258,768		200.00
201.00 Less Observation Beds	161,511		161,511		161,511		201.00
202.00 Total (see instructions)	20,097,257	0	20,097,257	0	20,097,257		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet C
Part I
Date/Time Prepared:
2/5/2017 2:36 pm

		Title XVIII			Hospital	Cost	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
					9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,711,273		1,711,273		30.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
44.00	04400	SKILLED NURSING FACILITY	27,294		27,294		44.00
46.00	04600	OTHER LONG TERM CARE	4,195,205		4,195,205		46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,306	1,833,017	1,834,323	0.807750	50.00
53.00	05300	ANESTHESIOLOGY	0	419,467	419,467	0.523414	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	151,424	5,241,730	5,393,154	0.357954	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	182,685	3,161,203	3,343,888	0.356332	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	60,783	321,264	382,047	0.123477	64.00
65.00	06500	RESPIRATORY THERAPY	67,903	34,713	102,616	0.586127	65.00
66.00	06600	PHYSICAL THERAPY	429,940	2,090,701	2,520,641	0.826495	66.00
67.00	06700	OCCUPATIONAL THERAPY	153,961	45,945	199,906	0.868473	67.00
68.00	06800	SPEECH PATHOLOGY	21,594	50,644	72,238	0.581813	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	34,191	346,748	380,939	0.265239	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	600,881	724,341	1,325,222	0.492806	73.00
76.00	03020	SLEEP LAB	0	43,521	43,521	1.217964	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	0.000000	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	8,814	0	8,814	1.450874	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,169,074	2,169,074		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	129,542	129,542		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	45,521	45,521	4.970805	90.00
91.00	09100	EMERGENCY	84,148	1,889,033	1,973,181	1.317615	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,000	88,154	90,154	1.791501	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	7,733,402	18,634,618	26,368,020		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	7,733,402	18,634,618	26,368,020		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet C
Part I
Date/Time Prepared:
2/5/2017 2:36 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
41.00	04100 SUBPROVIDER - IRF				41.00
42.00	04200 SUBPROVIDER				42.00
44.00	04400 SKILLED NURSING FACILITY				44.00
46.00	04600 OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000 LABORATORY	0.000000			60.00
60.01	06001 BLOOD LABORATORY	0.000000			60.01
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
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				88.00
88.01	08801 RURAL HEALTH CLINIC II				88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
93.00	04040 FAMILY PRACTICE	0.000000			93.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910 CORF				99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900 PANCREAS ACQUISITION				109.00
110.00	11000 INTESTINAL ACQUISITION				110.00
111.00	11100 ISLET ACQUISITION				111.00
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet C
Part I
Date/Time Prepared:
2/5/2017 2:36 pm

Cost Center Description	Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital		Total Costs
			Total Costs	RCE	Disallowance	Total Costs	
			3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	3,681,020		3,681,020	0		3,681,020	30.00
41.00 04100 SUBPROVIDER - IRF	0		0	0		0	41.00
42.00 04200 SUBPROVIDER	0		0	0		0	42.00
44.00 04400 SKILLED NURSING FACILITY	38,697		38,697	0		38,697	44.00
46.00 04600 OTHER LONG TERM CARE	2,543,598		2,543,598	0		2,543,598	46.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	1,481,675		1,481,675	0		1,481,675	50.00
53.00 05300 ANESTHESIOLOGY	219,555		219,555	0		219,555	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,930,500		1,930,500	0		1,930,500	54.00
57.00 05700 CT SCAN	0		0	0		0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0		0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0		0	0		0	59.00
60.00 06000 LABORATORY	1,191,535		1,191,535	0		1,191,535	60.00
60.01 06001 BLOOD LABORATORY	0		0	0		0	60.01
64.00 06400 INTRAVENOUS THERAPY	47,174		47,174	0		47,174	64.00
65.00 06500 RESPIRATORY THERAPY	60,146	0	60,146	0		60,146	65.00
66.00 06600 PHYSICAL THERAPY	2,083,298	0	2,083,298	0		2,083,298	66.00
67.00 06700 OCCUPATIONAL THERAPY	173,613	0	173,613	0		173,613	67.00
68.00 06800 SPEECH PATHOLOGY	42,029	0	42,029	0		42,029	68.00
69.00 06900 ELECTROCARDIOLOGY	0		0	0		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	101,040		101,040	0		101,040	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	653,078		653,078	0		653,078	73.00
76.00 03020 SLEEP LAB	53,007		53,007	0		53,007	76.00
76.01 03950 PAIN CLINIC / SERVICE	0		0	0		0	76.01
76.02 03530 SNF PHYSICAL THERAPY - SCC THERAPY	12,788		12,788	0		12,788	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	2,815,518		2,815,518	0		2,815,518	88.00
88.01 08801 RURAL HEALTH CLINIC II	142,817		142,817	0		142,817	88.01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0		0	89.00
90.00 09000 CLINIC	226,276		226,276	0		226,276	90.00
91.00 09100 EMERGENCY	2,599,893		2,599,893	0		2,599,893	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	161,511		161,511	0		161,511	92.00
93.00 04040 FAMILY PRACTICE	0		0	0		0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10 09910 CORP	0		0			0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00 10900 PANCREAS ACQUISITION	0		0			0	109.00
110.00 11000 INTESTINAL ACQUISITION	0		0			0	110.00
111.00 11100 ISLET ACQUISITION	0		0			0	111.00
113.00 11300 INTEREST EXPENSE							113.00
200.00 Subtotal (see instructions)	20,258,768	0	20,258,768	0		20,258,768	200.00
201.00 Less Observation Beds	161,511		161,511			161,511	201.00
202.00 Total (see instructions)	20,097,257	0	20,097,257	0		20,097,257	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet C
Part I
Date/Time Prepared:
2/5/2017 2:36 pm

		Title XIX			Hospital	Cost
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
9.00	10.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,711,273		1,711,273	30.00
41.00	04100	SUBPROVIDER - IRF	0		0	41.00
42.00	04200	SUBPROVIDER	0		0	42.00
44.00	04400	SKILLED NURSING FACILITY	27,294		27,294	44.00
46.00	04600	OTHER LONG TERM CARE	4,195,205		4,195,205	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,306	1,833,017	1,834,323	50.00
53.00	05300	ANESTHESIOLOGY	0	419,467	419,467	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	151,424	5,241,730	5,393,154	54.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	182,685	3,161,203	3,343,888	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	60,783	321,264	382,047	64.00
65.00	06500	RESPIRATORY THERAPY	67,903	34,713	102,616	65.00
66.00	06600	PHYSICAL THERAPY	429,940	2,090,701	2,520,641	66.00
67.00	06700	OCCUPATIONAL THERAPY	153,961	45,945	199,906	67.00
68.00	06800	SPEECH PATHOLOGY	21,594	50,644	72,238	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	34,191	346,748	380,939	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	600,881	724,341	1,325,222	73.00
76.00	03020	SLEEP LAB	0	43,521	43,521	76.00
76.01	03950	PAIN CLINIC / SERVICE	0	0	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	8,814	0	8,814	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,169,074	2,169,074	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	129,542	129,542	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	45,521	45,521	90.00
91.00	09100	EMERGENCY	84,148	1,889,033	1,973,181	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,000	88,154	90,154	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	111.00
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)	7,733,402	18,634,618	26,368,020	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	7,733,402	18,634,618	26,368,020	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet C
Part I
Date/Time Prepared:
2/5/2017 2:36 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
41.00	04100 SUBPROVIDER - IRF				41.00
42.00	04200 SUBPROVIDER				42.00
44.00	04400 SKILLED NURSING FACILITY				44.00
46.00	04600 OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000 LABORATORY	0.000000			60.00
60.01	06001 BLOOD LABORATORY	0.000000			60.01
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03020 SLEEP LAB	0.000000			76.00
76.01	03950 PAIN CLINIC / SERVICE	0.000000			76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0.000000			76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000			88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000			88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
93.00	04040 FAMILY PRACTICE	0.000000			93.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910 CORF				99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900 PANCREAS ACQUISITION				109.00
110.00	11000 INTESTINAL ACQUISITION				110.00
111.00	11100 ISLET ACQUISITION				111.00
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet D
Part II
Date/Time Prepared:
2/5/2017 2:36 pm

Cost Center Description	Title XVIII			Hospital	Cost	
	Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	694,583	1,834,323	0.378659	0	0	50.00
53.00 05300 ANESTHESIOLOGY	27,081	419,467	0.064561	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	590,458	5,393,154	0.109483	30,232	3,310	54.00
57.00 05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00 06000 LABORATORY	153,179	3,343,888	0.045809	69,661	3,191	60.00
60.01 06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
64.00 06400 INTRAVENOUS THERAPY	5,848	382,047	0.015307	31,767	486	64.00
65.00 06500 RESPIRATORY THERAPY	21,525	102,616	0.209763	23,793	4,991	65.00
66.00 06600 PHYSICAL THERAPY	504,806	2,520,641	0.200269	20,288	4,063	66.00
67.00 06700 OCCUPATIONAL THERAPY	39,915	199,906	0.199669	5,275	1,053	67.00
68.00 06800 SPEECH PATHOLOGY	1,597	72,238	0.022107	491	11	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5,278	380,939	0.013855	10,130	140	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	107,562	1,325,222	0.081165	89,727	7,283	73.00
76.00 03020 SLEEP LAB	14,546	43,521	0.334229	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	410	8,814	0.046517	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	703,541	2,169,074	0.324351	0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	5,702	129,542	0.044017	0	0	88.01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00 09000 CLINIC	12,105	45,521	0.265921	0	0	90.00
91.00 09100 EMERGENCY	585,801	1,973,181	0.296882	15,418	4,577	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	60,103	90,154	0.666670	1,176	784	92.00
93.00 04040 FAMILY PRACTICE	0	0	0.000000	0	0	93.00
200.00 Total (lines 50-199)	3,534,040	20,434,248		297,958	29,889	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet D
Part IV
Date/Time Prepared:
2/5/2017 2:36 pm

Cost Center Description	Title XVIII				Hospital	Cost
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 03020 SLEEP LAB	0	0	0	0	0	76.00
76.01 03950 PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02 03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04040 FAMILY PRACTICE	0	0	0	0	0	93.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet D
Part IV
Date/Time Prepared:
2/5/2017 2:36 pm

Cost Center Description		Title XVIII			Hospital		Cost
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	1,834,323	0.000000	0.000000	0	50.00
53.00	05300 ANESTHESIOLOGY	0	419,467	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	5,393,154	0.000000	0.000000	30,232	54.00
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	3,343,888	0.000000	0.000000	69,661	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	382,047	0.000000	0.000000	31,767	64.00
65.00	06500 RESPIRATORY THERAPY	0	102,616	0.000000	0.000000	23,793	65.00
66.00	06600 PHYSICAL THERAPY	0	2,520,641	0.000000	0.000000	20,288	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	199,906	0.000000	0.000000	5,275	67.00
68.00	06800 SPEECH PATHOLOGY	0	72,238	0.000000	0.000000	491	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	380,939	0.000000	0.000000	10,130	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,325,222	0.000000	0.000000	89,727	73.00
76.00	03020 SLEEP LAB	0	43,521	0.000000	0.000000	0	76.00
76.01	03950 PAIN CLINIC / SERVICE	0	0	0.000000	0.000000	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	8,814	0.000000	0.000000	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	2,169,074	0.000000	0.000000	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	129,542	0.000000	0.000000	0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000 CLINIC	0	45,521	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	1,973,181	0.000000	0.000000	15,418	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	90,154	0.000000	0.000000	1,176	92.00
93.00	04040 FAMILY PRACTICE	0	0	0.000000	0.000000	0	93.00
200.00	Total (lines 50-199)	0	20,434,248			297,958	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet D
Part IV
Date/Time Prepared:
2/5/2017 2:36 pm

Cost Center Description		Title XVIII			Hospital	Cost
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
60.01	06001 BLOOD LABORATORY	0	0	0		60.01
64.00	06400 INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	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	0	0		88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	0		88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	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
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet D
Part V
Date/Time Prepared:
2/5/2017 2:36 pm

		Title XVIII		Hospital		Cost	
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Charges		Costs		
			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	0.807750	0	724,696	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.523414	0	161,927	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.357954	0	1,832,466	0	0	54.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.356332	0	1,302,431	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0.123477	0	96,899	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.586127	0	13,939	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.826495	0	1,004,097	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.868473	0	23,702	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.581813	0	20,412	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.265239	0	147,807	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	0.492806	0	254,182	3,382	0	73.00
76.00	03020 SLEEP LAB	1.217964	0	13,970	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	1.450874	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000				0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000 CLINIC	4.970805	0	14,606	0	0	90.00
91.00	09100 EMERGENCY	1.317615	0	783,702	1,981	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.791501	0	60,567	0	0	92.00
93.00	04040 FAMILY PRACTICE	0.000000	0	0	0	0	93.00
200.00	Subtotal (see instructions)		0	6,455,403	5,363	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		0	6,455,403	5,363	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1302	Period: From 10/01/2015 To 09/30/2016	Worksheet D Part V Date/Time Prepared: 2/5/2017 2:36 pm
Title XVIII		Hospital	Cost

Cost Center Description	Costs		Hospital	Cost
	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	585,373	0		50.00
53.00 05300 ANESTHESIOLOGY	84,755	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	655,939	0		54.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	464,098	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
64.00 06400 INTRAVENOUS THERAPY	11,965	0		64.00
65.00 06500 RESPIRATORY THERAPY	8,170	0		65.00
66.00 06600 PHYSICAL THERAPY	829,881	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	20,585	0		67.00
68.00 06800 SPEECH PATHOLOGY	11,876	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	39,204	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	125,262	1,667		73.00
76.00 03020 SLEEP LAB	17,015	0		76.00
76.01 03950 PAIN CLINIC / SERVICE	0	0		76.01
76.02 03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0		76.02
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0		88.01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00 09000 CLINIC	72,604	0		90.00
91.00 09100 EMERGENCY	1,032,618	2,610		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	108,506	0		92.00
93.00 04040 FAMILY PRACTICE	0	0		93.00
200.00 Subtotal (see instructions)	4,067,851	4,277		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	4,067,851	4,277		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet D
Part V
Date/Time Prepared:
2/5/2017 2:36 pm

Component CCN: 14-Z302

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	0.807750	0	0	0	0 50.00
53.00 05300 ANESTHESIOLOGY	0.523414	0	0	0	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.357954	0	0	0	0 54.00
57.00 05700 CT SCAN	0.000000	0	0	0	0 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0 59.00
60.00 06000 LABORATORY	0.356332	0	0	0	0 60.00
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0 60.01
64.00 06400 INTRAVENOUS THERAPY	0.123477	0	0	0	0 64.00
65.00 06500 RESPIRATORY THERAPY	0.586127	0	0	0	0 65.00
66.00 06600 PHYSICAL THERAPY	0.826495	0	0	0	0 66.00
67.00 06700 OCCUPATIONAL THERAPY	0.868473	0	0	0	0 67.00
68.00 06800 SPEECH PATHOLOGY	0.581813	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	0.265239	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	0.492806	0	0	0	0 73.00
76.00 03020 SLEEP LAB	1.217964	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	1.450874	0	0	0	0 76.02
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0 88.00
88.01 08801 RURAL HEALTH CLINIC II	0.000000				0 88.01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0 89.00
90.00 09000 CLINIC	4.970805	0	0	0	0 90.00
91.00 09100 EMERGENCY	1.317615	0	0	0	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.791501	0	0	0	0 92.00
93.00 04040 FAMILY PRACTICE	0.000000				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:
From 10/01/2015
To 09/30/2016

Worksheet D
Part V
Date/Time Prepared:
2/5/2017 2:36 pm

Component CCN: 14-z302

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Costs		Swing Beds - SNF	Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00 03020 SLEEP LAB	0	0		76.00
76.01 03950 PAIN CLINIC / SERVICE	0	0		76.01
76.02 03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0		76.02
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0		88.01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00 04040 FAMILY PRACTICE	0	0		93.00
200.00 Subtotal (see instructions)	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	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 10/01/2015
To 09/30/2016

Worksheet D
Part IV
Date/Time Prepared:
2/5/2017 2:36 pm

Title XVIII

Skilled Nursing Facility

PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020 SLEEP LAB	0	0	0	0	0	76.00
76.01	03950 PAIN CLINIC / SERVICE	0	0	0	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0	0	0	93.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS
 Provider CCN: 14-1302
 Component CCN: 14-6140
 Period: From 10/01/2015 To 09/30/2016
 Worksheet D Part IV
 Date/Time Prepared: 2/5/2017 2:36 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	PPS
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	1,834,323	0.000000	0.000000	0	50.00
53.00	05300 ANESTHESIOLOGY	0	419,467	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	5,393,154	0.000000	0.000000	0	54.00
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	3,343,888	0.000000	0.000000	43	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	382,047	0.000000	0.000000	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	102,616	0.000000	0.000000	0	65.00
66.00	06600 PHYSICAL THERAPY	0	2,520,641	0.000000	0.000000	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	199,906	0.000000	0.000000	2,775	67.00
68.00	06800 SPEECH PATHOLOGY	0	72,238	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	380,939	0.000000	0.000000	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,325,222	0.000000	0.000000	5,443	73.00
76.00	03020 SLEEP LAB	0	43,521	0.000000	0.000000	0	76.00
76.01	03950 PAIN CLINIC / SERVICE	0	0	0.000000	0.000000	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	0	8,814	0.000000	0.000000	6,058	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	2,169,074	0.000000	0.000000	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	129,542	0.000000	0.000000	0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000 CLINIC	0	45,521	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	1,973,181	0.000000	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	90,154	0.000000	0.000000	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0.000000	0.000000	0	93.00
200.00	Total (lines 50-199)	0	20,434,248			14,319	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1302 Component CCN: 14-6140	Period: From 10/01/2015 To 09/30/2016	Worksheet D Part IV Date/Time Prepared: 2/5/2017 2:36 pm
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0	0	50.00
53.00 05300 ANESTHESIOLOGY	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
57.00 05700 CT SCAN	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	60.01
64.00 06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	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	0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0	0	88.01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00 09000 CLINIC	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	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
200.00 Total (lines 50-199)	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1302	Period: From 10/01/2015 To 09/30/2016	Worksheet D-1
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,052 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			398 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)			319 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			272 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)			1,112 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			44 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)			226 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			221 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)			272 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)			956 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)			3,681,020 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)			6,160 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)			31,640 25.00
26.00	Total swing-bed cost (see instructions)			2,867,333 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			813,687 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)			813,687 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			2,044.46 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			451,826 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)			451,826 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet D-1

Date/Time Prepared:
2/5/2017 2:36 pm

Cost Center Description	Title XVIII			Hospital	Cost
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					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)					144,474
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					596,300
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00 Total Program excludable cost (sum of lines 50 and 51)					0
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00 Relief payment (see instructions)					0
63.00 Allowable inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					556,093
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					1,954,504
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					2,510,597
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					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)					79
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,044.44
89.00 Observation bed cost (line 87 x line 88) (see instructions)					161,511

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet D-1

Date/Time Prepared:
2/5/2017 2:36 pm

Cost Center Description	Cost	Title XVIII		Hospital		Cost
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	1,369,819	3,681,020	0.372130	161,511	60,103	90.00
91.00 Nursing School cost	0	3,681,020	0.000000	161,511	0	91.00
92.00 Allied health cost	0	3,681,020	0.000000	161,511	0	92.00
93.00 All other Medical Education	0	3,681,020	0.000000	161,511	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1302 Component CCN: 14-6140	Period: From 10/01/2015 To 09/30/2016	Worksheet D-1 Date/Time Prepared: 2/5/2017 2:36 pm
	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)	41	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	41	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)	41	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)	39	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)	38,697	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)	38,697	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)	38,697	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 10/01/2015 To 09/30/2016		Worksheet D-1	
		Component CCN: 14-6140				Date/Time Prepared: 2/5/2017 2:36 pm	
		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)				38,697		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				943.83		71.00
72.00	Program routine service cost (line 9 x line 71)				36,809		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)				36,809		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)				36,809		83.00
84.00	Program inpatient ancillary services (see instructions)				13,896		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)				50,705		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 10/01/2015
 To 09/30/2016

Worksheet D-1
 Date/Time Prepared:
 2/5/2017 2:36 pm

Title XVIII

Skilled Nursing
 Facility

PPS

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider CCN: 14-1302 Period: From 10/01/2015 To 09/30/2016 Worksheet D-3
 Date/Time Prepared: 2/5/2017 2:36 pm

Cost Center Description		Title XVIII	Hospital	Cost
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		265,999	30.00
41.00	04100 SUBPROVIDER - IRF		0	41.00
42.00	04200 SUBPROVIDER		0	42.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.807750	0	50.00
53.00	05300 ANESTHESIOLOGY	0.523414	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.357954	30,232	54.00
57.00	05700 CT SCAN	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000 LABORATORY	0.356332	69,661	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0.123477	31,767	64.00
65.00	06500 RESPIRATORY THERAPY	0.586127	23,793	65.00
66.00	06600 PHYSICAL THERAPY	0.826495	20,288	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.868473	5,275	67.00
68.00	06800 SPEECH PATHOLOGY	0.581813	491	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.265239	10,130	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.492806	89,727	73.00
76.00	03020 SLEEP LAB	1.217964	0	76.00
76.01	03950 PAIN CLINIC / SERVICE	0.000000	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	1.450874	0	76.02
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000	0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000 CLINIC	4.970805	0	90.00
91.00	09100 EMERGENCY	1.317615	15,418	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.791501	1,176	92.00
93.00	04040 FAMILY PRACTICE	0.000000	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		297,958	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)		297,958	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 14-1302	Period: From 10/01/2015 To 09/30/2016	Worksheet D-3
	Component CCN: 14-Z302		Date/Time Prepared: 2/5/2017 2:36 pm

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.807750	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.523414	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.357954	78,118	27,963	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.356332	101,206	36,063	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0.123477	19,275	2,380	64.00
65.00	06500 RESPIRATORY THERAPY	0.586127	30,711	18,001	65.00
66.00	06600 PHYSICAL THERAPY	0.826495	326,869	270,156	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.868473	114,639	99,561	67.00
68.00	06800 SPEECH PATHOLOGY	0.581813	13,591	7,907	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.265239	17,160	4,552	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.492806	337,934	166,536	73.00
76.00	03020 SLEEP LAB	1.217964	0	0	76.00
76.01	03950 PAIN CLINIC / SERVICE	0.000000	0	0	76.01
76.02	03530 SNF PHYSICAL THERAPY - SCC THERAPY	1.450874	0	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLINIC	4.970805	0	0	90.00
91.00	09100 EMERGENCY	1.317615	2,776	3,658	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.791501	0	0	92.00
93.00	04040 FAMILY PRACTICE	0.000000	0	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		1,042,279	636,777	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)		1,042,279		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1302	Period: From 10/01/2015 To 09/30/2016	Worksheet D-3	
		Component CCN: 14-6140		Date/Time Prepared: 2/5/2017 2:36 pm	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.807750	0	50.00
53.00	05300	ANESTHESIOLOGY	0.523414	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.357954	0	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.356332	43	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.123477	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.586127	0	65.00
66.00	06600	PHYSICAL THERAPY	0.826495	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.868473	2,775	67.00
68.00	06800	SPEECH PATHOLOGY	0.581813	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.265239	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.492806	5,443	73.00
76.00	03020	SLEEP LAB	1.217964	0	76.00
76.01	03950	PAIN CLINIC / SERVICE	0.000000	0	76.01
76.02	03530	SNF PHYSICAL THERAPY - SCC THERAPY	1.450874	6,058	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	4.970805	0	90.00
91.00	09100	EMERGENCY	1.317615	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.791501	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		14,319	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)		14,319	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1302	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part B Date/Time Prepared: 2/5/2017 2:36 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		4,072,128	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
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 line 3 plus line 4 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)		4,072,128	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		4,112,849	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, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		22,993	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,007,116	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)		3,082,740	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)		3,082,740	30.00
31.00	Primary payer payments		724	31.00
32.00	Subtotal (line 30 minus line 31)		3,082,016	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)		22,931	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		14,905	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		10,328	36.00
37.00	Subtotal (see instructions)		3,096,921	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
39.98	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)		3,096,921	40.00
40.01	Sequestration adjustment (see instructions)		61,938	40.01
41.00	Interim payments		3,352,906	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-317,923	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1302	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part B Date/Time Prepared: 2/5/2017 2:36 pm
		Component CCN: 14-6140		
		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	PPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
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 line 3 plus line 4 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)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH 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, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance 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)		0	39.50
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
41.00	Interim payments		0	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet E-1
Part I
Date/Time Prepared:
2/5/2017 2:36 pm

		Title XVIII		Hospital	Cost	
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		527,481		3,256,440	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	04/26/2016	49,113	3.01
3.02			0	09/20/2016	47,353	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	04/26/2016	42,845		0	3.50
3.51		09/20/2016	13,040		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)		-55,885		96,466	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)		471,596		3,352,906	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		47,600		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		317,923	6.02
7.00	Total Medicare program liability (see instructions)		519,196		3,034,983	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: From 10/01/2015

Worksheet E-1

Component CCN: 14-Z302

To 09/30/2016

Part I

Date/Time Prepared: 2/5/2017 2:36 pm

		Title XVIII		Swing Beds - SNF	Cost	
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,894,906		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	04/26/2016	96,634		0	3.50
3.51		09/20/2016	67,329		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)		-163,963		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)		2,730,943		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		350,614		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,081,557		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 10/01/2015
To 09/30/2016

Worksheet E-1
Part I
Date/Time Prepared:
2/5/2017 2:36 pm

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		13,175		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)		13,175		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		1		0	6.02
7.00	Total Medicare program liability (see instructions)		13,174		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
				1.00	2.00	
8.00	Name of Contractor		0			8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet E-1
Part II
Date/Time Prepared:
2/5/2017 2:36 pm

		Title XVIII	Hospital	Cost	
				1.00	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from wkst. S-3, Pt. I col. 15 line 14			104	1.00
2.00	Medicare days from wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			221	2.00
3.00	Medicare HMO days from wkst. S-3, Pt. I, col. 6. line 2			35	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			319	4.00
5.00	Total hospital charges from wkst C, Pt. I, col. 8 line 200			26,368,020	5.00
6.00	Total hospital charity care charges from wkst. S-10, col. 3 line 20			119,655	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology wkst. S-2, Pt. I line 168			1	7.00
8.00	Calculation of the HIT incentive payment (see instructions)			1	8.00
9.00	Sequestration adjustment amount (see instructions)			0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			1	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30.00
31.00	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			1	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1302

Period:

Worksheet E-2

Component CCN: 14-Z302

From 10/01/2015
To 09/30/2016Date/Time Prepared:
2/5/2017 2:36 pm

		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		2,535,703	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from wkst. D-3, col. 3, line 200, for Part A, and sum of wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)		643,145	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		1,228	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)		3,178,848	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		3,178,848	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)		3,178,848	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		34,402	0	13.00
14.00	80% of Part B costs (line 12 x 80%)				14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		3,144,446	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT		0		16.55
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)		3,144,446	0	19.00
19.01	Sequestration adjustment (see instructions)		62,889	0	19.01
20.00	Interim payments		2,730,943	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		350,614	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1302	Period: From 10/01/2015 To 09/30/2016	Worksheet E-3 Part V Date/Time Prepared: 2/5/2017 2:36 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			596,300 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)			596,300 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			602,263 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)			602,263 19.00
20.00	Deductibles (exclude professional component)			70,420 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			531,843 22.00
23.00	Coinsurance			4,508 23.00
24.00	Subtotal (line 22 minus line 23)			527,335 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			3,780 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			2,457 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			1,260 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			529,792 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 29.50
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (see instructions)			529,792 30.00
30.01	Sequestration adjustment (see instructions)			10,596 30.01
31.00	Interim payments			471,596 31.00
32.00	Tentative settlement (for contractor use only)			0 32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)			47,600 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1302	Period: From 10/01/2015	Worksheet E-3 Part VI Date/Time Prepared: 2/5/2017 2:36 pm
	Component CCN: 14-6140	To 09/30/2016	
	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)		13,443	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)		13,443	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)		13,443	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (see instructions)		13,443	15.00
15.01	Sequestration adjustment (see instructions)		269	15.01
16.00	Interim payments		13,175	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, 16, and 17)		-1	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 10/01/2015
To 09/30/2016

Worksheet G

Date/Time Prepared:
2/5/2017 2:36 pm

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00	Cash on hand in banks	1,873,016	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	6,865,783	0	0	0 4.00
5.00	Other receivable	104,160	0	0	0 5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,414,992	0	0	0 6.00
7.00	Inventory	359,938	0	0	0 7.00
8.00	Prepaid expenses	288,084	0	0	0 8.00
9.00	Other current assets	0	0	0	0 9.00
10.00	Due from other funds	0	0	0	0 10.00
11.00	Total current assets (sum of lines 1-10)	7,075,989	0	0	0 11.00
FIXED ASSETS					
12.00	Land	448,597	0	0	0 12.00
13.00	Land improvements	3,740,813	0	0	0 13.00
14.00	Accumulated depreciation	-2,078,885	0	0	0 14.00
15.00	Buildings	38,287,471	0	0	0 15.00
16.00	Accumulated depreciation	-16,262,125	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	7,807,275	0	0	0 23.00
24.00	Accumulated depreciation	-6,230,864	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	2,556,630	0	0	0 27.00
28.00	Accumulated depreciation	-904,309	0	0	0 28.00
29.00	Minor equipment-nondepreciable	36,153	0	0	0 29.00
30.00	Total fixed assets (sum of lines 12-29)	27,400,756	0	0	0 30.00
OTHER ASSETS					
31.00	Investments	7,382,508	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	1,578,928	0	0	0 34.00
35.00	Total other assets (sum of lines 31-34)	8,961,436	0	0	0 35.00
36.00	Total assets (sum of lines 11, 30, and 35)	43,438,181	0	0	0 36.00
CURRENT LIABILITIES					
37.00	Accounts payable	635,041	0	0	0 37.00
38.00	Salaries, wages, and fees payable	2,054,879	0	0	0 38.00
39.00	Payroll taxes payable	0	0	0	0 39.00
40.00	Notes and loans payable (short term)	565,707	0	0	0 40.00
41.00	Deferred income	1,267,749	0	0	0 41.00
42.00	Accelerated payments	0	0	0	0 42.00
43.00	Due to other funds	25,000	0	0	0 43.00
44.00	Other current liabilities	0	0	0	0 44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,548,376	0	0	0 45.00
LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0 46.00
47.00	Notes payable	43,598,315	0	0	0 47.00
48.00	Unsecured loans	0	0	0	0 48.00
49.00	Other long term liabilities	0	0	0	0 49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	43,598,315	0	0	0 50.00
51.00	Total liabilities (sum of lines 45 and 50)	48,146,691	0	0	0 51.00
CAPITAL ACCOUNTS					
52.00	General fund balance	-4,708,510			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)	-4,708,510	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	43,438,181	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet G-1

Date/Time Prepared:
2/5/2017 2:36 pm

	General Fund		Special Purpose Fund		Endowment Fund	
	1.00	2.00	3.00	4.00	5.00	
	1.00	Fund balances at beginning of period				
2.00	Net income (loss) (from wkst. G-3, line 29)		-5,037,871		0	2.00
3.00	Total (sum of line 1 and line 2)		294,523		0	3.00
4.00	Additions (credit adjustments) (specify)		-4,743,348		0	4.00
5.00	RESTRICTED INVESTMENT INCOME	34,838		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)	34,838		0	0	10.00
11.00	Subtotal (line 3 plus line 10)		-4,708,510		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0	0	12.00
13.00	ROUNDING	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)		-4,708,510		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	RESTRICTED INVESTMENT INCOME		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	ROUNDING		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 10/01/2015
To 09/30/2016

Worksheet G-2
Parts I & II
Date/Time Prepared:
2/5/2017 2:36 pm

Cost Center Description	Inpatient	Outpatient	Total	
	1.00	2.00	3.00	
PART I - PATIENT REVENUES				
General Inpatient Routine Services				
1.00 Hospital	1,711,273		1,711,273	1.00
2.00 SUBPROVIDER - IPF				2.00
3.00 SUBPROVIDER - IRF	0		0	3.00
4.00 SUBPROVIDER	0		0	4.00
5.00 Swing bed - SNF	0		0	5.00
6.00 Swing bed - NF	0		0	6.00
7.00 SKILLED NURSING FACILITY	27,294		27,294	7.00
8.00 NURSING FACILITY				8.00
9.00 OTHER LONG TERM CARE	4,195,205		4,195,205	9.00
10.00 Total general inpatient care services (sum of lines 1-9)	5,933,772		5,933,772	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)	5,933,772		5,933,772	17.00
18.00 Ancillary services	1,798,561	0	1,798,561	18.00
19.00 Outpatient services	0	16,290,480	16,290,480	19.00
20.00 RURAL HEALTH CLINIC	0	2,169,311	2,169,311	20.00
20.01 RURAL HEALTH CLINIC II	0	129,542	129,542	20.01
21.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULANCE SERVICES				23.00
24.00 CMHC				24.00
24.10 CORF	0	0	0	24.10
25.00 AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00 HOSPICE				26.00
27.00 PROFESSIONAL FEES	0	3,279,236	3,279,236	27.00
28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	7,732,333	21,868,569	29,600,902	28.00
PART II - OPERATING EXPENSES				
29.00 Operating expenses (per Wkst. A, column 3, line 200)		23,249,196		29.00
30.00 ADD (SPECIFY)	0			30.00
31.00 PROVISION FOR BAD DEBTS	798,088			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)		798,088		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)		24,047,284		43.00

Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet G-3

Date/Time Prepared:
2/5/2017 2:36 pm

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	29,600,902	1.00
2.00	Less contractual allowances and discounts on patients' accounts	7,721,834	2.00
3.00	Net patient revenues (line 1 minus line 2)	21,879,068	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	24,047,284	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,168,216	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	67,961	6.00
7.00	Income from investments	20,770	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	258,979	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	191,864	17.00
18.00	Revenue from sale of medical records and abstracts	5,156	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	32,047	22.00
23.00	Governmental appropriations	15,440	23.00
24.00	AQUATICS REVENUE	20,298	24.00
24.01	ASSISTED LIVING UNITS	703,957	24.01
24.02	ADULT DAY CARE PROGRAM	238,374	24.02
24.03	FITNESS CENTER REVENUE	155,144	24.03
24.04	GRANT REVENUE	395,585	24.04
24.05	MISCELLANEOUS REVENUE	97,502	24.05
24.06	GAIN ON SALE OF EQUIPMENT	259,662	24.06
25.00	Total other income (sum of lines 6-24)	2,462,739	25.00
26.00	Total (line 5 plus line 25)	294,523	26.00
27.00		0	27.00
27.01		0	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	294,523	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1302

Period: From 10/01/2015

Worksheet M-1

Component CCN: 14-8511

To 09/30/2016

Date/Time Prepared: 2/5/2017 2:36 pm

		RHC I		Cost			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	747,178	0	747,178	-49,097	698,081	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	157,398	0	157,398	-18,297	139,101	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	274,143	0	274,143	0	274,143	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	206,989	206,989	-32,341	174,648	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,178,719	206,989	1,385,708	-99,735	1,285,973	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	9,220	9,220	0	9,220	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	9,220	9,220	0	9,220	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,178,719	216,209	1,394,928	-99,735	1,295,193	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	710	710	29.00
30.00	Administrative Costs	128,368	155,591	283,959	0	283,959	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	128,368	155,591	283,959	710	284,669	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,307,087	371,800	1,678,887	-99,025	1,579,862	32.00

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC I	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	-43,221	654,860		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	139,101		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	274,143		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	174,648		9.00
10.00	Subtotal (sum of lines 1 through 9)	-43,221	1,242,752		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	9,220		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	9,220		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-43,221	1,251,972		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	-1	709		29.00
30.00	Administrative Costs	0	283,959		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-1	284,668		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-43,222	1,536,640		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1302

Period: From 10/01/2015

Worksheet M-1

Component CCN: 14-8557

To 09/30/2016

Date/Time Prepared: 2/5/2017 2:36 pm

		RHC II		Cost			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	58,004	0	58,004	0	58,004	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	2,774	0	2,774	0	2,774	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	21,064	0	21,064	0	21,064	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	2,348	2,348	0	2,348	9.00
10.00	Subtotal (sum of lines 1 through 9)	81,842	2,348	84,190	0	84,190	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	1,085	1,085	0	1,085	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,085	1,085	0	1,085	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	81,842	3,433	85,275	0	85,275	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	123	566	689	0	689	29.00
30.00	Administrative Costs	5,411	15,389	20,800	6,940	27,740	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	5,534	15,955	21,489	6,940	28,429	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	87,376	19,388	106,764	6,940	113,704	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1302

Period:
From 10/01/2015
To 09/30/2016

Worksheet M-1

Component CCN: 14-8557

Date/Time Prepared:
2/5/2017 2:36 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC II	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	58,004		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	2,774		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	-5,842	15,222		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	2,348		9.00
10.00	Subtotal (sum of lines 1 through 9)	-5,842	78,348		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	1,085		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	1,085		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-5,842	79,433		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	689		29.00
30.00	Administrative Costs	0	27,740		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	28,429		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-5,842	107,862		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1302

Period: From 10/01/2015

Worksheet M-2

Component CCN: 14-8511

To 09/30/2016

Date/Time Prepared: 2/5/2017 2:36 pm

		RHC I				Cost
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
		1.00	2.00	3.00	4.00	5.00
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	2.51	7,458	3,660	9,187	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.87	2,163	2,100	1,827	3.00
4.00	Subtotal (sum of lines 1 through 3)	3.38	9,621		11,014	4.00
5.00	Visiting Nurse	0.00	0			5.00
6.00	Clinical Psychologist	0.00	0			6.00
7.00	Clinical Social Worker	0.00	0			7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.38	9,621			8.00
9.00	Physician Services Under Agreements		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)					1,251,972
11.00	Total nonreimbursable costs (from wkst. M-1, col. 7, line 28)					0
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,251,972
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000
14.00	Total hospital-based RHC/FQHC overhead - (from worksheet. M-1, col. 7, line 31)					284,668
15.00	Parent provider overhead allocated to facility (see instructions)					1,278,878
16.00	Total overhead (sum of lines 14 and 15)					1,563,546
17.00	Allowable GME overhead (see instructions)					0
18.00	Enter the amount from line 16					1,563,546
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,563,546
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,815,518

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1302

Period: From 10/01/2015

Worksheet M-2

Component CCN: 14-8557

To 09/30/2016

Date/Time Prepared: 2/5/2017 2:36 pm

		RHC II				Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.12	477	4,200	504		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.03	78	2,100	63		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.15	555		567	567	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)	0.15	555			567	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)					79,433	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)					79,433	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)					28,429	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					34,955	15.00
16.00	Total overhead (sum of lines 14 and 15)					63,384	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					63,384	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					63,384	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					142,817	20.00

Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1302 Component CCN: 14-8511	Period: From 10/01/2015 To 09/30/2016	Worksheet M-3 Date/Time Prepared: 2/5/2017 2:36 pm
		Title XVIII	RHC I	Cost
				1.00
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,815,518 1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			132,480 2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,683,038 3.00
4.00	Total visits (from Wkst. M-2, column 5, line 8)			11,014 4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0 5.00
6.00	Total adjusted visits (line 4 plus line 5)			11,014 6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			243.60 7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	80.44	81.32	8.00
9.00	Rate for Program covered visits (see instructions)	243.60	243.60	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	2,454	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	597,794	0	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	597,794	16.00
16.01	Total program charges (see instructions)(from contractor's records)		532,144	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		10,630	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		11,942	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.)		437,398	16.04
16.05	Total program cost (see instructions)	0	449,340	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		39,104	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		96,482	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		449,340	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		54,851	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		504,191	22.00
23.00	Allowable bad debts (see instructions)		1,785	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		1,160	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
26.00	Net reimbursable amount (see instructions)		505,351	26.00
26.01	Sequestration adjustment (see instructions)		10,107	26.01
27.00	Interim payments		458,670	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, 27, and 28)		36,574	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	Period: From 10/01/2015 To 09/30/2016	Worksheet M-3
	Component CCN: 14-8557		Date/Time Prepared: 2/5/2017 2:36 pm

		Title XVIII	RHC II	Cost
				1.00
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			142,817 1.00
2.00	Cost of vaccines and their administration (from wkst. M-4, line 15)			594 2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			142,223 3.00
4.00	Total Visits (from wkst. M-2, column 5, line 8)			567 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)			567 6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			250.83 7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	80.44	81.32	8.00
9.00	Rate for Program covered visits (see instructions)	250.83	250.83	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	47	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	11,789	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	11,789	16.00
16.01	Total program charges (see instructions)(from contractor's records)		10,000	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		9,431	16.04
16.05	Total program cost (see instructions)	0	9,431	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		0	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		196	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		9,431	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		594	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		10,025	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
26.00	Net reimbursable amount (see instructions)		10,025	26.00
26.01	Sequestration adjustment (see instructions)		201	26.01
27.00	Interim payments		2,350	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, 27, and 28)		7,474	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

Health Financial Systems

MIDWEST MEDICAL CENTER

In Lieu of Form CMS-2552-10

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1302 Component CCN: 14-8511	Period: From 10/01/2015 To 09/30/2016	Worksheet M-4 Date/Time Prepared: 2/5/2017 2:36 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from wkst. M-1, col. 7, line 10)		1,242,752	1,242,752	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001276	0.001987	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		1,586	2,469	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		44,070	10,785	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		45,656	13,254	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from worksheet M-1, col. 7, line 22)		1,251,972	1,251,972	6.00
7.00	Total overhead (from wkst. M-2, line 19)		1,563,546	1,563,546	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.036467	0.010586	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		57,018	16,552	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		102,674	29,806	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		321	500	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		319.86	59.61	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		118	287	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		37,743	17,108	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to wkst. M-3, line 2)			132,480	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to wkst. M-3, line 21)			54,851	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1302 Component CCN: 14-8557	Period: From 10/01/2015 To 09/30/2016	Worksheet M-4 Date/Time Prepared: 2/5/2017 2:36 pm
		Title XVIII	RHC II	Cost
			Pneumococcal 1.00	Influenza 2.00
1.00	Health care staff cost (from wkst. M-1, col. 7, line 10)		78,348	78,348 1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000127	0.000064 2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		10	5 3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		294	21 4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		304	26 5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from worksheet M-1, col. 7, line 22)		79,433	79,433 6.00
7.00	Total overhead (from wkst. M-2, line 19)		63,384	63,384 7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.003827	0.000327 8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		243	21 9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		547	47 10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		2	1 11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		273.50	47.00 12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		2	1 13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		547	47 14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to wkst. M-3, line 2)			594 15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to wkst. M-3, line 21)			594 16.00

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 10/01/2015
To 09/30/2016

worksheet M-5
Date/Time Prepared:
2/5/2017 2:36 pm

		RHC II	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		39	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		2,311	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to worksheet M-3, line 27)		2,350	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		7,474	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		9,824	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00