

State Copy

Health Financial Systems

HAMMOND-HENRY HOSPITAL

In Lieu of Form CMS-2552-10

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

OMB NO. 0938-0050

EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1319	Period: From 06/01/2018 To 05/31/2019	Worksheet S Parts I-III Date/Time Prepared: 10/25/2019 8:36 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 10/25/2019	Time: 8:36 am
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☒ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.
	(3) Settled with Audit	9. ☒ Final Report for this Provider CCN	
	(4) Reopened		
	(5) Amended		

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HAMMOND-HENRY HOSPITAL (14-1319) for the cost reporting period beginning 06/01/2018 and ending 05/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-56,961	-673,411	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-69,504	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	-1	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	1		0	9.00
10.00	KEWANEE RHC I	0		270,945		0	10.00
10.01	WYOMING RHC II	0		44,947		0	10.01
10.02	GENESEO RHC III	0		12,868		0	10.02
200.00	Total	0	-126,466	-344,650	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 14-1319		Period: From 06/01/2018 To 05/31/2019		Worksheet S-2 Part I Date/Time Prepared: 10/25/2019 8:36 am	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 600 N. COLLEGE AVENUE			PO Box:		1.00				
2.00	City: GENESEO			State: IL		Zip Code: 61254-1099		County: HENRY		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	XIX
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		HAMMOND-HENRY HOSPITAL	141319	19340	1	06/04/2002	N	O	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		HAMMOND-HENRY SWING BED	142319	99914		05/21/2003	N	O	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF		HAMMOND-HENRY SKILLED NURSING	145464	99914		06/01/1983	N	P	N
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA		HAMMOND-HENRY HOME HEALTH SERVICES	147450	99914		06/05/1986	N	P	N
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		HAMMOND-HENRY HOSPITAL RHP-KEWANEE	148576	99914		05/01/2017	N	O	N
15.01	Hospital-Based Health Clinic - RHC II		HAMMOND-HENRY HOSPITAL RHP-WYOMING	148577	99914		05/01/2017	N	O	N
15.02	Hospital-Based Health Clinic - RHC III		HAMMOND-HENRY HOSPITAL RHP-GENESEO	148587	99914		05/16/2018	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
17.10	Hospital-Based (CORF) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						06/01/2018	05/31/2019		20.00
21.00	Type of Control (see instructions)						11			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1319		Period: From 06/01/2018 To 05/31/2019		Worksheet S-2 Part I Date/Time Prepared: 10/25/2019 8:36 am			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00	
					Urban/Rural S	Date of Geogr			
					1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2						26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2						27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0						35.00	
					Beginning:	Ending:			
					1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0						37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
					Y/N	Y/N			
					1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N					N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N					N	40.00	
					V	XVIII	XIX		
					1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N					N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N					N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.	N					N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N					N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N							56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N							58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N							59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 14-1319		Period: From 06/01/2018 To 05/31/2019		Worksheet S-2 Part I Date/Time Prepared: 10/25/2019 8:36 am	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
			1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)		N			60.00		
			Y/N	IME	Direct GME	IME	Direct GME	
			1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)							61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)							61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)							61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).							61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)							61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)							61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
			1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20	
							1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)								
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01	
Teaching Hospitals that Claim Residents in Nonprovider Settings								
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00	
					Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
					1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.								
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019Worksheet S-2
Part I
Date/Time Prepared:
10/25/2019 8:36 am

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

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			1.00	2.00	3.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		Y		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00

MCRIF32 - 15.8.166.2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1319		Period: From 06/01/2018 To 05/31/2019		Worksheet S-2 Part I Date/Time Prepared: 10/25/2019 8:36 am	
		1.00		2.00			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00	
		1.00		2.00		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	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	Y		Y		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC			N		N	
161.10	CORF			N		N	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name		County		State	
		0		1.00		2.00	
						3.00	
						4.00	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.00		169.00	
						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)			06/01/2018		05/31/2019	
						170.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1319	Period: From 06/01/2018 To 05/31/2019	Worksheet S-2 Part I Date/Time Prepared: 10/25/2019 8:36 am
		1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1319	Period: From 06/01/2018 To 05/31/2019	Worksheet S-2 Part II Date/Time Prepared: 10/25/2019 8:36 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	09/17/2019	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N			14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N			15.00
			Part A		Part B
			Y/N	Date	Y/N
			1.00	2.00	3.00
				Date	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	10/04/2019	Y	10/04/2019
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019Worksheet S-2
Part II
Date/Time Prepared:
10/25/2019 8:36 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		Y		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		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.		Y		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.		Y		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		Y		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAVID	GOODMAN		41.00
42.00	Enter the employer/company name of the cost report preparer.	WIPFLI, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	608-270-2962	DGOODMAN@WIPFLI.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1319	Period: From 06/01/2018 To 05/31/2019	Worksheet S-2 Part II Date/Time Prepared: 10/25/2019 8:36 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CPA		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019Worksheet S-3
Part I
Date/Time Prepared:
10/25/2019 8:36 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	58,656.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	58,656.00	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	43.00				0	13.00
14.00 Total (see instructions)		25	9,125	58,656.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	37	13,505		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	46.00	0	0			21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 KEWANEE RHC	88.00				0	26.00
26.01 WYOMING RHC	88.01				0	26.01
26.02 GENESEO RHC	88.02				0	26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		62				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019Worksheet S-3
Part I
Date/Time Prepared:
10/25/2019 8:36 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,295	3	2,346		1.00
2.00	HMO and other (see instructions)	90	92			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	440	0	604		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	74		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,735	3	3,024		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		0	0		13.00
14.00	Total (see instructions)	1,735	3	3,024	0.00	248.10
15.00	CAH visits	0	0	0		15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY	448	0	13,008	0.00	26.52
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE			0	0.00	0.00
22.00	HOME HEALTH AGENCY	4,035	0	8,713	0.00	8.91
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
24.10	HOSPICE (non-distinct part)			0		24.10
25.00	CMHC - CMHC					25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00
26.00	KEWANEE RHC	2,624	0	12,943	0.00	21.32
26.01	WYOMING RHC	535	0	2,111	0.00	2.98
26.02	GENESEO RHC	1,150	0	4,578	0.00	8.68
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				0.00	316.51
28.00	Observation Bed Days		0	1,115		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			0		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	0	0		32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.01
33.00	LTCH non-covered days	0				33.00
33.01	LTCH site neutral days and discharges	0				33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019Worksheet S-3
Part I
Date/Time Prepared:
10/25/2019 8:36 am

Component		Full Time Equivalents	Discharges			Total All Patients	
		Nonpaid Workers	Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	420	2	771	1.00
2.00	HMO and other (see instructions)			31	27		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	420	2	771	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	0.00				0	21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					25.10
26.00	KEWANEE RHC	0.00					26.00
26.01	WYOMING RHC	0.00					26.01
26.02	GENESEO RHC	0.00					26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 14-1319 Component CCN: 14-7450		Period: From 06/01/2018 To 05/31/2019		Worksheet S-4 Date/Time Prepared: 10/25/2019 8:36 am	
				Home Health Agency I		PPS	
				1.00			
0.00 County		HENRY				0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	15,099	0	0	15,099	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	180.00	20.00	66.00	263.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.86	0.00	0.86	5.00
6.00	Direct Nursing Service			0.00	0.00	0.00	6.00
7.00	Nursing Supervisor			1.06	0.00	1.06	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			6.99	0.00	6.99	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			19340			20.00
20.01				99914			20.01
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	1,918	283	69	56	2,326	21.00
22.00	Skilled Nursing Visit Charges	327,786	48,365	11,792	9,570	397,513	22.00
23.00	Physical Therapy Visits	741	33	9	19	802	23.00
24.00	Physical Therapy Visit Charges	155,949	6,937	1,893	3,996	168,775	24.00
25.00	Occupational Therapy Visits	381	39	10	26	456	25.00
26.00	Occupational Therapy Visit Charges	80,175	8,204	2,104	5,472	95,955	26.00
27.00	Speech Pathology Visits	33	6	1	4	44	27.00
28.00	Speech Pathology Visit Charges	6,947	1,260	210	840	9,257	28.00
29.00	Medical Social Service Visits	9	1	0	0	10	29.00
30.00	Medical Social Service Visit Charges	2,362	260	0	0	2,622	30.00
31.00	Home Health Aide Visits	306	78	1	12	397	31.00
32.00	Home Health Aide Visit Charges	28,400	7,242	92	1,120	36,854	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,388	440	90	117	4,035	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	601,619	72,268	16,091	20,998	710,976	35.00
36.00	Total Number of Episodes (standard/non outlier)	212		33	8	253	36.00
37.00	Total Number of Outlier Episodes		11		1	12	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019

Worksheet S-7

Date/Time Prepared:
10/25/2019 8:36 am

		1.00	2.00	3.00	4.00
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	05/21/2003		2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	3.00
4.00		RUL	0	0	4.00
5.00		RVX	0	0	5.00
6.00		RVL	7	0	6.00
7.00		RHX	0	0	7.00
8.00		RHL	0	0	8.00
9.00		RMX	0	0	9.00
10.00		RML	0	0	10.00
11.00		RLX	0	0	11.00
12.00		RUC	6	0	12.00
13.00		RUB	0	0	13.00
14.00		RUA	0	0	14.00
15.00		RVC	40	0	15.00
16.00		RVB	14	0	16.00
17.00		RVA	115	0	17.00
18.00		RHC	50	0	18.00
19.00		RHB	27	0	19.00
20.00		RHA	79	0	20.00
21.00		RMC	12	0	21.00
22.00		RMB	29	0	22.00
23.00		RMA	10	0	23.00
24.00		RLB	0	0	24.00
25.00		RLA	0	0	25.00
26.00		ES3	0	0	26.00
27.00		ES2	0	0	27.00
28.00		ES1	0	0	28.00
29.00		HE2	14	0	29.00
30.00		HE1	0	0	30.00
31.00		HD2	0	0	31.00
32.00		HD1	0	0	32.00
33.00		HC2	0	0	33.00
34.00		HC1	0	0	34.00
35.00		HB2	0	0	35.00
36.00		HB1	19	0	36.00
37.00		LE2	3	0	37.00
38.00		LE1	0	0	38.00
39.00		LD2	13	0	39.00
40.00		LD1	0	0	40.00
41.00		LC2	0	0	41.00
42.00		LC1	0	0	42.00
43.00		LB2	0	0	43.00
44.00		LB1	0	0	44.00
45.00		CE2	0	0	45.00
46.00		CE1	0	0	46.00
47.00		CD2	0	0	47.00
48.00		CD1	0	0	48.00
49.00		CC2	0	0	49.00
50.00		CC1	4	0	50.00
51.00		CB2	0	0	51.00
52.00		CB1	5	0	52.00
53.00		CA2	0	0	53.00
54.00		CA1	1	0	54.00
55.00		SE3	0	0	55.00
56.00		SE2	0	0	56.00
57.00		SE1	0	0	57.00
58.00		SSC	0	0	58.00
59.00		SSB	0	0	59.00
60.00		SSA	0	0	60.00
61.00		IB2	0	0	61.00
62.00		IB1	0	0	62.00
63.00		IA2	0	0	63.00
64.00		IA1	0	0	64.00
65.00		BB2	0	0	65.00
66.00		BB1	0	0	66.00
67.00		BA2	0	0	67.00
68.00		BA1	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019

Worksheet S-7

Date/Time Prepared:
10/25/2019 8:36 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		448	0	448	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	99914	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		943,273	35.70	Y	202.00
203.00	Recruitment		0	0.00	N	203.00
204.00	Retention of employees		0	0.00	N	204.00
205.00	Training		439	0.02	N	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)		2,642,403			207.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1319 Component CCN: 14-8576		Period: From 06/01/2018 To 05/31/2019		Worksheet S-8 Date/Time Prepared: 10/25/2019 8:36 am	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			1258 WEST SOUTH STREET #2			1.00		
				City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County			KEWANEE IL 61443			2.00		
				1.00					
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0		3.00	
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)						4.00		
5.00	Migrant Health Center (Section 329(d), PHS Act)						5.00		
6.00	Health Services for the Homeless (Section 340(d), PHS Act)						6.00		
7.00	Appalachian Regional Commission						7.00		
8.00	Look-Alikes						8.00		
9.00	OTHER (SPECIFY)						9.00		
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N			0		10.00
				Sunday		Monday		Tuesday	
				from to		from to		from	
				1.00 2.00		3.00 4.00		5.00	
Facility hours of operations (1)									
11.00	CLINIC			07:30 18:00			07:30		11.00
				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		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			HENRY			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			18:00 07:30 18:00 07:30 18:00			11.00		

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1319 Component CCN: 14-8576	Period: From 06/01/2018 To 05/31/2019	Worksheet S-8 Date/Time Prepared: 10/25/2019 8:36 am
			RHC I		Cost
			Friday		Saturday
			from	to	from
			11.00	12.00	13.00
Facility hours of operations (1)					
11.00	CLINIC	07:30	18:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1319 Component CCN: 14-8577		Period: From 06/01/2018 To 05/31/2019		Worksheet S-8 Date/Time Prepared: 10/25/2019 8:36 am		
				RHC II		Cost				
				1.00						
Clinic Address and Identification										
1.00	Street				101 SOUTH GALENA AVENUE			1.00		
				City		State		ZIP Code		
				1.00		2.00		3.00		
2.00	City, State, ZIP Code, County				WYOMING IL 61491			2.00		
						1.00				
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0		3.00	
				Grant Award		Date				
				1.00		2.00				
Source of Federal Funds										
4.00	Community Health Center (Section 330(d), PHS Act)							4.00		
5.00	Migrant Health Center (Section 329(d), PHS Act)							5.00		
6.00	Health Services for the Homeless (Section 340(d), PHS Act)							6.00		
7.00	Appalachian Regional Commission							7.00		
8.00	Look-Alikes							8.00		
9.00	OTHER (SPECIFY)							9.00		
						1.00		2.00		
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N		0		10.00	
				Sunday		Monday		Tuesday		
				from to		from to		from		
				1.00 2.00		3.00 4.00		5.00		
Facility hours of operations (1)										
11.00	CLINIC				08:30		17:00		08:30	
						1.00		2.00		
12.00	Have you received an approval for an exception to the productivity standard?				N				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N		0		13.00	
				Provider name		CCN number				
				1.00		2.00				
14.00	RHC/FQHC name, CCN number								14.00	
				Y/N		V		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				STARK				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		08:30		12:00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1319 Component CCN: 14-8577	Period: From 06/01/2018 To 05/31/2019	Worksheet S-8 Date/Time Prepared: 10/25/2019 8:36 am	
			RHC II		Cost	
			Friday		Saturday	
			from	to	from	to
			11.00	12.00	13.00	14.00
Facility hours of operations (1)						
11.00	CLINIC	08:30	17:00			11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1319 Component CCN: 14-8587		Period: From 06/01/2018 To 05/31/2019		Worksheet S-8 Date/Time Prepared: 10/25/2019 8:36 am	
				RHC III		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street				600 N. COLLEGE AVENUE				1.00
				City	State	ZIP Code			
				1.00	2.00	3.00			
2.00	City, State, ZIP Code, County				GENESE0		IL 61254-1099		2.00
						1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0		3.00
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)								4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)								5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)								6.00
7.00	Appalachian Regional Commission								7.00
8.00	Look-Alikes								8.00
9.00	OTHER (SPECIFY)								9.00
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N		0		10.00
				Sunday		Monday		Tuesday	
				from	to	from	to	from	
				1.00	2.00	3.00	4.00	5.00	
Facility hours of operations (1)									
11.00	CLINIC				08:30		17:00		11.00
				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				HENRY				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		08:30		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1319 Component CCN: 14-8587	Period: From 06/01/2018 To 05/31/2019	Worksheet S-8 Date/Time Prepared: 10/25/2019 8:36 am	
			RHC III		Cost	
			Friday		Saturday	
			from	to	from	to
			11.00	12.00	13.00	14.00
Facility hours of operations (1)						
11.00	CLINIC	08:30	17:00			11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1319	Period: From 06/01/2018 To 05/31/2019	Worksheet S-10 Date/Time Prepared: 10/25/2019 8:36 am
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.338003 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	11,486,168		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0		5.00
6.00	Medicaid charges	13,302,725		6.00
7.00	Medicaid cost (line 1 times line 6)	4,496,361		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)	0		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	0		9.00
10.00	Stand-alone CHIP charges	0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0		12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	163,678	0	163,678 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	55,324	0	55,324 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	55,324	0	55,324 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,105,076		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	66,089		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	101,675		27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,003,401		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	712,742		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	768,066		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	768,066		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019

Worksheet A

Date/Time Prepared:

10/25/2019 8:36 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,970,602	1,970,602	512,757	2,483,359 1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,146,907	1,146,907	-6,416	1,140,491 2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	171,472	3,994,617	4,166,089	-753,649	3,412,440 4.00
5.01	00550	DATA PROCESSING	329,217	1,104,418	1,433,635	0	1,433,635 5.01
5.02	00560	PURCHASING RECEIVING AND STORES	118,810	4,643	123,453	0	123,453 5.02
5.03	00570	ADMITTING	164,486	64,074	228,560	0	228,560 5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	461,769	342,693	804,462	0	804,462 5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	542,982	2,251,435	2,794,417	-90,999	2,703,418 5.05
7.00	00700	OPERATION OF PLANT	237,560	941,992	1,179,552	0	1,179,552 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	27,261	96,933	124,194	0	124,194 8.00
9.00	00900	HOUSEKEEPING	390,859	138,256	529,115	0	529,115 9.00
10.00	01000	DIETARY	465,613	447,044	912,657	0	912,657 10.00
11.00	01100	CAFETERIA	0	0	0	0	0 11.00
13.00	01300	NURSING ADMINISTRATION	166,102	1,378	167,480	0	167,480 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	24,407	24,407	0	24,407 14.00
15.00	01500	PHARMACY	224,594	225,089	449,683	0	449,683 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	430,774	62,779	493,553	0	493,553 16.00
17.00	01700	SOCIAL SERVICE	110,386	1,407	111,793	0	111,793 17.00
18.00	01080	INSERVICE EDUCATION	141,679	41,801	183,480	0	183,480 18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,971,300	389,462	2,360,762	0	2,360,762 30.00
43.00	04300	NURSERY	0	0	0	0	0 43.00
44.00	04400	SKILLED NURSING FACILITY	998,451	184,371	1,182,822	320,292	1,503,114 44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0 46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,346,545	3,567,885	4,914,430	-1,569,427	3,345,003 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	887,463	0	887,463	87,612	975,075 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	854,786	1,123,914	1,978,700	13,391	1,992,091 54.00
60.00	06000	LABORATORY	676,532	1,051,515	1,728,047	6,942	1,734,989 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	134,625	134,625	0	134,625 62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
66.00	06600	PHYSICAL THERAPY	1,363,430	70,094	1,433,524	0	1,433,524 66.00
67.00	06700	OCCUPATIONAL THERAPY	382,645	18,949	401,594	0	401,594 67.00
68.00	06800	SPEECH PATHOLOGY	129,278	15,013	144,291	0	144,291 68.00
69.00	06900	ELECTROCARDIOLOGY	232,176	210,512	442,688	0	442,688 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,613,233	1,613,233 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,329,921	1,329,921	0	1,329,921 73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0 76.00
76.01	03610	SLEEP LAB	68,281	49,461	117,742	0	117,742 76.01
76.02	03950	IV THERAPY	0	0	0	0	0 76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	KEWANEE RHC	1,511,002	410,314	1,921,316	159,413	2,080,729 88.00
88.01	08801	WYOMING RHC	174,711	118,523	293,234	20,526	313,760 88.01
88.02	08802	GENESEO RHC	744,154	80,398	824,552	113,847	938,399 88.02
90.00	09000	CLINIC	678,318	210,592	888,910	136,131	1,025,041 90.00
90.01	09001	PAIN CLINIC	63,003	129,523	192,526	838	193,364 90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0 90.02
90.03	09003	SURGICAL CLINIC	35,277	1,527,396	1,562,673	0	1,562,673 90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0 90.04
91.00	09100	EMERGENCY	1,471,005	1,101,726	2,572,731	155,592	2,728,323 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT					
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0 99.10
101.00	10100	HOME HEALTH AGENCY	528,633	127,463	656,096	0	656,096 101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		777,321	777,321	-777,321	0 113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,100,554	25,489,453	43,590,007	-57,238	43,532,769 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0 190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0 192.00
192.01	19203	MUSCATINE CLINIC	0	555	555	0	555 192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0 192.02
192.03	19202	LEASED SPACE	117,379	63,308	180,687	0	180,687 192.03
192.04	19204	ANNAWAN CLINIC	259,505	110,093	369,598	31,986	401,584 192.04
192.05	19205	CAMBRIDGE CLINIC	222,808	76,090	298,898	25,252	324,150 192.05
194.00	07955	FOUNDATION	0	0	0	0	0 194.00
194.01	07950	SPORTS MEDICINE	84,856	19,667	104,523	0	104,523 194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0 194.02
194.03	07952	ANESTHESIA BILLING	0	0	0	0	0 194.03

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019

Worksheet A

Date/Time Prepared:
10/25/2019 8:36 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	7,137	7,137	0	7,137	194.07
200.00		TOTAL (SUM OF LINES 118 through 199)	18,785,102	25,766,303	44,551,405	0	44,551,405	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019

Worksheet A

Date/Time Prepared:
10/25/2019 8:36 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	30,033	2,513,392	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,140,491	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,412,440	4.00
5.01	00550	DATA PROCESSING	0	1,433,635	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-102,635	20,818	5.02
5.03	00570	ADMITTING	0	228,560	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	-97,232	707,230	5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	-136,472	2,566,946	5.05
7.00	00700	OPERATION OF PLANT	0	1,179,552	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	124,194	8.00
9.00	00900	HOUSEKEEPING	0	529,115	9.00
10.00	01000	DIETARY	-208,566	704,091	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	167,480	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	24,407	14.00
15.00	01500	PHARMACY	0	449,683	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,801	490,752	16.00
17.00	01700	SOCIAL SERVICE	0	111,793	17.00
18.00	01080	INSERVICE EDUCATION	0	183,480	18.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-490,365	1,870,397	30.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	-890	1,502,224	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-120,508	3,224,495	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-975,075	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,992,091	54.00
60.00	06000	LABORATORY	-1,750	1,733,239	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	134,625	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
66.00	06600	PHYSICAL THERAPY	-484	1,433,040	66.00
67.00	06700	OCCUPATIONAL THERAPY	-161	401,433	67.00
68.00	06800	SPEECH PATHOLOGY	0	144,291	68.00
69.00	06900	ELECTROCARDIOLOGY	-15,487	427,201	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,613,233	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,329,921	73.00
76.00	03020	ACUPUNCTURE	0	0	76.00
76.01	03610	SLEEP LAB	-322	117,420	76.01
76.02	03950	IV THERAPY	0	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	KEWANEE RHC	0	2,080,729	88.00
88.01	08801	WYOMING RHC	0	313,760	88.01
88.02	08802	GENESEO RHC	0	938,399	88.02
90.00	09000	CLINIC	-609,025	416,016	90.00
90.01	09001	PAIN CLINIC	-108,156	85,208	90.01
90.02	09002	SPECIALTY CLINIC	0	0	90.02
90.03	09003	SURGICAL CLINIC	-992,456	570,217	90.03
90.04	09004	GENESEO CLINIC	0	0	90.04
91.00	09100	EMERGENCY	-766,031	1,962,292	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	656,096	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,598,383	38,934,386	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	555	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	192.02
192.03	19202	LEASED SPACE	0	180,687	192.03
192.04	19204	ANNAWAN CLINIC	0	401,584	192.04
192.05	19205	CAMBRIDGE CLINIC	0	324,150	192.05
194.00	07955	FOUNDATION	0	0	194.00
194.01	07950	SPORTS MEDICINE	0	104,523	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	194.02
194.03	07952	ANESTHESIA BILLING	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	194.04

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019

Worksheet A

Date/Time Prepared:
10/25/2019 8:36 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
194.05	07954	COLONA CLINIC	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	7,137	194.07
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,598,383	39,953,022	200.00

RECLASSIFICATIONS

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019

Worksheet A-6

Date/Time Prepared:
10/25/2019 8:36 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - COLONA CLINIC BUILDING DEPRECIATION				
1.00	CLINIC	90.00	0	40,158	1.00
	TOTALS		0	40,158	
	C - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	777,321	1.00
	TOTALS		0	777,321	
	E - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	68,272	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	21,198	2.00
3.00	CLINIC	90.00	0	1,529	3.00
	TOTALS		0	90,999	
	H - IMPLANT EXP RECLASS				
1.00	IMPL. DEV. CHARGED TO	72.00	0	1,613,233	1.00
	PATIENTS				
	TOTALS		0	1,613,233	
	I - RECLASS PROVIDER BENEFITS				
1.00	ANESTHESIOLOGY	53.00	0	131,418	1.00
2.00	CLINIC	90.00	0	94,444	2.00
3.00	PAIN CLINIC	90.01	0	838	3.00
4.00	CAMBRIDGE CLINIC	192.05	0	25,252	4.00
5.00	EMERGENCY	91.00	0	155,592	5.00
6.00	ANNAWAN CLINIC	192.04	0	31,986	6.00
7.00	KEWANEE RHC	88.00	0	177,697	7.00
8.00	WYOMING RHC	88.01	0	22,298	8.00
9.00	GENESEO RHC	88.02	0	114,124	9.00
	TOTALS		0	753,649	
	J - RECLASS SNF DEPRECIATION AND INTERST				
1.00	SKILLED NURSING FACILITY	44.00	0	178,648	1.00
2.00	SKILLED NURSING FACILITY	44.00	0	114,030	2.00
3.00	SKILLED NURSING FACILITY	44.00	0	27,614	3.00
	TOTALS		0	320,292	
	K - TO CLOSE ANESTHESIA TO OR				
1.00	OPERATING ROOM	50.00	0	43,806	1.00
	TOTALS		0	43,806	
	L - RHC LAB AND RADIOLOGY COSTS				
1.00	LABORATORY	60.00	6,942	0	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	13,391	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		20,333	0	
500.00	Grand Total: Increases		20,333	3,639,458	500.00

RECLASSIFICATIONS

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019

Worksheet A-6

Date/Time Prepared:
10/25/2019 8:36 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - COLONA CLINIC BUILDING DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	40,158	9	1.00
	TOTALS		0	40,158		
	C - INTEREST EXPENSE					
1.00	INTEREST EXPENSE	113.00	0	777,321	11	1.00
	TOTALS		0	777,321		
	E - OTHER CAPITAL COSTS					
1.00	ALL OTHER ADMINISTRATIVE AND GE	5.05	0	90,999	12	1.00
2.00		0.00	0	0	12	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		0	90,999		
	H - IMPLANT EXP RECLASS					
1.00	OPERATING ROOM	50.00	0	1,613,233	0	1.00
	TOTALS		0	1,613,233		
	I - RECLASS PROVIDER BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	753,649	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
	TOTALS		0	753,649		
	J - RECLASS SNF DEPRECIATION AND INTERST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	178,648	9	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	114,030	11	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	27,614	9	3.00
	TOTALS		0	320,292		
	K - TO CLOSE ANESTHESIA TO OR					
1.00	ANESTHESIOLOGY	53.00	0	43,806	0	1.00
	TOTALS		0	43,806		
	L - RHC LAB AND RADIOLOGY COSTS					
1.00	KEWANEE RHC	88.00	18,284	0	0	1.00
2.00	WYOMING RHC	88.01	1,772	0	0	2.00
3.00	GENESEO RHC	88.02	277	0	0	3.00
	TOTALS		20,333	0		
500.00	Grand Total: Decreases		20,333	3,639,458		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019Worksheet A-7
Part I
Date/Time Prepared:
10/25/2019 8:36 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,316,669	18,900	0	18,900	0	1.00
2.00	Land Improvements	1,629,936	28,781	0	28,781	0	2.00
3.00	Buildings and Fixtures	45,000,048	67,737	0	67,737	23,490	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	13,788,290	815,386	0	815,386	420,331	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	61,734,943	930,804	0	930,804	443,821	8.00
9.00	Reconciling Items	-151,510	-777,260	0	-777,260	-311,761	9.00
10.00	Total (line 8 minus line 9)	61,886,453	1,708,064	0	1,708,064	755,582	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,335,569	0				1.00
2.00	Land Improvements	1,658,717	0				2.00
3.00	Buildings and Fixtures	45,044,295	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	14,183,345	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	62,221,926	0				8.00
9.00	Reconciling Items	-617,009	0				9.00
10.00	Total (line 8 minus line 9)	62,838,935	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019Worksheet A-7
Part II
Date/Time Prepared:
10/25/2019 8:36 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,970,602	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,146,907	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,117,509	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,970,602				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,146,907				2.00
3.00	Total (sum of lines 1-2)	0	3,117,509				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019Worksheet A-7
Part III
Date/Time Prepared:
10/25/2019 8:36 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	44,858,481	0	44,858,481	0.759775	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	14,183,345	0	14,183,345	0.240225	0	2.00
3.00	Total (sum of lines 1-2)	59,041,826	0	59,041,826	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,751,796	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,119,293	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,871,089	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	693,324	68,272	0	0	2,513,392	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	21,198	0	0	1,140,491	2.00
3.00	Total (sum of lines 1-2)	693,324	89,470	0	0	3,653,883	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019

Worksheet A-8

Date/Time Prepared:
10/25/2019 8:36 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	A	-102,635	PURCHASING RECEIVING AND STORES	5.02	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-3,838	ALL OTHER ADMINISTRATIVE AND GE	5.05	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	-3,093,966			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	-208,566	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-2,801	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	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 - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019

Worksheet A-8

Date/Time Prepared:
10/25/2019 8:36 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	ADVERTISING EXPENSE	A	-59,667	ALL OTHER ADMINISTRATIVE AND GE	5.05	0	33.00
33.01	PART B BILLING	A	-97,232	CASHIERING/ACCOUNTS RECEIVABLE	5.04	0	33.01
33.02	PHYSICIAN RECRUITING	A	-62,317	ALL OTHER ADMINISTRATIVE AND GE	5.05	0	33.02
33.03	UNAMMORTIZED BOND ISSUE COST	B	30,033	CAP REL COSTS-BLDG & FIXT	1.00	11	33.03
33.04	TV SERVICE - MED SURG	A	-4,031	ADULTS & PEDIATRICS	30.00	0	33.04
33.05	TV SERVICE - CARDIAC	A	-322	ELECTROCARDIOLOGY	69.00	0	33.05
33.06	TV SERVICE - LTC	A	-6,611	SKILLED NURSING FACILITY	44.00	0	33.06
33.07	TV SERVICE - OR	A	-2,580	OPERATING ROOM	50.00	0	33.07
33.08	TV SERVICE - ER	A	-1,129	EMERGENCY	91.00	0	33.08
33.09	TV SERVICE - PT	A	-484	PHYSICAL THERAPY	66.00	0	33.09
33.10	TV SERVICE - OT	A	-161	OCCUPATIONAL THERAPY	67.00	0	33.10
33.11	TV SERVICE - SLEEP	A	-322	SLEEP LAB	76.01	0	33.11
33.12	CRNA EXPENSES	A	-975,075	ANESTHESIOLOGY	53.00	0	33.12
33.13	UNAMMORTIZED BOND ISSUE COST	A	5,721	SKILLED NURSING FACILITY	44.00	0	33.13
33.14	LOBBYING	A	-10,650	ALL OTHER ADMINISTRATIVE AND GE	5.05	0	33.14
33.15	EMPLOYEE LAB TEST REVENUE	B	-1,750	LABORATORY	60.00	0	33.15
33.16	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.16
33.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.17
33.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.18
33.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.19
33.21	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.21
33.23	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.23
33.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.24
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,598,383				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: 14-1319

Period:
From 06/01/2018
To 05/31/2019

Worksheet A-8-2

Date/Time Prepared:
10/25/2019 8:36 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	26,158	0	26,158	0	0	1.00
2.00	91.00	EMERGENCY	1,795,545	764,902	1,030,643	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	15,165	15,165	0	0	0	3.00
4.00	90.00	CLINIC	609,025	609,025	0	0	0	4.00
5.00	90.03	SURGICAL CLINIC	992,456	992,456	0	0	0	5.00
6.00	50.00	OPERATING ROOM	117,928	117,928	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	165,959	165,959	0	0	0	7.00
8.00	30.00	ADULTS & PEDIATRICS	320,375	320,375	0	0	0	8.00
9.00	90.01	PAIN CLINIC	108,156	108,156	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,150,767	3,093,966	1,056,801		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	90.00	CLINIC	0	0	0	0	0	4.00
5.00	90.03	SURGICAL CLINIC	0	0	0	0	0	5.00
6.00	50.00	OPERATING ROOM	0	0	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	7.00
8.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	8.00
9.00	90.01	PAIN CLINIC	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	0		1.00
2.00	91.00	EMERGENCY	0	0	0	764,902		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	15,165		3.00
4.00	90.00	CLINIC	0	0	0	609,025		4.00
5.00	90.03	SURGICAL CLINIC	0	0	0	992,456		5.00
6.00	50.00	OPERATING ROOM	0	0	0	117,928		6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	165,959		7.00
8.00	30.00	ADULTS & PEDIATRICS	0	0	0	320,375		8.00
9.00	90.01	PAIN CLINIC	0	0	0	108,156		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,093,966		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019Worksheet B
Part I
Date/Time Prepared:
10/25/2019 8:36 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,513,392	2,513,392			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,140,491		1,140,491		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,412,440	11,971	242	3,424,653	4.00
5.01	00550	DATA PROCESSING	1,433,635	73,751	196,421	69,603	1,773,410
5.02	00560	PURCHASING RECEIVING AND STORES	20,818	74,760	0	25,119	6,358
5.03	00570	ADMITTING	228,560	32,428	0	34,776	48,067
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	707,230	25,481	2,120	87,205	15,260
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	2,566,946	101,756	8,848	114,090	312,057
7.00	00700	OPERATION OF PLANT	1,179,552	195,843	10,468	50,225	19,074
8.00	00800	LAUNDRY & LINEN SERVICE	124,194	18,630	1,383	5,764	0
9.00	00900	HOUSEKEEPING	529,115	33,534	0	82,636	2,035
10.00	01000	DIETARY	704,091	84,953	7,486	98,440	10,173
11.00	01100	CAFETERIA	0	56,106	0	0	5,595
13.00	01300	NURSING ADMINISTRATION	167,480	14,616	13,945	35,117	40,438
14.00	01400	CENTRAL SERVICES & SUPPLY	24,407	0	0	0	0
15.00	01500	PHARMACY	449,683	40,289	2,032	47,484	55,697
16.00	01600	MEDICAL RECORDS & LIBRARY	490,752	39,399	7,887	91,075	95,626
17.00	01700	SOCIAL SERVICE	111,793	9,567	693	23,338	8,901
18.00	01080	INSERVICE EDUCATION	183,480	0	0	29,954	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,870,397	326,951	89,370	416,766	83,673
43.00	04300	NURSERY	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	1,502,224	0	0	211,094	38,657
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,224,495	366,039	346,117	284,688	52,137
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,992,091	202,406	209,668	183,551	63,073
60.00	06000	LABORATORY	1,733,239	71,948	69,808	144,501	52,391
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	134,625	2,188	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	1,433,040	229,666	26,234	288,258	56,206
67.00	06700	OCCUPATIONAL THERAPY	401,433	88,919	899	80,899	13,479
68.00	06800	SPEECH PATHOLOGY	144,291	9,712	0	27,332	2,543
69.00	06900	ELECTROCARDIOLOGY	427,201	38,726	5,184	49,087	11,445
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,613,233	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,329,921	0	0	0	0
76.00	03020	ACUPUNCTURE	0	0	0	0	0
76.01	03610	SLEEP LAB	117,420	17,957	0	14,436	21,109
76.02	03950	IV THERAPY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	KEWANEE RHC	2,080,729	0	64,229	315,592	510,939
88.01	08801	WYOMING RHC	313,760	0	7,551	36,563	15,514
88.02	08802	GENESEO RHC	938,399	78,366	18,613	157,271	45,779
90.00	09000	CLINIC	416,016	0	5,404	35,369	40,692
90.01	09001	PAIN CLINIC	85,208	625	0	12,361	9,410
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0
90.03	09003	SURGICAL CLINIC	570,217	6,298	1,587	7,458	19,329
90.04	09004	GENESEO CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	1,962,292	119,232	25,542	162,675	74,009
92.00	09200	OBSERVATION BEDS (NON-DISTINCT					
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	656,096	27,092	4,142	111,764	17,803
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	38,934,386	2,399,209	1,125,873	3,334,491	1,747,469
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	23,750	0	0	0
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0
192.01	19203	MUSCATINE CLINIC	555	0	0	0	0
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0
192.03	19202	LEASED SPACE	180,687	18,630	2,889	24,816	0
192.04	19204	ANNAWAN CLINIC	401,584	0	1,284	24,372	4,324
192.05	19205	CAMBRIDGE CLINIC	324,150	0	10,227	23,034	14,242
194.00	07955	FOUNDATION	0	9,543	0	0	7,375

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019Worksheet B
Part I
Date/Time Prepared:
10/25/2019 8:36 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
194.01	07950	SPORTS MEDICINE	104,523	0	218	17,940	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	62,260	0	0	0	194.06
194.07	07957	COMMUNITY HEALTH	7,137	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	39,953,022	2,513,392	1,140,491	3,424,653	1,773,410	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019Worksheet B
Part I
Date/Time Prepared:
10/25/2019 8:36 am

Cost Center Description			PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/AC COUNTS RECEIVABLE	Subtotal	ALL OTHER ADMINISTRATIVE AND GE	
			5.02	5.03	5.04	5A.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	127,055					5.02
5.03	00570	ADMITTING	209	344,040				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	134	0	837,430			5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	408	0	0	3,104,105	3,104,105	5.05
7.00	00700	OPERATION OF PLANT	1,861	0	0	1,457,023	122,945	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	96	0	0	150,067	12,663	8.00
9.00	00900	HOUSEKEEPING	1,411	0	0	648,731	54,741	9.00
10.00	01000	DIETARY	1,207	0	0	906,350	76,479	10.00
11.00	01100	CAFETERIA	0	0	0	61,701	5,206	11.00
13.00	01300	NURSING ADMINISTRATION	1	0	0	271,597	22,918	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,087	0	0	25,494	2,151	14.00
15.00	01500	PHARMACY	145	0	0	595,330	50,235	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	95	0	0	724,834	61,162	16.00
17.00	01700	SOCIAL SERVICE	21	0	0	154,313	13,021	17.00
18.00	01080	INSERVICE EDUCATION	311	0	0	213,745	18,036	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,226	14,192	31,071	2,835,646	239,275	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,128	0	19,276	1,772,379	149,555	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	35,402	91,317	199,838	4,600,033	388,165	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,411	78,179	171,163	2,907,542	245,341	54.00
60.00	06000	LABORATORY	18,163	57,083	124,977	2,272,110	191,723	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	939	2,056	139,808	11,797	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	569	23,110	50,596	2,107,679	177,848	66.00
67.00	06700	OCCUPATIONAL THERAPY	112	7,194	15,750	608,685	51,361	67.00
68.00	06800	SPEECH PATHOLOGY	56	1,423	3,116	188,473	15,904	68.00
69.00	06900	ELECTROCARDIOLOGY	535	16,555	36,244	584,977	49,361	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,264	2,768	4,032	340	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	44,317	13,616	29,812	1,700,978	143,530	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,450	42,584	1,391,955	117,455	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	73	2,701	5,913	179,609	15,156	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	KEWANEE RHC	1,434	0	25,512	2,998,435	253,011	88.00
88.01	08801	WYOMING RHC	249	0	3,096	376,733	31,789	88.01
88.02	08802	GENESE0 RHC	532	0	8,255	1,247,215	105,241	88.02
90.00	09000	CLINIC	964	0	10,194	508,639	42,919	90.00
90.01	09001	PAIN CLINIC	337	0	184	108,125	9,124	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	524	0	2,748	608,161	51,317	90.03
90.04	09004	GENESE0 CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	2,868	17,017	37,257	2,400,892	202,590	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				0		92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	1,168	0	6,887	824,952	69,610	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	126,054	344,040	829,297	38,680,348	3,001,969	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	23,750	2,004	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	15	0	0	570	48	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	77	0	0	227,099	19,163	192.03
192.04	19204	ANNAWAN CLINIC	539	0	5,616	437,719	36,935	192.04
192.05	19205	CAMBRIDGE CLINIC	255	0	2,517	374,425	31,594	192.05
194.00	07955	FOUNDATION	0	0	0	16,918	1,428	194.00
194.01	07950	SPORTS MEDICINE	115	0	0	122,796	10,362	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLING	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04

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Cost Center Description			PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/AC COUNTS RECEIVABLE	Subtotal	ALL OTHER ADMINISTRATIV E AND GE	
			5.02	5.03	5.04	5A.04	5.05	
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	62,260	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	7,137	602	194.07
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	127,055	344,040	837,430	39,953,022	3,104,105	202.00

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Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE						5.05
7.00	00700	OPERATION OF PLANT	1,579,968					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,041	174,771				8.00
9.00	00900	HOUSEKEEPING	21,673	8,499	733,644			9.00
10.00	01000	DIETARY	54,905	1,088	22,544	1,061,366		10.00
11.00	01100	CAFETERIA	36,261	0	21,627	694,672	819,467	11.00
13.00	01300	NURSING ADMINISTRATION	9,446	0	0	0	13,151	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	26,039	0	2,749	0	13,062	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25,464	0	1,924	0	53,135	16.00
17.00	01700	SOCIAL SERVICE	6,183	0	825	0	8,530	17.00
18.00	01800	INSERVICE EDUCATION	0	0	0	0	9,596	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	211,308	40,801	181,358	90,277	124,664	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	278,639	43,942	180,440	276,417	117,822	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	236,570	26,852	142,318	0	87,611	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	130,815	18,654	30,516	0	64,065	54.00
60.00	06000	LABORATORY	46,500	0	17,503	0	63,976	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	1,414	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	148,433	12,909	21,810	0	92,720	66.00
67.00	06700	OCCUPATIONAL THERAPY	57,468	0	4,949	0	23,058	67.00
68.00	06800	SPEECH PATHOLOGY	6,277	0	0	0	8,130	68.00
69.00	06900	ELECTROCARDIOLOGY	25,029	0	8,064	0	17,860	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	11,606	1,106	1,527	0	5,687	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	KEWANEE RHC	0	0	0	0	0	88.00
88.01	08801	WYOMING RHC	0	0	0	0	0	88.01
88.02	08802	GENESEO RHC	50,648	280	7,056	0	38,563	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PAIN CLINIC	404	524	0	0	3,910	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	4,070	0	12,738	0	4,931	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	77,059	20,116	28,409	0	56,068	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	17,509	0	3,207	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,495,761	174,771	689,564	1,061,366	806,539	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	15,350	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	62,689	0	30,975	0	5,020	192.03
192.04	19204	ANNAWAN CLINIC	0	0	0	0	0	192.04
192.05	19205	CAMBRIDGE CLINIC	0	0	0	0	0	192.05
194.00	07955	FOUNDATION	6,168	0	0	0	7,908	194.00
194.01	07950	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05

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Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	13,105	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,579,968	174,771	733,644	1,061,366	819,467	202.00

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Cost Center Description			NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	317,112					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	27,645				14.00
15.00	01500	PHARMACY	9,475	0	696,890			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	866,519		16.00
17.00	01700	SOCIAL SERVICE	6,188	0	0	0	189,060	17.00
18.00	01080	INSERVICE EDUCATION	6,961	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	90,428	0	0	33,098	88,011	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	2,331	87,801	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	63,551	0	0	212,864	282	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	46,471	0	0	182,331	0	54.00
60.00	06000	LABORATORY	46,407	0	0	133,131	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	2,190	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	53,898	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	16,778	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,319	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	38,609	423	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	27,645	0	2,948	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	31,757	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	696,890	45,363	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	4,125	0	0	6,299	0	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	KEWANEE RHC	0	0	0	27,177	0	88.00
88.01	08801	WYOMING RHC	0	0	0	3,298	0	88.01
88.02	08802	GENESE0 RHC	0	0	0	8,794	0	88.02
90.00	09000	CLINIC	0	0	0	10,859	0	90.00
90.01	09001	PAIN CLINIC	2,836	0	0	196	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	0	2,927	0	90.03
90.04	09004	GENESE0 CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	40,670	0	0	39,688	12,543	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	317,112	27,645	696,890	857,855	189,060	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	0	0	0	0	192.03
192.04	19204	ANNAWAN CLINIC	0	0	0	5,982	0	192.04
192.05	19205	CAMBRIDGE CLINIC	0	0	0	2,682	0	192.05
194.00	07955	FOUNDATION	0	0	0	0	0	194.00
194.01	07950	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLING	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04

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Cost Center Description			NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	317,112	27,645	696,890	866,519	189,060	202.00

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Cost Center Description			OTHER GENERAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			INSERVICE EDUCATION				
			18.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	DATA PROCESSING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00570	ADMITTING					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE					5.05
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
18.00	01080	INSERVICE EDUCATION	248,338				18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,289	3,944,155	0	3,944,155	30.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	5,763	2,915,089	0	2,915,089	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	59,773	5,818,019	0	5,818,019	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	51,173	3,676,908	0	3,676,908	54.00
60.00	06000	LABORATORY	37,365	2,808,715	0	2,808,715	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	615	155,824	0	155,824	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	15,127	2,630,424	0	2,630,424	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,709	767,008	0	767,008	67.00
68.00	06800	SPEECH PATHOLOGY	932	223,035	0	223,035	68.00
69.00	06900	ELECTROCARDIOLOGY	10,836	735,159	0	735,159	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	827	35,792	0	35,792	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,913	1,885,178	0	1,885,178	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,731	2,264,394	0	2,264,394	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	1,768	226,883	0	226,883	76.01
76.02	03950	IV THERAPY	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	KEWANEE RHC	7,627	3,286,250	0	3,286,250	88.00
88.01	08801	WYOMING RHC	926	412,746	0	412,746	88.01
88.02	08802	GENESEO RHC	2,468	1,460,265	0	1,460,265	88.02
90.00	09000	CLINIC	3,048	565,465	0	565,465	90.00
90.01	09001	PAIN CLINIC	55	125,174	0	125,174	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	822	684,966	0	684,966	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	90.04
91.00	09100	EMERGENCY	11,139	2,889,174	0	2,889,174	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			0		92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	915,278	0	915,278	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	245,906	38,425,901	0	38,425,901	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	41,104	0	41,104	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	618	0	618	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	344,946	0	344,946	192.03
192.04	19204	ANNAWAN CLINIC	1,679	482,315	0	482,315	192.04
192.05	19205	CAMBRIDGE CLINIC	753	409,454	0	409,454	192.05
194.00	07955	FOUNDATION	0	32,422	0	32,422	194.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019Worksheet B
Part I
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Cost Center Description			OTHER GENERAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			INSERVICE EDUCATION					
			18.00	24.00	25.00	26.00		
194.01	07950	SPORTS MEDICINE	0	133,158	0	133,158		194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0		194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0		194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0		194.04
194.05	07954	COLONA CLINIC	0	0	0	0		194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	75,365	0	75,365		194.06
194.07	07957	COMMUNITY HEALTH	0	7,739	0	7,739		194.07
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	248,338	39,953,022	0	39,953,022		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019Worksheet B
Part II
Date/Time Prepared:
10/25/2019 8:36 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	11,971	242	12,213	4.00
5.01	00550	DATA PROCESSING	0	73,751	196,421	270,172	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	74,760	0	74,760	5.02
5.03	00570	ADMITTING	0	32,428	0	32,428	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	25,481	2,120	27,601	5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	0	101,756	8,848	110,604	5.05
7.00	00700	OPERATION OF PLANT	0	195,843	10,468	206,311	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,630	1,383	20,013	8.00
9.00	00900	HOUSEKEEPING	0	33,534	0	33,534	9.00
10.00	01000	DIETARY	0	84,953	7,486	92,439	10.00
11.00	01100	CAFETERIA	0	56,106	0	56,106	11.00
13.00	01300	NURSING ADMINISTRATION	0	14,616	13,945	28,561	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	40,289	2,032	42,321	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	39,399	7,887	47,286	16.00
17.00	01700	SOCIAL SERVICE	0	9,567	693	10,260	17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	326,951	89,370	416,321	30.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	366,039	346,117	712,156	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	202,406	209,668	412,074	54.00
60.00	06000	LABORATORY	0	71,948	69,808	141,756	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	2,188	0	2,188	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	229,666	26,234	255,900	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	88,919	899	89,818	67.00
68.00	06800	SPEECH PATHOLOGY	0	9,712	0	9,712	68.00
69.00	06900	ELECTROCARDIOLOGY	0	38,726	5,184	43,910	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	17,957	0	17,957	76.01
76.02	03950	IV THERAPY	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	KEWANEE RHC	0	0	64,229	64,229	88.00
88.01	08801	WYOMING RHC	0	0	7,551	7,551	88.01
88.02	08802	GENESE0 RHC	0	78,366	18,613	96,979	88.02
90.00	09000	CLINIC	0	0	5,404	5,404	90.00
90.01	09001	PAIN CLINIC	0	625	0	625	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	6,298	1,587	7,885	90.03
90.04	09004	GENESE0 CLINIC	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	119,232	25,542	144,774	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	27,092	4,142	31,234	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,399,209	1,125,873	3,525,082	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	23,750	0	23,750	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	18,630	2,889	21,519	192.03
192.04	19204	ANNAWAN CLINIC	0	0	1,284	1,284	192.04
192.05	19205	CAMBRIDGE CLINIC	0	0	10,227	10,227	192.05
194.00	07955	FOUNDATION	0	9,543	0	9,543	194.00
194.01	07950	SPORTS MEDICINE	0	0	218	218	194.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019Worksheet B
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
			1.00	2.00	2A	4.00	
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	62,260	0	62,260	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	0	194.07
200.00		Cross Foot Adjustments			0		200.00
201.00		Negative Cost Centers		0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,513,392	1,140,491	3,653,883	12,213

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1319

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Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/AC COUNTS RECEIVABLE	ALL OTHER ADMINISTRATIVE AND GE	
			5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING	270,420					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	970	75,820				5.02
5.03	00570	ADMITTING	7,330	125	40,007			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,327	80	0	30,319		5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	47,584	244	0	0	158,839	5.05
7.00	00700	OPERATION OF PLANT	2,909	1,111	0	0	6,291	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	57	0	0	648	8.00
9.00	00900	HOUSEKEEPING	310	842	0	0	2,801	9.00
10.00	01000	DIETARY	1,551	721	0	0	3,914	10.00
11.00	01100	CAFETERIA	853	0	0	0	266	11.00
13.00	01300	NURSING ADMINISTRATION	6,166	1	0	0	1,173	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	649	0	0	110	14.00
15.00	01500	PHARMACY	8,493	86	0	0	2,571	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,582	57	0	0	3,130	16.00
17.00	01700	SOCIAL SERVICE	1,357	12	0	0	666	17.00
18.00	01080	INSERVICE EDUCATION	0	186	0	0	923	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,759	1,925	1,648	1,124	12,244	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	5,895	673	0	698	7,653	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,950	21,126	10,654	7,246	19,858	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,618	4,423	9,080	6,194	12,555	54.00
60.00	06000	LABORATORY	7,989	10,838	6,630	4,523	9,811	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	109	74	604	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	8,571	340	2,684	1,831	9,101	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,055	67	836	570	2,628	67.00
68.00	06800	SPEECH PATHOLOGY	388	34	165	113	814	68.00
69.00	06900	ELECTROCARDIOLOGY	1,745	319	1,923	1,312	2,526	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	147	100	17	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	26,447	1,582	1,079	7,345	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,259	1,541	6,010	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	3,219	43	314	214	776	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	KEWANEE RHC	77,909	856	0	923	12,947	88.00
88.01	08801	WYOMING RHC	2,366	149	0	112	1,627	88.01
88.02	08802	GENESE0 RHC	6,981	317	0	299	5,385	88.02
90.00	09000	CLINIC	6,205	575	0	369	2,196	90.00
90.01	09001	PAIN CLINIC	1,435	201	0	7	467	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	2,947	312	0	99	2,626	90.03
90.04	09004	GENESE0 CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	11,285	1,711	1,976	1,348	10,367	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	2,715	697	0	249	3,562	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	266,464	75,224	40,007	30,025	153,612	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	103	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	9	0	0	2	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	46	0	0	981	192.03
192.04	19204	ANNAWAN CLINIC	659	321	0	203	1,890	192.04
192.05	19205	CAMBRIDGE CLINIC	2,172	152	0	91	1,617	192.05
194.00	07955	FOUNDATION	1,125	0	0	0	73	194.00
194.01	07950	SPORTS MEDICINE	0	68	0	0	530	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLING	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1319

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Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/AC COUNTS RECEIVABLE	ALL OTHER ADMINISTRATIV E AND GE	
			5.01	5.02	5.03	5.04	5.05	
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	0	31	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	270,420	75,820	40,007	30,319	158,839	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1319

Period:
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To 05/31/2019Worksheet B
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Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE						5.05
7.00	00700	OPERATION OF PLANT	216,801					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,652	22,391				8.00
9.00	00900	HOUSEKEEPING	2,974	1,089	41,845			9.00
10.00	01000	DIETARY	7,534	139	1,286	107,935		10.00
11.00	01100	CAFETERIA	4,976	0	1,234	70,644	134,079	11.00
13.00	01300	NURSING ADMINISTRATION	1,296	0	0	0	2,152	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	3,573	0	157	0	2,137	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,494	0	110	0	8,694	16.00
17.00	01700	SOCIAL SERVICE	848	0	47	0	1,396	17.00
18.00	01800	INSERVICE EDUCATION	0	0	0	0	1,570	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	28,995	5,227	10,344	9,181	20,395	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	38,236	5,630	10,292	28,110	19,278	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	32,462	3,440	8,117	0	14,335	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,950	2,390	1,741	0	10,482	54.00
60.00	06000	LABORATORY	6,381	0	998	0	10,468	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	194	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	20,368	1,654	1,244	0	15,171	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,886	0	282	0	3,773	67.00
68.00	06800	SPEECH PATHOLOGY	861	0	0	0	1,330	68.00
69.00	06900	ELECTROCARDIOLOGY	3,434	0	460	0	2,922	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	1,592	142	87	0	930	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	KEWANEE RHC	0	0	0	0	0	88.00
88.01	08801	WYOMING RHC	0	0	0	0	0	88.01
88.02	08802	GENESEO RHC	6,950	36	402	0	6,310	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PAIN CLINIC	55	67	0	0	640	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	559	0	727	0	807	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	10,574	2,577	1,620	0	9,174	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	2,403	0	183	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	205,247	22,391	39,331	107,935	131,964	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	2,106	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	8,602	0	1,767	0	821	192.03
192.04	19204	ANNAWAN CLINIC	0	0	0	0	0	192.04
192.05	19205	CAMBRIDGE CLINIC	0	0	0	0	0	192.05
194.00	07955	FOUNDATION	846	0	0	0	1,294	194.00
194.01	07950	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019Worksheet B
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Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	747	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	216,801	22,391	41,845	107,935	134,079	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1319

Period:
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Cost Center Description			NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	39,474					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	759				14.00
15.00	01500	PHARMACY	1,179	0	60,686			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	77,678		16.00
17.00	01700	SOCIAL SERVICE	770	0	0	0	15,439	17.00
18.00	01080	INSERVICE EDUCATION	867	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,256	0	0	2,969	7,187	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	209	7,170	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,911	0	0	19,047	23	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,785	0	0	16,354	0	54.00
60.00	06000	LABORATORY	5,777	0	0	11,941	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	196	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,834	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,505	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	298	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,463	35	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	759	0	264	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,848	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	60,686	4,069	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	513	0	0	565	0	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	KEWANEE RHC	0	0	0	2,438	0	88.00
88.01	08801	WYOMING RHC	0	0	0	296	0	88.01
88.02	08802	GENESE0 RHC	0	0	0	789	0	88.02
90.00	09000	CLINIC	0	0	0	974	0	90.00
90.01	09001	PAIN CLINIC	353	0	0	18	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	0	263	0	90.03
90.04	09004	GENESE0 CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	5,063	0	0	3,560	1,024	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,474	759	60,686	76,900	15,439	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	0	0	0	0	192.03
192.04	19204	ANNAWAN CLINIC	0	0	0	537	0	192.04
192.05	19205	CAMBRIDGE CLINIC	0	0	0	241	0	192.05
194.00	07955	FOUNDATION	0	0	0	0	0	194.00
194.01	07950	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1319

Period:
From 06/01/2018
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Cost Center Description			NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	39,474	759	60,686	77,678	15,439	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1319

Period:
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Cost Center Description			OTHER GENERAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			INSERVICE EDUCATION				
			18.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	DATA PROCESSING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00570	ADMITTING					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE					5.05
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
18.00	01080	INSERVICE EDUCATION	3,653				18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	136	543,196	0	543,196	30.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	85	124,682	0	124,682	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	885	866,225	0	866,225	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	751	510,052	0	510,052	54.00
60.00	06000	LABORATORY	548	218,175	0	218,175	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	9	3,374	0	3,374	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	222	322,948	0	322,948	66.00
67.00	06700	OCCUPATIONAL THERAPY	69	109,778	0	109,778	67.00
68.00	06800	SPEECH PATHOLOGY	14	13,826	0	13,826	68.00
69.00	06900	ELECTROCARDIOLOGY	159	62,383	0	62,383	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	12	1,299	0	1,299	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	131	39,432	0	39,432	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	187	74,752	0	74,752	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	26	26,429	0	26,429	76.01
76.02	03950	IV THERAPY	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	KEWANEE RHC	112	160,540	0	160,540	88.00
88.01	08801	WYOMING RHC	14	12,245	0	12,245	88.01
88.02	08802	GENESEO RHC	36	125,045	0	125,045	88.02
90.00	09000	CLINIC	45	15,894	0	15,894	90.00
90.01	09001	PAIN CLINIC	1	3,913	0	3,913	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	12	16,264	0	16,264	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	90.04
91.00	09100	EMERGENCY	163	205,796	0	205,796	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			0		92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	41,442	0	41,442	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,617	3,497,690	0	3,497,690	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	25,959	0	25,959	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	11	0	11	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	33,825	0	33,825	192.03
192.04	19204	ANNAWAN CLINIC	25	5,006	0	5,006	192.04
192.05	19205	CAMBRIDGE CLINIC	11	14,593	0	14,593	192.05
194.00	07955	FOUNDATION	0	12,881	0	12,881	194.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1319

Period:
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Cost Center Description			OTHER GENERAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			INSERVICE EDUCATION					
			18.00	24.00	25.00	26.00		
194.01	07950	SPORTS MEDICINE	0	880	0	880		194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0		194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0		194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0		194.04
194.05	07954	COLONA CLINIC	0	0	0	0		194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	63,007	0	63,007		194.06
194.07	07957	COMMUNITY HEALTH	0	31	0	31		194.07
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	3,653	3,653,883	0	3,653,883		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (TIME SPENT)	PURCHASING RECEIVING AND STORES (SUPPLY COS T)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	104,556					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,119,397				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	498	238	16,198,298			4.00
5.01	00550	DATA PROCESSING	3,068	192,788	329,217	174,325		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	3,110	0	118,810	625	4,625,104	5.02
5.03	00570	ADMITTING	1,349	0	164,486	4,725	7,620	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,060	2,081	412,470	1,500	4,879	5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	4,233	8,684	539,632	30,675	14,855	5.05
7.00	00700	OPERATION OF PLANT	8,147	10,274	237,560	1,875	67,751	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	775	1,357	27,261	0	3,487	8.00
9.00	00900	HOUSEKEEPING	1,395	0	390,859	200	51,368	9.00
10.00	01000	DIETARY	3,534	7,348	465,613	1,000	43,955	10.00
11.00	01100	CAFETERIA	2,334	0	0	550	0	11.00
13.00	01300	NURSING ADMINISTRATION	608	13,687	166,102	3,975	40	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	39,561	14.00
15.00	01500	PHARMACY	1,676	1,994	224,594	5,475	5,274	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,639	7,741	430,774	9,400	3,451	16.00
17.00	01700	SOCIAL SERVICE	398	680	110,386	875	750	17.00
18.00	01080	INSERVICE EDUCATION	0	0	141,679	0	11,320	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,601	87,717	1,971,300	8,225	117,441	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	998,451	3,800	41,052	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,227	339,716	1,346,545	5,125	1,288,720	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,420	205,790	868,177	6,200	269,791	54.00
60.00	06000	LABORATORY	2,993	68,517	683,474	5,150	661,166	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	91	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	9,554	25,749	1,363,430	5,525	20,726	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,699	882	382,645	1,325	4,091	67.00
68.00	06800	SPEECH PATHOLOGY	404	0	129,278	250	2,045	68.00
69.00	06900	ELECTROCARDIOLOGY	1,611	5,088	232,176	1,125	19,477	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,613,233	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	747	0	68,281	2,075	2,647	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	KEWANEE RHC	0	63,041	1,492,718	50,225	52,200	88.00
88.01	08801	WYOMING RHC	0	7,411	172,939	1,525	9,082	88.01
88.02	08802	GENESEO RHC	3,260	18,269	743,877	4,500	19,356	88.02
90.00	09000	CLINIC	0	5,304	167,293	4,000	35,104	90.00
90.01	09001	PAIN CLINIC	26	0	58,467	925	12,263	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	262	1,558	35,277	1,900	19,063	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	4,960	25,070	769,434	7,275	104,397	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	1,127	4,065	528,633	1,750	42,505	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	99,806	1,105,049	15,771,838	171,775	4,588,670	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	988	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	555	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	775	2,836	117,379	0	2,813	192.03
192.04	19204	ANNAWAN CLINIC	0	1,260	115,278	425	19,604	192.04
192.05	19205	CAMBRIDGE CLINIC	0	10,038	108,947	1,400	9,279	192.05
194.00	07955	FOUNDATION	397	0	0	725	0	194.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019

Worksheet B-1

Date/Time Prepared:
10/25/2019 8:36 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (TIME SPENT)	PURCHASING RECEIVING AND STORES (SUPPLY COS T)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5.01	5.02	
194.01	07950	SPORTS MEDICINE	0	214	84,856	0	4,173	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	2,590	0	0	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	0	10	194.07
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)	2,513,392	1,140,491	3,424,653	1,773,410	127,055	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.038716	1.018844	0.211421	10.173010	0.027471	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			12,213	270,420	75,820	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000754	1.551240	0.016393	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019

Worksheet B-1

Date/Time Prepared:
10/25/2019 8:36 am

Cost Center Description			ADMITTING (GROSS CHARGES)	CASHIERING/AC COUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	ALL OTHER ADMINISTRATIVE AND GE (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING	103,245,977					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	114,799,989				5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	0	0	-3,104,105	36,786,657		5.05
7.00	00700	OPERATION OF PLANT	0	0	0	1,457,023	101,696	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	150,067	775	8.00
9.00	00900	HOUSEKEEPING	0	0	0	648,731	1,395	9.00
10.00	01000	DIETARY	0	0	0	906,350	3,534	10.00
11.00	01100	CAFETERIA	0	0	0	61,701	2,334	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	271,597	608	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	25,494	0	14.00
15.00	01500	PHARMACY	0	0	0	595,330	1,676	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	724,834	1,639	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	154,313	398	17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	213,745	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,259,224	4,259,224	0	2,835,646	13,601	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	2,642,403	0	1,772,379	17,935	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	27,398,493	27,398,493	0	4,600,033	15,227	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,463,037	23,463,037	0	2,907,542	8,420	54.00
60.00	06000	LABORATORY	17,131,830	17,131,830	0	2,272,110	2,993	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	281,868	281,868	0	139,808	91	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	6,935,747	6,935,747	0	2,107,679	9,554	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,159,035	2,159,035	0	608,685	3,699	67.00
68.00	06800	SPEECH PATHOLOGY	427,137	427,137	0	188,473	404	68.00
69.00	06900	ELECTROCARDIOLOGY	4,968,342	4,968,342	0	584,977	1,611	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	379,404	379,404	0	4,032	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,086,574	4,086,574	0	1,700,978	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,837,451	5,837,451	0	1,391,955	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	810,605	810,605	0	179,609	747	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	KEWANEE RHC	0	3,497,207	0	2,998,435	0	88.00
88.01	08801	WYOMING RHC	0	424,460	0	376,733	0	88.01
88.02	08802	GENESEO RHC	0	1,131,651	0	1,247,215	3,260	88.02
90.00	09000	CLINIC	0	1,397,335	0	508,639	0	90.00
90.01	09001	PAIN CLINIC	0	25,230	0	108,125	26	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	376,675	0	608,161	262	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	5,107,230	5,107,230	0	2,400,892	4,960	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	944,126	0	824,952	1,127	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	103,245,977	113,685,064	-3,104,105	35,576,243	96,276	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	23,750	988	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	570	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	0	0	227,099	4,035	192.03
192.04	19204	ANNAWAN CLINIC	0	769,836	0	437,719	0	192.04
192.05	19205	CAMBRIDGE CLINIC	0	345,089	0	374,425	0	192.05
194.00	07955	FOUNDATION	0	0	0	16,918	397	194.00
194.01	07950	SPORTS MEDICINE	0	0	0	122,796	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019

Worksheet B-1

Date/Time Prepared:
10/25/2019 8:36 am

Cost Center Description			ADMITTING (GROSS CHARGES)	CASHIERING/AC COUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	ALL OTHER ADMINISTRATIVE AND GE (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	7.00	
194.03	07952	ANESTHESIA BILLING	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	-62,260	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	7,137	0	194.07
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)	344,040	837,430		3,104,105	1,579,968	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.003332	0.007295		0.084381	15.536186	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	40,007	30,319		158,839	216,801	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000387	0.000264		0.004318	2.131854	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019

Worksheet B-1

Date/Time Prepared:
10/25/2019 8:36 am

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATIO N (FTES)	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	DATA PROCESSING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00570	ADMITTING					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE					5.05
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	243,865				8.00
9.00	00900	HOUSEKEEPING	11,859	240,170			9.00
10.00	01000	DIETARY	1,518	7,380	148,417		10.00
11.00	01100	CAFETERIA	0	7,080	97,140	18,445	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	296	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	900	0	294	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	630	0	1,196	16.00
17.00	01700	SOCIAL SERVICE	0	270	0	192	17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	216	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	56,931	59,370	12,624	2,806	30.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	61,315	59,070	38,653	2,652	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	37,468	46,590	0	1,972	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,029	9,990	0	1,442	54.00
60.00	06000	LABORATORY	0	5,730	0	1,440	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	18,012	7,140	0	2,087	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,620	0	519	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	183	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,640	0	402	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	1,543	500	0	128	76.01
76.02	03950	IV THERAPY	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	KEWANEE RHC	0	0	0	0	88.00
88.01	08801	WYOMING RHC	0	0	0	0	88.01
88.02	08802	GENESEO RHC	391	2,310	0	868	88.02
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	PAIN CLINIC	731	0	0	88	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	4,170	0	111	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	90.04
91.00	09100	EMERGENCY	28,068	9,300	0	1,262	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT					92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	1,050	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	243,865	225,740	148,417	18,154	9,840
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	10,140	0	113	192.03
192.04	19204	ANNAWAN CLINIC	0	0	0	0	192.04
192.05	19205	CAMBRIDGE CLINIC	0	0	0	0	192.05
194.00	07955	FOUNDATION	0	0	0	178	194.00
194.01	07950	SPORTS MEDICINE	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	194.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019

Worksheet B-1

Date/Time Prepared:
10/25/2019 8:36 am

Cost Center Description			LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATIO N (FTES)	
			8.00	9.00	10.00	11.00	13.00	
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	4,290	0	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	0	0	194.07
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)	174,771	733,644	1,061,366	819,467	317,112	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.716671	3.054686	7.151243	44.427596	32.226829	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	22,391	41,845	107,935	134,079	39,474	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.091817	0.174231	0.727241	7.269124	4.011585	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019

Worksheet B-1

Date/Time Prepared:
10/25/2019 8:36 am

Cost Center Description			CENTRAL SERVICES & SUPPLY (COSTED REQ UIS)	PHARMACY (COSTED REQ UIS)	MEDICAL RECORDS & LIBRARY (GROSS PT. CHARGES)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE INSERVICE EDUCATION (GROSS CHAR GES)	
			14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	100					14.00
15.00	01500	PHARMACY	0	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	111,513,473			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	67,075		17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	0	113,855,863	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	4,259,224	31,225	4,259,224	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	300,013	31,150	2,642,403	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	27,398,493	100	27,398,493	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	23,463,037	0	23,463,037	54.00
60.00	06000	LABORATORY	0	0	17,131,830	0	17,131,830	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	281,868	0	281,868	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	6,935,747	0	6,935,747	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,159,035	0	2,159,035	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	427,137	0	427,137	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	4,968,342	150	4,968,342	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	100	0	379,404	0	379,404	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	4,086,574	0	4,086,574	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	5,837,451	0	5,837,451	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	810,605	0	810,605	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	KEWANEE RHC	0	0	3,497,207	0	3,497,207	88.00
88.01	08801	WYOMING RHC	0	0	424,460	0	424,460	88.01
88.02	08802	GENESEO RHC	0	0	1,131,651	0	1,131,651	88.02
90.00	09000	CLINIC	0	0	1,397,335	0	1,397,335	90.00
90.01	09001	PAIN CLINIC	0	0	25,230	0	25,230	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	376,675	0	376,675	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	5,107,230	4,450	5,107,230	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	110,398,548	67,075	112,740,938	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	0	0	0	0	192.03
192.04	19204	ANNAWAN CLINIC	0	0	769,836	0	769,836	192.04
192.05	19205	CAMBRIDGE CLINIC	0	0	345,089	0	345,089	192.05
194.00	07955	FOUNDATION	0	0	0	0	0	194.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019

Worksheet B-1

Date/Time Prepared:
10/25/2019 8:36 am

Cost Center Description			CENTRAL SERVICES & SUPPLY (COSTED REQ UIS)	PHARMACY (COSTED REQ UIS)	MEDICAL RECORDS & LIBRARY (GROSS PT. CHARGES)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE	
							INSERVICE EDUCATION (GROSS CHAR GES)	
			14.00	15.00	16.00	17.00	18.00	
194.01	07950	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	0	0	194.07
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)	27,645	696,890	866,519	189,060	248,338	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	276.450000	6,968.900000	0.007771	2.818636	0.002181	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	759	60,686	77,678	15,439	3,653	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.590000	606.860000	0.000697	0.230175	0.000032	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019Worksheet C
Part I
Date/Time Prepared:
10/25/2019 8:36 am

			Title XVIII	Hospital	Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		3,944,155	0	3,944,155
43.00	04300	NURSERY		0	0	0
44.00	04400	SKILLED NURSING FACILITY		2,915,089	0	2,915,089
46.00	04600	OTHER LONG TERM CARE		0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		5,818,019	0	5,818,019
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0
53.00	05300	ANESTHESIOLOGY		0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC		3,676,908	0	3,676,908
60.00	06000	LABORATORY		2,808,715	0	2,808,715
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD		155,824	0	155,824
64.00	06400	INTRAVENOUS THERAPY		0	0	0
66.00	06600	PHYSICAL THERAPY	0	2,630,424	0	2,630,424
67.00	06700	OCCUPATIONAL THERAPY	0	767,008	0	767,008
68.00	06800	SPEECH PATHOLOGY	0	223,035	0	223,035
69.00	06900	ELECTROCARDIOLOGY		735,159	0	735,159
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT		35,792	0	35,792
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		1,885,178	0	1,885,178
73.00	07300	DRUGS CHARGED TO PATIENTS		2,264,394	0	2,264,394
76.00	03020	ACUPUNCTURE		0	0	0
76.01	03610	SLEEP LAB		226,883	0	226,883
76.02	03950	IV THERAPY		0	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC		3,286,250	0	3,286,250
88.01	08801	WYOMING RHC		412,746	0	412,746
88.02	08802	GENESEO RHC		1,460,265	0	1,460,265
90.00	09000	CLINIC		565,465	0	565,465
90.01	09001	PAIN CLINIC		125,174	0	125,174
90.02	09002	SPECIALTY CLINIC		0	0	0
90.03	09003	SURGICAL CLINIC		684,966	0	684,966
90.04	09004	GENESEO CLINIC		0	0	0
91.00	09100	EMERGENCY		2,889,174	0	2,889,174
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		1,079,142	0	1,079,142
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF		0	0	0
101.00	10100	HOME HEALTH AGENCY		915,278	0	915,278
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0
200.00		Subtotal (see instructions)	0	39,505,043	0	39,505,043
201.00		Less Observation Beds		1,079,142	0	1,079,142
202.00		Total (see instructions)	0	38,425,901	0	38,425,901

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019Worksheet C
Part I
Date/Time Prepared:
10/25/2019 8:36 am

			Title XVIII		Hospital	Cost		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,065,104		3,065,104			30.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	2,642,403		2,642,403			44.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,151,714	19,246,779	27,398,493	0.212348	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	865,373	22,597,664	23,463,037	0.156711	0.000000	54.00
60.00	06000	LABORATORY	1,329,568	15,802,262	17,131,830	0.163947	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	158,846	123,022	281,868	0.552826	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	738,770	6,196,977	6,935,747	0.379256	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	388,980	1,770,055	2,159,035	0.355255	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	67,000	360,137	427,137	0.522163	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	433,940	4,534,402	4,968,342	0.147969	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	293,746	85,658	379,404	0.094337	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,234,831	851,743	4,086,574	0.461310	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,994,939	3,842,512	5,837,451	0.387908	0.000000	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	810,605	810,605	0.279893	0.000000	76.01
76.02	03950	IV THERAPY	0	0	0	0.000000	0.000000	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	KEWANEE RHC	0	3,497,207	3,497,207			88.00
88.01	08801	WYOMING RHC	0	424,460	424,460			88.01
88.02	08802	GENESE0 RHC	0	1,131,651	1,131,651			88.02
90.00	09000	CLINIC	600	1,396,735	1,397,335	0.404674	0.000000	90.00
90.01	09001	PAIN CLINIC	0	25,230	25,230	4.961316	0.000000	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0.000000	0.000000	90.02
90.03	09003	SURGICAL CLINIC	0	376,675	376,675	1.818454	0.000000	90.03
90.04	09004	GENESE0 CLINIC	0	0	0	0.000000	0.000000	90.04
91.00	09100	EMERGENCY	132,834	4,974,396	5,107,230	0.565703	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	63,701	1,130,419	1,194,120	0.903713	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	944,126	944,126			101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	23,562,349	90,122,715	113,685,064			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	23,562,349	90,122,715	113,685,064			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-1319	Period: From 06/01/2018 To 05/31/2019	Worksheet C Part I Date/Time Prepared: 10/25/2019 8:36 am
			Title XVIII	Hospital	Cost
Cost Center Description			PPS Inpatient Ratio		
			11.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
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	0.212348		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.156711		54.00
60.00	06000	LABORATORY	0.163947		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.552826		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600	PHYSICAL THERAPY	0.379256		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.355255		67.00
68.00	06800	SPEECH PATHOLOGY	0.522163		68.00
69.00	06900	ELECTROCARDIOLOGY	0.147969		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.094337		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.461310		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.387908		73.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.279893		76.01
76.02	03950	IV THERAPY	0.000000		76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	KEWANEE RHC			88.00
88.01	08801	WYOMING RHC			88.01
88.02	08802	GENESE0 RHC			88.02
90.00	09000	CLINIC	0.404674		90.00
90.01	09001	PAIN CLINIC	4.961316		90.01
90.02	09002	SPECIALTY CLINIC	0.000000		90.02
90.03	09003	SURGICAL CLINIC	1.818454		90.03
90.04	09004	GENESE0 CLINIC	0.000000		90.04
91.00	09100	EMERGENCY	0.565703		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.903713		92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF			99.10
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019Worksheet C
Part I
Date/Time Prepared:
10/25/2019 8:36 am

			Title XIX	Hospital	Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		3,944,155	0	3,944,155
43.00	04300	NURSERY		0	0	0
44.00	04400	SKILLED NURSING FACILITY		2,915,089	0	2,915,089
46.00	04600	OTHER LONG TERM CARE		0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		5,818,019	0	5,818,019
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0
53.00	05300	ANESTHESIOLOGY		0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC		3,676,908	0	3,676,908
60.00	06000	LABORATORY		2,808,715	0	2,808,715
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD		155,824	0	155,824
64.00	06400	INTRAVENOUS THERAPY		0	0	0
66.00	06600	PHYSICAL THERAPY	0	2,630,424	0	2,630,424
67.00	06700	OCCUPATIONAL THERAPY	0	767,008	0	767,008
68.00	06800	SPEECH PATHOLOGY	0	223,035	0	223,035
69.00	06900	ELECTROCARDIOLOGY		735,159	0	735,159
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT		35,792	0	35,792
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		1,885,178	0	1,885,178
73.00	07300	DRUGS CHARGED TO PATIENTS		2,264,394	0	2,264,394
76.00	03020	ACUPUNCTURE		0	0	0
76.01	03610	SLEEP LAB		226,883	0	226,883
76.02	03950	IV THERAPY		0	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC		3,286,250	0	3,286,250
88.01	08801	WYOMING RHC		412,746	0	412,746
88.02	08802	GENESEO RHC		1,460,265	0	1,460,265
90.00	09000	CLINIC		565,465	0	565,465
90.01	09001	PAIN CLINIC		125,174	0	125,174
90.02	09002	SPECIALTY CLINIC		0	0	0
90.03	09003	SURGICAL CLINIC		684,966	0	684,966
90.04	09004	GENESEO CLINIC		0	0	0
91.00	09100	EMERGENCY		2,889,174	0	2,889,174
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		1,079,142	0	1,079,142
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF		0	0	0
101.00	10100	HOME HEALTH AGENCY		915,278	0	915,278
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
200.00		Subtotal (see instructions)	0	39,505,043	0	39,505,043
201.00		Less Observation Beds		1,079,142		1,079,142
202.00		Total (see instructions)	0	38,425,901	0	38,425,901

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019Worksheet C
Part I
Date/Time Prepared:
10/25/2019 8:36 am

			Title XIX			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,065,104		3,065,104			30.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	2,642,403		2,642,403			44.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,151,714	19,246,779	27,398,493	0.212348	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	865,373	22,597,664	23,463,037	0.156711	0.000000	54.00
60.00	06000	LABORATORY	1,329,568	15,802,262	17,131,830	0.163947	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	158,846	123,022	281,868	0.552826	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	738,770	6,196,977	6,935,747	0.379256	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	388,980	1,770,055	2,159,035	0.355255	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	67,000	360,137	427,137	0.522163	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	433,940	4,534,402	4,968,342	0.147969	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	293,746	85,658	379,404	0.094337	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,234,831	851,743	4,086,574	0.461310	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,994,939	3,842,512	5,837,451	0.387908	0.000000	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	810,605	810,605	0.279893	0.000000	76.01
76.02	03950	IV THERAPY	0	0	0	0.000000	0.000000	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	KEWANEE RHC	0	3,497,207	3,497,207	0.939678	0.000000	88.00
88.01	08801	WYOMING RHC	0	424,460	424,460	0.972403	0.000000	88.01
88.02	08802	GENESE0 RHC	0	1,131,651	1,131,651	1.290385	0.000000	88.02
90.00	09000	CLINIC	600	1,396,735	1,397,335	0.404674	0.000000	90.00
90.01	09001	PAIN CLINIC	0	25,230	25,230	4.961316	0.000000	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0.000000	0.000000	90.02
90.03	09003	SURGICAL CLINIC	0	376,675	376,675	1.818454	0.000000	90.03
90.04	09004	GENESE0 CLINIC	0	0	0	0.000000	0.000000	90.04
91.00	09100	EMERGENCY	132,834	4,974,396	5,107,230	0.565703	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	63,701	1,130,419	1,194,120	0.903713	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	944,126	944,126			101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	23,562,349	90,122,715	113,685,064			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	23,562,349	90,122,715	113,685,064			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019Worksheet C
Part I
Date/Time Prepared:
10/25/2019 8:36 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.000000		76.01
76.02	03950	IV THERAPY	0.000000		76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	KEWANEE RHC	0.000000		88.00
88.01	08801	WYOMING RHC	0.000000		88.01
88.02	08802	GENESE0 RHC	0.000000		88.02
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	PAIN CLINIC	0.000000		90.01
90.02	09002	SPECIALTY CLINIC	0.000000		90.02
90.03	09003	SURGICAL CLINIC	0.000000		90.03
90.04	09004	GENESE0 CLINIC	0.000000		90.04
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF			99.10
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-1319	Period: From 06/01/2018 To 05/31/2019	Worksheet D Part II Date/Time Prepared: 10/25/2019 8:36 am
Title XVIII				Hospital		Cost
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	866,225	27,398,493	0.031616	3,617,498	114,371	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	510,052	23,463,037	0.021739	303,983	6,608	54.00
60.00 06000 LABORATORY	218,175	17,131,830	0.012735	601,422	7,659	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD	3,374	281,868	0.011970	68,228	817	62.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
66.00 06600 PHYSICAL THERAPY	322,948	6,935,747	0.046563	164,936	7,680	66.00
67.00 06700 OCCUPATIONAL THERAPY	109,778	2,159,035	0.050846	84,677	4,305	67.00
68.00 06800 SPEECH PATHOLOGY	13,826	427,137	0.032369	11,499	372	68.00
69.00 06900 ELECTROCARDIOLOGY	62,383	4,968,342	0.012556	252,882	3,175	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	1,299	379,404	0.003424	188,423	645	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	39,432	4,086,574	0.009649	1,434,917	13,846	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	74,752	5,837,451	0.012806	860,354	11,018	73.00
76.00 03020 ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01 03610 SLEEP LAB	26,429	810,605	0.032604	0	0	76.01
76.02 03950 IV THERAPY	0	0	0.000000	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 KEWANEE RHC	160,540	3,497,207	0.045905	0	0	88.00
88.01 08801 WYOMING RHC	12,245	424,460	0.028848	0	0	88.01
88.02 08802 GENESEO RHC	125,045	1,131,651	0.110498	0	0	88.02
90.00 09000 CLINIC	15,894	1,397,335	0.011375	559	6	90.00
90.01 09001 PAIN CLINIC	3,913	25,230	0.155093	0	0	90.01
90.02 09002 SPECIALTY CLINIC	0	0	0.000000	0	0	90.02
90.03 09003 SURGICAL CLINIC	16,264	376,675	0.043178	0	0	90.03
90.04 09004 GENESEO CLINIC	0	0	0.000000	0	0	90.04
91.00 09100 EMERGENCY	205,796	5,107,230	0.040295	3,884	157	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	148,622	1,194,120	0.124462	2,513	313	92.00
200.00 Total (lines 50 through 199)	2,936,992	107,033,431		7,595,775	170,972	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019

Worksheet D
Part IV
Date/Time Prepared:
10/25/2019 8:36 am

Cost Center Description			Title XVIII		Hospital		Cost
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health
			1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0 62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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	ACUPUNCTURE	0	0	0	0	0 76.00
76.01	03610	SLEEP LAB	0	0	0	0	0 76.01
76.02	03950	IV THERAPY	0	0	0	0	0 76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	KEWANEE RHC	0	0	0	0	0 88.00
88.01	08801	WYOMING RHC	0	0	0	0	0 88.01
88.02	08802	GENESEO RHC	0	0	0	0	0 88.02
90.00	09000	CLINIC	0	0	0	0	0 90.00
90.01	09001	PAIN CLINIC	0	0	0	0	0 90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0 90.02
90.03	09003	SURGICAL CLINIC	0	0	0	0	0 90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0 90.04
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0 92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019Worksheet D
Part IV
Date/Time Prepared:
10/25/2019 8:36 am

Cost Center Description			Title XVIII		Hospital	Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)
			4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	27,398,493	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	23,463,037	0.000000
60.00	06000	LABORATORY	0	0	0	17,131,830	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	281,868	0.000000
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	6,935,747	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,159,035	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	427,137	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,968,342	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	379,404	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,086,574	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,837,451	0.000000
76.00	03020	ACUPUNCTURE	0	0	0	0	0.000000
76.01	03610	SLEEP LAB	0	0	0	810,605	0.000000
76.02	03950	IV THERAPY	0	0	0	0	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	KEWANEE RHC	0	0	0	3,497,207	0.000000
88.01	08801	WYOMING RHC	0	0	0	424,460	0.000000
88.02	08802	GENESEO RHC	0	0	0	1,131,651	0.000000
90.00	09000	CLINIC	0	0	0	1,397,335	0.000000
90.01	09001	PAIN CLINIC	0	0	0	25,230	0.000000
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0.000000
90.03	09003	SURGICAL CLINIC	0	0	0	376,675	0.000000
90.04	09004	GENESEO CLINIC	0	0	0	0	0.000000
91.00	09100	EMERGENCY	0	0	0	5,107,230	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	1,194,120	0.000000
200.00		Total (lines 50 through 199)	0	0	0	107,033,431	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019Worksheet D
Part IV
Date/Time Prepared:
10/25/2019 8:36 am

Cost Center Description			Title XVIII		Hospital		Cost
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	3,617,498	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	303,983	0	0	0
60.00	06000	LABORATORY	0.000000	601,422	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.000000	68,228	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0
66.00	06600	PHYSICAL THERAPY	0.000000	164,936	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	0.000000	84,677	0	0	0
68.00	06800	SPEECH PATHOLOGY	0.000000	11,499	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0.000000	252,882	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	188,423	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,434,917	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	860,354	0	0	0
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0
76.01	03610	SLEEP LAB	0.000000	0	0	0	0
76.02	03950	IV THERAPY	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	KEWANEE RHC	0.000000	0	0	0	0
88.01	08801	WYOMING RHC	0.000000	0	0	0	0
88.02	08802	GENESE0 RHC	0.000000	0	0	0	0
90.00	09000	CLINIC	0.000000	559	0	0	0
90.01	09001	PAIN CLINIC	0.000000	0	0	0	0
90.02	09002	SPECIALTY CLINIC	0.000000	0	0	0	0
90.03	09003	SURGICAL CLINIC	0.000000	0	0	0	0
90.04	09004	GENESE0 CLINIC	0.000000	0	0	0	0
91.00	09100	EMERGENCY	0.000000	3,884	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000	2,513	0	0	0
200.00		Total (lines 50 through 199)		7,595,775	0	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019Worksheet D
Part V
Date/Time Prepared:
10/25/2019 8:36 am

			Title XVIII		Hospital		Cost	
	Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.212348	0	5,803,469	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.156711	0	6,801,322	0	0	54.00
60.00	06000	LABORATORY	0.163947	0	5,157,070	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.552826	0	85,950	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.379256	0	1,951,921	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.355255	0	437,434	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.522163	0	50,910	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.147969	0	1,630,473	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.094337	0	68,693	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.461310	0	229,677	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.387908	0	1,752,670	5,499	0	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.279893	0	198,829	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	0	0	76.02
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	KEWANEE RHC	0.000000				0	88.00
88.01	08801	WYOMING RHC	0.000000				0	88.01
88.02	08802	GENESE0 RHC	0.000000				0	88.02
90.00	09000	CLINIC	0.404674	0	113,483	1,478	0	90.00
90.01	09001	PAIN CLINIC	4.961316	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	1.818454	0	40,253	0	0	90.03
90.04	09004	GENESE0 CLINIC	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.565703	0	1,481,690	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.903713	0	416,174	0	0	92.00
200.00		Subtotal (see instructions)		0	26,220,018	6,977	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	26,220,018	6,977	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN:14-1319		Period: From 06/01/2018 To 05/31/2019	Worksheet D Part V Date/Time Prepared: 10/25/2019 8:36 am
			Title XVIII		Hospital	Cost
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,232,355	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,065,842	0		54.00
60.00	06000	LABORATORY	845,486	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	47,515	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	740,278	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	155,401	0		67.00
68.00	06800	SPEECH PATHOLOGY	26,583	0		68.00
69.00	06900	ELECTROCARDIOLOGY	241,259	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	6,480	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	105,952	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	679,875	2,133		73.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	55,651	0		76.01
76.02	03950	IV THERAPY	0	0		76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0	0		88.00
88.01	08801	WYOMING RHC	0	0		88.01
88.02	08802	GENESE0 RHC	0	0		88.02
90.00	09000	CLINIC	45,924	598		90.00
90.01	09001	PAIN CLINIC	0	0		90.01
90.02	09002	SPECIALTY CLINIC	0	0		90.02
90.03	09003	SURGICAL CLINIC	73,198	0		90.03
90.04	09004	GENESE0 CLINIC	0	0		90.04
91.00	09100	EMERGENCY	838,196	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	376,102	0		92.00
200.00		Subtotal (see instructions)	6,536,097	2,731		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,536,097	2,731		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1319

Period:

Worksheet D

Component CCN:14-Z319

From 06/01/2018
To 05/31/2019Part V
Date/Time Prepared:
10/25/2019 8:36 am

			Title XVIII	Swing Beds - SNF		Cost	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.212348	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.156711	0	0	0	54.00
60.00	06000	LABORATORY	0.163947	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.552826	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.379256	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.355255	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.522163	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.147969	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.094337	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.461310	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.387908	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	76.00
76.01	03610	SLEEP LAB	0.279893	0	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	0	76.02
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0.000000			0	88.00
88.01	08801	WYOMING RHC	0.000000			0	88.01
88.02	08802	GENESE0 RHC	0.000000			0	88.02
90.00	09000	CLINIC	0.404674	0	0	0	90.00
90.01	09001	PAIN CLINIC	4.961316	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.000000	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	1.818454	0	0	0	90.03
90.04	09004	GENESE0 CLINIC	0.000000	0	0	0	90.04
91.00	09100	EMERGENCY	0.565703	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.903713	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1319

Period:

Worksheet D

Component CCN:14-Z319

From 06/01/2018
To 05/31/2019Part V
Date/Time Prepared:

10/25/2019 8:36 am

			Title XVIII		Swing Beds - SNF		Cost		
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0					50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0					52.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
60.00	06000	LABORATORY	0	0					60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0					62.00
64.00	06400	INTRAVENOUS THERAPY	0	0					64.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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	ACUPUNCTURE	0	0					76.00
76.01	03610	SLEEP LAB	0	0					76.01
76.02	03950	IV THERAPY	0	0					76.02
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	KEWANEE RHC	0	0					88.00
88.01	08801	WYOMING RHC	0	0					88.01
88.02	08802	GENESEO RHC	0	0					88.02
90.00	09000	CLINIC	0	0					90.00
90.01	09001	PAIN CLINIC	0	0					90.01
90.02	09002	SPECIALTY CLINIC	0	0					90.02
90.03	09003	SURGICAL CLINIC	0	0					90.03
90.04	09004	GENESEO CLINIC	0	0					90.04
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0					92.00
200.00		Subtotal (see instructions)	0	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	0					202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1319 Component CCN: 14-5464		Period: From 06/01/2018 To 05/31/2019		Worksheet D Part IV Date/Time Prepared: 10/25/2019 8:36 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	0	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	KEWANEE RHC	0	0	0	0	0	0	88.00
88.01	08801	WYOMING RHC	0	0	0	0	0	0	88.01
88.02	08802	GENESE0 RHC	0	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	09001	PAIN CLINIC	0	0	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	0	0	0	0	90.03
90.04	09004	GENESE0 CLINIC	0	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1319 Component CCN: 14-5464		Period: From 06/01/2018 To 05/31/2019		Worksheet D Part IV Date/Time Prepared: 10/25/2019 8:36 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	27,398,493	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	23,463,037	0.000000	54.00
60.00	06000	LABORATORY		0	0	0	17,131,830	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD		0	0	0	281,868	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0.000000	64.00
66.00	06600	PHYSICAL THERAPY		0	0	0	6,935,747	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	2,159,035	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	427,137	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	4,968,342	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT		0	0	0	379,404	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	4,086,574	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	5,837,451	0.000000	73.00
76.00	03020	ACUPUNCTURE		0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB		0	0	0	810,605	0.000000	76.01
76.02	03950	IV THERAPY		0	0	0	0	0.000000	76.02
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	KEWANEE RHC		0	0	0	3,497,207	0.000000	88.00
88.01	08801	WYOMING RHC		0	0	0	424,460	0.000000	88.01
88.02	08802	GENESEO RHC		0	0	0	1,131,651	0.000000	88.02
90.00	09000	CLINIC		0	0	0	1,397,335	0.000000	90.00
90.01	09001	PAIN CLINIC		0	0	0	25,230	0.000000	90.01
90.02	09002	SPECIALTY CLINIC		0	0	0	0	0.000000	90.02
90.03	09003	SURGICAL CLINIC		0	0	0	376,675	0.000000	90.03
90.04	09004	GENESEO CLINIC		0	0	0	0	0.000000	90.04
91.00	09100	EMERGENCY		0	0	0	5,107,230	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		0	0	0	1,194,120	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	107,033,431		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1319

Component CCN: 14-5464

Period:
From 06/01/2018
To 05/31/2019

Worksheet D
Part IV
Date/Time Prepared:
10/25/2019 8:36 am

				Title XVIII		Skilled Nursing Facility	PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	23,444	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	10,656	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	13,559	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.000000	1,110	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.000000	114,582	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	82,139	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	17,205	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,445	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	68,996	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	KEWANEE RHC	0.000000	0	0	0	0	88.00
88.01	08801	WYOMING RHC	0.000000	0	0	0	0	88.01
88.02	08802	GENESEO RHC	0.000000	0	0	0	0	88.02
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	PAIN CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	GENESEO CLINIC	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)			333,136	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN:14-1319 Component CCN:14-5464		Period: From 06/01/2018 To 05/31/2019		Worksheet D Part V Date/Time Prepared: 10/25/2019 8:36 am	
				Title XVIII		Skilled Nursing Facility		PPS	
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	0.212348	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.156711	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0.163947	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.552826	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.379256	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.355255	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.522163	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.147969	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.094337	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.461310	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.387908	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.279893	0	0	0	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	KEWANEE RHC	0.000000					0	88.00
88.01	08801	WYOMING RHC	0.000000					0	88.01
88.02	08802	GENESEO RHC	0.000000					0	88.02
90.00	09000	CLINIC	0.404674	0	0	0	0	0	90.00
90.01	09001	PAIN CLINIC	4.961316	0	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.000000	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	1.818454	0	0	0	0	0	90.03
90.04	09004	GENESEO CLINIC	0.000000	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.565703	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.903713	0	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	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	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN:14-1319 Component CCN:14-5464		Period: From 06/01/2018 To 05/31/2019		Worksheet D Part V Date/Time Prepared: 10/25/2019 8:36 am		
			Title XVIII		Skilled Nursing Facility		PPS		
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0					52.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
60.00	06000	LABORATORY	0	0					60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0					62.00
64.00	06400	INTRAVENOUS THERAPY	0	0					64.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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	ACUPUNCTURE	0	0					76.00
76.01	03610	SLEEP LAB	0	0					76.01
76.02	03950	IV THERAPY	0	0					76.02
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	KEWANEE RHC	0	0					88.00
88.01	08801	WYOMING RHC	0	0					88.01
88.02	08802	GENESE0 RHC	0	0					88.02
90.00	09000	CLINIC	0	0					90.00
90.01	09001	PAIN CLINIC	0	0					90.01
90.02	09002	SPECIALTY CLINIC	0	0					90.02
90.03	09003	SURGICAL CLINIC	0	0					90.03
90.04	09004	GENESE0 CLINIC	0	0					90.04
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0					92.00
200.00		Subtotal (see instructions)	0	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	0					202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1319	Period: From 06/01/2018 To 05/31/2019	Worksheet D-1 Date/Time Prepared: 10/25/2019 8:36 am	
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)			4,139	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,461	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)			2,346	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			205	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)			399	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			38	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)			36	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			1,295	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)			126	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)			314	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			133.47	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			133.47	20.00
21.00	Total general inpatient routine service cost (see instructions)			3,944,155	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			5,072	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)			4,805	25.00
26.00	Total swing-bed cost (see instructions)			594,452	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			3,349,703	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)			3,349,703	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)			967.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,253,353	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)			1,253,353	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019

Worksheet D-1

Date/Time Prepared:
10/25/2019 8:36 am

		Title XVIII		Hospital	Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
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)					2,106,331
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,359,684
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)					121,948
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					303,902
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					425,850
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)					1,115
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					967.84
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,079,142

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1319		Period: From 06/01/2018 To 05/31/2019		Worksheet D-1 Date/Time Prepared: 10/25/2019 8:36 am	
		Title XVIII		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	543,196	3,944,155	0.137722	1,079,142	148,622	90.00
91.00	Nursing School cost	0	3,944,155	0.000000	1,079,142	0	91.00
92.00	Allied health cost	0	3,944,155	0.000000	1,079,142	0	92.00
93.00	All other Medical Education	0	3,944,155	0.000000	1,079,142	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1319 Component CCN: 14-5464	Period: From 06/01/2018 To 05/31/2019	Worksheet D-1 Date/Time Prepared: 10/25/2019 8:36 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		13,008	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		13,008	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)		13,008	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)		448	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)		2,915,089	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)		2,915,089	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)		2,915,089	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: 14-1319 Component CCN: 14-5464	Period: From 06/01/2018 To 05/31/2019	Worksheet D-1 Date/Time Prepared: 10/25/2019 8:36 am
				Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT						43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges						54.00
55.00 Target amount per discharge						55.00
56.00 Target amount (line 54 x line 55)						56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00 Bonus payment (see instructions)						58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00 Relief payment (see instructions)						62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					2,915,089	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					224.10	71.00
72.00 Program routine service cost (line 9 x line 71)					100,397	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)					100,397	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)					100,397	83.00
84.00 Program inpatient ancillary services (see instructions)					118,083	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)					218,480	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:14-1319 Component CCN:14-5464		Period: From 06/01/2018 To 05/31/2019		Worksheet D-1 Date/Time Prepared: 10/25/2019 8:36 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
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: 14-1319	Period: From 06/01/2018 To 05/31/2019	Worksheet D-3 Date/Time Prepared: 10/25/2019 8:36 am
			Title XVIII	Hospital	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,492,487	30.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.212348	3,617,498	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.156711	303,983	54.00
60.00	06000	LABORATORY	0.163947	601,422	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.552826	68,228	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
66.00	06600	PHYSICAL THERAPY	0.379256	164,936	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.355255	84,677	67.00
68.00	06800	SPEECH PATHOLOGY	0.522163	11,499	68.00
69.00	06900	ELECTROCARDIOLOGY	0.147969	252,882	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.094337	188,423	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.461310	1,434,917	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.387908	860,354	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	76.00
76.01	03610	SLEEP LAB	0.279893	0	76.01
76.02	03950	IV THERAPY	0.000000	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	KEWANEE RHC	0.000000		88.00
88.01	08801	WYOMING RHC	0.000000		88.01
88.02	08802	GENESEO RHC	0.000000		88.02
90.00	09000	CLINIC	0.404674	559	90.00
90.01	09001	PAIN CLINIC	4.961316	0	90.01
90.02	09002	SPECIALTY CLINIC	0.000000	0	90.02
90.03	09003	SURGICAL CLINIC	1.818454	0	90.03
90.04	09004	GENESEO CLINIC	0.000000	0	90.04
91.00	09100	EMERGENCY	0.565703	3,884	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.903713	2,513	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,595,775	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)		7,595,775	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1319 Component CCN: 14-Z319	Period: From 06/01/2018 To 05/31/2019	Worksheet D-3 Date/Time Prepared: 10/25/2019 8:36 am	
Cost Center Description			Title XVIII	Swing Beds - SNF	Cost	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.212348	45,294	9,618	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.156711	10,928	1,713	54.00
60.00	06000	LABORATORY	0.163947	47,517	7,790	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.552826	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.379256	143,120	54,279	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.355255	65,314	23,203	67.00
68.00	06800	SPEECH PATHOLOGY	0.522163	17,635	9,208	68.00
69.00	06900	ELECTROCARDIOLOGY	0.147969	13,453	1,991	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.094337	459	43	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.461310	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.387908	95,928	37,211	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.279893	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0.000000		0	88.00
88.01	08801	WYOMING RHC	0.000000		0	88.01
88.02	08802	GENESEO RHC	0.000000		0	88.02
90.00	09000	CLINIC	0.404674	0	0	90.00
90.01	09001	PAIN CLINIC	4.961316	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.000000	0	0	90.02
90.03	09003	SURGICAL CLINIC	1.818454	0	0	90.03
90.04	09004	GENESEO CLINIC	0.000000	0	0	90.04
91.00	09100	EMERGENCY	0.565703	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.903713	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		439,648	145,056	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)		439,648		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1319 Component CCN: 14-5464	Period: From 06/01/2018 To 05/31/2019	Worksheet D-3 Date/Time Prepared: 10/25/2019 8:36 am	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.212348	23,444	4,978	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.156711	10,656	1,670	54.00
60.00	06000 LABORATORY	0.163947	13,559	2,223	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD	0.552826	1,110	614	62.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
66.00	06600 PHYSICAL THERAPY	0.379256	114,582	43,456	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.355255	82,139	29,180	67.00
68.00	06800 SPEECH PATHOLOGY	0.522163	17,205	8,984	68.00
69.00	06900 ELECTROCARDIOLOGY	0.147969	1,445	214	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.094337	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.461310	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.387908	68,996	26,764	73.00
76.00	03020 ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610 SLEEP LAB	0.279893	0	0	76.01
76.02	03950 IV THERAPY	0.000000	0	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 KEWANEE RHC	0.000000		0	88.00
88.01	08801 WYOMING RHC	0.000000		0	88.01
88.02	08802 GENESEO RHC	0.000000		0	88.02
90.00	09000 CLINIC	0.404674	0	0	90.00
90.01	09001 PAIN CLINIC	4.961316	0	0	90.01
90.02	09002 SPECIALTY CLINIC	0.000000	0	0	90.02
90.03	09003 SURGICAL CLINIC	1.818454	0	0	90.03
90.04	09004 GENESEO CLINIC	0.000000	0	0	90.04
91.00	09100 EMERGENCY	0.565703	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0.903713	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		333,136	118,083	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)		333,136		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1319	Period: From 06/01/2018 To 05/31/2019	Worksheet E Part B Date/Time Prepared: 10/25/2019 8:36 am
		Title XVIII	Hospital	Cost
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		6,538,828	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		6,538,828	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		6,604,216	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		93,398	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		4,173,522	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)		2,337,296	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)		2,337,296	30.00
31.00	Primary payer payments		78	31.00
32.00	Subtotal (line 30 minus line 31)		2,337,218	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)		82,891	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		53,879	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		2,391,097	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		2,391,097	40.00
40.01	Sequestration adjustment (see instructions)		47,822	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		3,016,686	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-673,411	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: 14-1319 Component CCN: 14-5464	Period: From 06/01/2018 To 05/31/2019	Worksheet E Part B Date/Time Prepared: 10/25/2019 8:36 am
		Title XVIII	Skilled Nursing Facility	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
4.01	Outlier reconciliation amount (see instructions)			4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		0	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		0	37.00
38.00	MSP-LCC reconciliation amount from PS&R			38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		0	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
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: 14-1319

Period:
From 06/01/2018
To 05/31/2019Worksheet E-1
Part I
Date/Time Prepared:
10/25/2019 8:36 am

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,007,805		3,496,877	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	11/15/2018	48,957	11/15/2018	288,131	3.50
3.51		05/16/2019	26,637	05/16/2019	192,060	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)		-75,594		-480,191	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)		2,932,211		3,016,686	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		56,961		673,411	6.02
7.00	Total Medicare program liability (see instructions)		2,875,250		2,343,275	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.		06101		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN:14-1319

Period:

Worksheet E-1

Component CCN:14-Z319

From 06/01/2018
To 05/31/2019Part I
Date/Time Prepared:
10/25/2019 8:36 am

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		631,412		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)		631,412		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		69,504		0	6.02
7.00	Total Medicare program liability (see instructions)		561,908		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.		06101		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

 Provider CCN: 14-1319
 Component CCN: 14-5464

 Period:
 From 06/01/2018
 To 05/31/2019

 Worksheet E-1
 Part I
 Date/Time Prepared:
 10/25/2019 8:36 am

		Title XVIII		Skilled Nursing Facility		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		166,065		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)		166,065		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)		166,064		0	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.		06101			8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-1319	Period: From 06/01/2018 To 05/31/2019	Worksheet E-1 Part II Date/Time Prepared: 10/25/2019 8:36 am
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN:14-1319

Period:

Worksheet E-2

Component CCN:14-Z319

From 06/01/2018

To 05/31/2019

Date/Time Prepared:
10/25/2019 8:36 am

		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		430,109	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)		146,507	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		440	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)		576,616	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		576,616	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)		576,616	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		3,240	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		573,376	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		573,376	0	19.00
19.01	Sequestration adjustment (see instructions)		11,468	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
20.00	Interim payments		631,412	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)		-69,504	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-1319	Period: From 06/01/2018 To 05/31/2019	Worksheet E-3 Part V Date/Time Prepared: 10/25/2019 8:36 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		3,359,684	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)		3,359,684	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		3,393,281	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)		3,393,281	19.00
20.00	Deductibles (exclude professional component)		471,562	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		2,921,719	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		2,921,719	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		18,784	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		12,210	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		2,933,929	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		2,933,929	30.00
30.01	Sequestration adjustment (see instructions)		58,679	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		2,932,211	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		-56,961	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:14-1319 Component CCN:14-5464	Period: From 06/01/2018 To 05/31/2019	Worksheet E-3 Part VI Date/Time Prepared: 10/25/2019 8:36 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)			189,063 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)			189,063 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			18,683 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)			170,380 12.00
13.00	Inpatient primary payer payments			0 13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 14.50
14.99	Demonstration payment adjustment amount before sequestration			0 14.99
15.00	Subtotal (see instructions)			170,380 15.00
15.01	Sequestration adjustment (see instructions)			3,408 15.01
15.02	Demonstration payment adjustment amount after sequestration			908 15.02
16.00	Interim payments			166,065 16.00
17.00	Tentative settlement (for contractor use only)			0 17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)			-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: 14-1319

Period:
From 06/01/2018
To 05/31/2019

Worksheet G

Date/Time Prepared:
10/25/2019 8:36 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	9,170,049	0	0	0	1.00
2.00	Temporary investments	22,635,740	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	27,918,333	0	0	0	4.00
5.00	Other receivable	958,246	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-24,226,139	0	0	0	6.00
7.00	Inventory	756,785	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	1,313,554	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)	38,526,568	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,335,569	0	0	0	12.00
13.00	Land improvements	1,658,717	0	0	0	13.00
14.00	Accumulated depreciation	-1,025,279	0	0	0	14.00
15.00	Buildings	43,199,763	0	0	0	15.00
16.00	Accumulated depreciation	-23,966,100	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	14,183,345	0	0	0	19.00
20.00	Accumulated depreciation	-10,816,412	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	1,844,531	0	0	0	23.00
24.00	Accumulated depreciation	-942,141	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	617,009	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	26,089,002	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	467,080	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	8,146,569	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,613,649	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	73,229,219	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	0	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,244,050	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	408,708	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,694,371	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,347,129	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	2,899,629	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	26,641,719	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	29,541,348	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	34,888,477	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	38,340,742	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	38,340,742	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	73,229,219	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019

Worksheet G-1

Date/Time Prepared:
10/25/2019 8:36 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		34,648,343		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,664,690				2.00
3.00	Total (sum of line 1 and line 2)		38,313,033		0		3.00
4.00	NET INCOME FROM FOUNDATION	27,710		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		27,710		0		10.00
11.00	Subtotal (line 3 plus line 10)		38,340,743		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		38,340,743		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	NET INCOME FROM FOUNDATION		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
10/25/2019 8:36 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,065,104		3,065,104	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				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	2,642,403		2,642,403	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,707,507		5,707,507	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)	5,707,507		5,707,507	17.00
18.00	Ancillary services	17,775,960	82,163,751	99,939,711	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	KEWANEE RHC	0	3,497,207	3,497,207	20.00
20.01	WYOMING RHC	0	424,460	424,460	20.01
20.02	GENESEO RHC	0	1,131,651	1,131,651	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		944,126	944,126	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	COLONA CLINIC	0	1,596,965	1,596,965	27.00
27.01	SURGICAL CLINIC	0	376,675	376,675	27.01
27.02	OTHER (SPECIFY)	0	0	0	27.02
27.03	PROFESSIONAL FEES	2,046,585	11,556,244	13,602,829	27.03
27.04	CAMBRIDGE CLINIC	0	345,089	345,089	27.04
27.05	ANNAWAN CLINIC	0	769,836	769,836	27.05
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	25,530,052	102,806,004	128,336,056	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		44,551,405		29.00
30.00	PROVISION FOR BAD DEBT	2,105,076			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		2,105,076		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)		46,656,481		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1319

Period:
From 06/01/2018
To 05/31/2019

Worksheet G-3

Date/Time Prepared:
10/25/2019 8:36 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	128,336,056	1.00
2.00	Less contractual allowances and discounts on patients' accounts	80,603,582	2.00
3.00	Net patient revenues (line 1 minus line 2)	47,732,474	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	46,656,481	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,075,993	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	83,791	6.00
7.00	Income from investments	296,097	7.00
8.00	Revenues from telephone and other miscellaneous communication services	212	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	102,635	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	210,478	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	2,801	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	CHANGE IN IMRF PENSION	361,537	24.00
24.01	RENTAL INCOME	424,653	24.01
24.02	PROPERTY INCOME	750,810	24.02
24.03	340B PHARMACY REVENUE	365,746	24.03
24.04	OTHER OPERATING REVENUE	123,079	24.04
25.00	Total other income (sum of lines 6-24)	2,721,839	25.00
26.00	Total (line 5 plus line 25)	3,797,832	26.00
27.00	340B PHARMACY EXPENSES	133,142	27.00
27.02	OTHER EXPENSES (SPECIFY)	0	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	133,142	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,664,690	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS					Provider CCN: 14-1319 HHA CCN: 14-7450	Period: From 06/01/2018 To 05/31/2019	Worksheet H Date/Time Prepared: 10/25/2019 8:36 am
					Home Health Agency I		PPS
	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures		0		0	0	1.00
2.00	Capital Related - Movable Equipment		0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	111,062	0	31	7,497	22,094	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	375,920	0	55,763	0	2,600	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	550	0	0	10.00
11.00	Home Health Aide	41,651	0	61	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	38,867	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	528,633	0	56,405	7,497	63,561	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00	Capital Related - Movable Equipment	0	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	0	140,684	0	140,684		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	434,283	0	434,283		6.00
7.00	Physical Therapy	0	0	0	0		7.00
8.00	Occupational Therapy	0	0	0	0		8.00
9.00	Speech Pathology	0	0	0	0		9.00
10.00	Medical Social Services	0	550	0	550		10.00
11.00	Home Health Aide	0	41,712	0	41,712		11.00
12.00	Supplies (see instructions)	0	38,867	0	38,867		12.00
13.00	Drugs	0	0	0	0		13.00
14.00	DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	0	0	0		22.00
23.00	All Others (specify)	0	0	0	0		23.00
23.50	Telemedicine	0	0	0	0		23.50
24.00	Total (sum of lines 1-23)	0	656,096	0	656,096		24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-1319

Period:

Worksheet H-1

HHA CCN: 14-7450

From 06/01/2018
To 05/31/2019Part I
Date/Time Prepared:
10/25/2019 8:36 amHome Health
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PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportatio n	Subtotal (cols. 0-4)		
			Bldgs & Fixtures	Movable Equipment					
		0	1.00	2.00	3.00	4.00	4A.00		
	GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00	
2.00	Capital Related - Movable Equipment	0		0			0	2.00	
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00	
4.00	Transportation	0	0	0	0	0		4.00	
5.00	Administrative and General	140,684	0	0	0	0	140,684	5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	434,283	0	0	0	0	434,283	6.00	
7.00	Physical Therapy	0	0	0	0	0	0	7.00	
8.00	Occupational Therapy	0	0	0	0	0	0	8.00	
9.00	Speech Pathology	0	0	0	0	0	0	9.00	
10.00	Medical Social Services	550	0	0	0	0	550	10.00	
11.00	Home Health Aide	41,712	0	0	0	0	41,712	11.00	
12.00	Supplies (see instructions)	38,867	0	0	0	0	38,867	12.00	
13.00	Drugs	0	0	0	0	0	0	13.00	
14.00	DME	0	0	0	0	0	0	14.00	
	HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	0	23.00	
23.50	Telemedicine	0	0	0	0	0	0	23.50	
24.00	Total (sum of lines 1-23)	656,096	0	0	0	0	656,096	24.00	
		Administrativ e & General	Total (cols. 4A + 5)						
		5.00	6.00						
	GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures							1.00	
2.00	Capital Related - Movable Equipment							2.00	
3.00	Plant Operation & Maintenance							3.00	
4.00	Transportation							4.00	
5.00	Administrative and General	140,684						5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	118,540	552,823					6.00	
7.00	Physical Therapy	0	0					7.00	
8.00	Occupational Therapy	0	0					8.00	
9.00	Speech Pathology	0	0					9.00	
10.00	Medical Social Services	150	700					10.00	
11.00	Home Health Aide	11,385	53,097					11.00	
12.00	Supplies (see instructions)	10,609	49,476					12.00	
13.00	Drugs	0	0					13.00	
14.00	DME	0	0					14.00	
	HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0					15.00	
16.00	Respiratory Therapy	0	0					16.00	
17.00	Private Duty Nursing	0	0					17.00	
18.00	Clinic	0	0					18.00	
19.00	Health Promotion Activities	0	0					19.00	
20.00	Day Care Program	0	0					20.00	
21.00	Home Delivered Meals Program	0	0					21.00	
22.00	Homemaker Service	0	0					22.00	
23.00	All Others (specify)	0	0					23.00	
23.50	Telemedicine	0	0					23.50	
24.00	Total (sum of lines 1-23)		656,096					24.00	

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-1319

Period:

Worksheet H-1

HHA CCN: 14-7450

From 06/01/2018
To 05/31/2019Part II
Date/Time Prepared:
10/25/2019 8:36 amHome Health
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PPS

		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportatio n (MILEAGE)	Reconciliatio n	Administrativ e & General (ACCUM. COST)	
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-140,684	515,412	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	434,283	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	550	10.00
11.00	Home Health Aide	0	0	0	0	0	41,712	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	38,867	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-140,684	515,412	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		140,684	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.272954	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1319

Period:

Worksheet H-2

HHA CCN: 14-7450

From 06/01/2018
To 05/31/2019Part I
Date/Time Prepared:
10/25/2019 8:36 amHome Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	PURCHASING RECEIVING AND STORES	
			BLDG & FIXT	MVBLE EQUIP				
		0	1.00	2.00	4.00	5.01	5.02	
1.00	Administrative and General	0	27,092	4,142	111,764	17,803	1,168	1.00
2.00	Skilled Nursing Care	552,823	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	700	0	0	0	0	0	6.00
7.00	Home Health Aide	53,097	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	49,476	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	656,096	27,092	4,142	111,764	17,803	1,168	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		ADMITTING	CASHIERING/AC COUNTS RECEIVABLE	Subtotal	ALL OTHER ADMINISTRATIV E AND GE	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5.03	5.04	5A.04	5.05	7.00	8.00	
1.00	Administrative and General	0	6,887	168,856	14,248	17,509	0	1.00
2.00	Skilled Nursing Care	0	0	552,823	46,648	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	700	59	0	0	6.00
7.00	Home Health Aide	0	0	53,097	4,480	0	0	7.00
8.00	Supplies (see instructions)	0	0	49,476	4,175	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	6,887	824,952	69,610	17,509	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.000000				21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1319

Period:

Worksheet H-2

HHA CCN: 14-7450

From 06/01/2018

Part I

To 05/31/2019

Date/Time Prepared:

10/25/2019 8:36 am

Home Health
Agency I

PPS

Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	3,207	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	3,207	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE INSERVICE EDUCATION	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		16.00	17.00	18.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	0	203,820	0	203,820	1.00
2.00	Skilled Nursing Care	0	0	0	599,471	0	599,471	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	759	0	759	6.00
7.00	Home Health Aide	0	0	0	57,577	0	57,577	7.00
8.00	Supplies (see instructions)	0	0	0	53,651	0	53,651	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	915,278	0	915,278	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1319

Period:

Worksheet H-2

HHA CCN: 14-7450

From 06/01/2018
To 05/31/2019Part I
Date/Time Prepared:
10/25/2019 8:36 amHome Health
Agency I

PPS

Cost Center Description		Allocated HHA A&G (see Part II)	Total HHA Costs		
		27.00	28.00		
1.00	Administrative and General				1.00
2.00	Skilled Nursing Care	171,738	771,209		2.00
3.00	Physical Therapy	0	0		3.00
4.00	Occupational Therapy	0	0		4.00
5.00	Speech Pathology	0	0		5.00
6.00	Medical Social Services	217	976		6.00
7.00	Home Health Aide	16,495	74,072		7.00
8.00	Supplies (see instructions)	15,370	69,021		8.00
9.00	Drugs	0	0		9.00
10.00	DME	0	0		10.00
11.00	Home Dialysis Aide Services	0	0		11.00
12.00	Respiratory Therapy	0	0		12.00
13.00	Private Duty Nursing	0	0		13.00
14.00	Clinic	0	0		14.00
15.00	Health Promotion Activities	0	0		15.00
16.00	Day Care Program	0	0		16.00
17.00	Home Delivered Meals Program	0	0		17.00
18.00	Homemaker Service	0	0		18.00
19.00	All Others (specify)	0	0		19.00
19.50	Telemedicine	0	0		19.50
20.00	Total (sum of lines 1-19) (2)	203,820	915,278		20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.286482			21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1319

Period: From 06/01/2018

Worksheet H-2

HHA CCN: 14-7450

To 05/31/2019

Part II

Date/Time Prepared: 10/25/2019 8:36 am

Home Health Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (TIME SPENT)	PURCHASING RECEIVING AND STORES (SUPPLY COST)	ADMITTING (GROSS CHARGES)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
		1.00	2.00	4.00	5.01	5.02	5.03	
1.00	Administrative and General	1,127	4,065	528,633	1,750	42,505	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,127	4,065	528,633	1,750	42,505	0	20.00
21.00	Total cost to be allocated	27,092	4,142	111,764	17,803	1,168	0	21.00
22.00	Unit cost multiplier	24.039042	1.018942	0.211421	10.173143	0.027479	0.000000	22.00
Cost Center Description		CASHIERING/AC COUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	ALL OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		5.04	5A.05	5.05	7.00	8.00	9.00	
1.00	Administrative and General	944,126	0	168,856	1,127	0	1,050	1.00
2.00	Skilled Nursing Care	0	0	552,823	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	700	0	0	0	6.00
7.00	Home Health Aide	0	0	53,097	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	49,476	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	944,126	0	824,952	1,127	0	1,050	20.00
21.00	Total cost to be allocated	6,887	0	69,610	17,509	0	3,207	21.00
22.00	Unit cost multiplier	0.007295	0	0.084381	15.535936	0.000000	3.054286	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1319

Period:

Worksheet H-2

HHA CCN: 14-7450

From 06/01/2018
To 05/31/2019Part II
Date/Time Prepared:
10/25/2019 8:36 am

						Home Health Agency I	PPS		
Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQ UIS)	PHARMACY (COSTED REQ UIS)	MEDICAL RECORDS & LIBRARY (GROSS PT. CHARGES)		
									10.00
1.00	Administrative and General	0	0	0	0	0	0	1.00	
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00	
3.00	Physical Therapy	0	0	0	0	0	0	3.00	
4.00	Occupational Therapy	0	0	0	0	0	0	4.00	
5.00	Speech Pathology	0	0	0	0	0	0	5.00	
6.00	Medical Social Services	0	0	0	0	0	0	6.00	
7.00	Home Health Aide	0	0	0	0	0	0	7.00	
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00	
9.00	Drugs	0	0	0	0	0	0	9.00	
10.00	DME	0	0	0	0	0	0	10.00	
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00	Clinic	0	0	0	0	0	0	14.00	
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00	Day Care Program	0	0	0	0	0	0	16.00	
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00	Homemaker Service	0	0	0	0	0	0	18.00	
19.00	All Others (specify)	0	0	0	0	0	0	19.00	
19.50	Telemedicine	0	0	0	0	0	0	19.50	
20.00	Total (sum of lines 1-19)	0	0	0	0	0	0	20.00	
21.00	Total cost to be allocated	0	0	0	0	0	0	21.00	
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	22.00	
Cost Center Description		SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE						
			INSERVICE EDUCATION (GROSS CHARGES)						
		17.00	18.00						
1.00	Administrative and General	0	0					1.00	
2.00	Skilled Nursing Care	0	0					2.00	
3.00	Physical Therapy	0	0					3.00	
4.00	Occupational Therapy	0	0					4.00	
5.00	Speech Pathology	0	0					5.00	
6.00	Medical Social Services	0	0					6.00	
7.00	Home Health Aide	0	0					7.00	
8.00	Supplies (see instructions)	0	0					8.00	
9.00	Drugs	0	0					9.00	
10.00	DME	0	0					10.00	
11.00	Home Dialysis Aide Services	0	0					11.00	
12.00	Respiratory Therapy	0	0					12.00	
13.00	Private Duty Nursing	0	0					13.00	
14.00	Clinic	0	0					14.00	
15.00	Health Promotion Activities	0	0					15.00	
16.00	Day Care Program	0	0					16.00	
17.00	Home Delivered Meals Program	0	0					17.00	
18.00	Homemaker Service	0	0					18.00	
19.00	All Others (specify)	0	0					19.00	
19.50	Telemedicine	0	0					19.50	
20.00	Total (sum of lines 1-19)	0	0					20.00	
21.00	Total cost to be allocated	0	0					21.00	
22.00	Unit cost multiplier	0.000000	0.000000					22.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1319

Period:

Worksheet H-3

HHA CCN: 14-7450

From 06/01/2018

Part I

To 05/31/2019

Date/Time Prepared:

10/25/2019 8:36 am

Title XVIII

Home Health

PPS

Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
	0	1.00	2.00	3.00	4.00	5.00	

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION

Cost Per Visit Computation

1.00	Skilled Nursing Care	2.00	771,209		771,209	4,946	155.93	1.00
2.00	Physical Therapy	3.00	0	115,716	115,716	1,674	69.13	2.00
3.00	Occupational Therapy	4.00	0	54,634	54,634	948	57.63	3.00
4.00	Speech Pathology	5.00	0	19,743	19,743	136	145.17	4.00
5.00	Medical Social Services	6.00	976		976	73	13.37	5.00
6.00	Home Health Aide	7.00	74,072		74,072	936	79.14	6.00
7.00	Total (sum of lines 1-6)		846,257	190,093	1,036,350	8,713		7.00

Program Visits

Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Part B			
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles		
	0	1.00	2.00	3.00	4.00	5.00	

Limitation Cost Computation

8.00	Skilled Nursing Care	19340	0	2,039			8.00
8.01	Skilled Nursing Care	99914	0	287			8.01
9.00	Physical Therapy	19340	0	766			9.00
9.01	Physical Therapy	99914	0	36			9.01
10.00	Occupational Therapy	19340	0	414			10.00
10.01	Occupational Therapy	99914	0	42			10.01
11.00	Speech Pathology	19340	0	34			11.00
11.01	Speech Pathology	99914	0	10			11.01
12.00	Medical Social Services	19340	0	9			12.00
12.01	Medical Social Services	99914	0	1			12.01
13.00	Home Health Aide	19340	0	318			13.00
13.01	Home Health Aide	99914	0	79			13.01
14.00	Total (sum of lines 8-13)		0	4,035			14.00

Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
	0	1.00	2.00	3.00	4.00	5.00	

Supplies and Drugs Cost Computations

15.00	Cost of Medical Supplies	8.00	69,021	0	69,021	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

Cost Center Description	Part A	Part B	Part A	Part B			
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance				
	6.00	7.00	8.00	9.00	10.00	11.00	

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION

Cost Per Visit Computation

1.00	Skilled Nursing Care	0	2,326		0	362,693	1.00
2.00	Physical Therapy	0	802		0	55,442	2.00
3.00	Occupational Therapy	0	456		0	26,279	3.00
4.00	Speech Pathology	0	44		0	6,387	4.00
5.00	Medical Social Services	0	10		0	134	5.00
6.00	Home Health Aide	0	397		0	31,419	6.00
7.00	Total (sum of lines 1-6)	0	4,035		0	482,354	7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1319

Period:

Worksheet H-3

HHA CCN: 14-7450

From 06/01/2018
To 05/31/2019Part I
Date/Time Prepared:
10/25/2019 8:36 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description						Agency 1			
		6.00	7.00	8.00	9.00	10.00	11.00		
8.00	Limitation Cost Computation								8.00
8.01	Skilled Nursing Care							8.01	
9.00	Physical Therapy							9.00	
9.01	Physical Therapy							9.01	
10.00	Occupational Therapy							10.00	
10.01	Occupational Therapy							10.01	
11.00	Speech Pathology							11.00	
11.01	Speech Pathology							11.01	
12.00	Medical Social Services							12.00	
12.01	Medical Social Services							12.01	
13.00	Home Health Aide							13.00	
13.01	Home Health Aide							13.01	
14.00	Total (sum of lines 8-13)							14.00	
Cost Center Description		Program Covered Charges			Cost of Services				
		Part A	Part B		Part A	Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
		6.00	7.00	8.00	9.00	10.00	11.00		
Supplies and Drugs Cost Computations									
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00	
16.00	Cost of Drugs		0	0		0	0	16.00	
Cost Center Description		Total Program Cost (sum of cols. 9-10)							
		12.00							
		PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation									
1.00	Skilled Nursing Care	362,693						1.00	
2.00	Physical Therapy	55,442						2.00	
3.00	Occupational Therapy	26,279						3.00	
4.00	Speech Pathology	6,387						4.00	
5.00	Medical Social Services	134						5.00	
6.00	Home Health Aide	31,419						6.00	
7.00	Total (sum of lines 1-6)	482,354						7.00	
Cost Center Description									
		12.00							
Limitation Cost Computation									
8.00	Skilled Nursing Care							8.00	
8.01	Skilled Nursing Care							8.01	
9.00	Physical Therapy							9.00	
9.01	Physical Therapy							9.01	
10.00	Occupational Therapy							10.00	
10.01	Occupational Therapy							10.01	
11.00	Speech Pathology							11.00	
11.01	Speech Pathology							11.01	
12.00	Medical Social Services							12.00	
12.01	Medical Social Services							12.01	
13.00	Home Health Aide							13.00	
13.01	Home Health Aide							13.01	
14.00	Total (sum of lines 8-13)							14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1319

Period:

Worksheet H-3

HHA CCN: 14-7450

From 06/01/2018
To 05/31/2019Part II
Date/Time Prepared:
10/25/2019 8:36 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.379256	305,114	115,716	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.355255	153,788	54,634	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.522163	37,810	19,743	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.094337	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.387908	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1319 HHA CCN: 14-7450	Period: From 06/01/2018 To 05/31/2019	Worksheet H-4 Part I-II Date/Time Prepared: 10/25/2019 8:36 am
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0 1.00
2.00	Total charges	0	0	0 2.00
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0 3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0 4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000 5.00
6.00	Total customary charges (see instructions)	0	0	0 6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0 7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0 8.00
9.00	Primary payer amounts	0	0	0 9.00
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0 10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	560,173 11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	32,331 12.00
13.00	Total PPS Reimbursement - LUPA Episodes		0	14,780 13.00
14.00	Total PPS Reimbursement - PEP Episodes		0	8,790 14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	12,962 15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	82 16.00
17.00	Total Other Payments		0	0 17.00
18.00	DME Payments		0	0 18.00
19.00	Oxygen Payments		0	0 19.00
20.00	Prosthetic and Orthotic Payments		0	0 20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0 21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	629,118 22.00
23.00	Excess reasonable cost (from line 8)		0	0 23.00
24.00	Subtotal (line 22 minus line 23)		0	629,118 24.00
25.00	Coinsurance billed to program patients (from your records)			0 25.00
26.00	Net cost (line 24 minus line 25)		0	629,118 26.00
27.00	Reimbursable bad debts (from your records)			0 27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0 28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	629,118 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0 30.50
30.99	Demonstration payment adjustment amount before sequestration		0	0 30.99
31.00	Subtotal (see instructions)		0	629,118 31.00
31.01	Sequestration adjustment (see instructions)		0	12,582 31.01
31.02	Demonstration payment adjustment amount after sequestration		0	0 31.02
32.00	Interim payments (see instructions)		0	616,535 32.00
33.00	Tentative settlement (for contractor use only)		0	0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	1 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0 35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1319 HHA CCN: 14-7450	Period: From 06/01/2018 To 05/31/2019	Worksheet H-5 Date/Time Prepared: 10/25/2019 8:36 am		
				Home Health Agency I	PPS	
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		616,535	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		616,535	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		1	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		616,536	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.		06101		8.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1319

Period:

Worksheet M-1

Component CCN: 14-8576

From 06/01/2018
To 05/31/2019Date/Time Prepared:
10/25/2019 8:36 am

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	709,640	0	709,640	177,697	887,337
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	253,165	0	253,165	0	253,165
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	200,351	0	200,351	0	200,351
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	121,623	0	121,623	-18,284	103,339
10.00	Subtotal (sum of lines 1 through 9)	1,284,779	0	1,284,779	159,413	1,444,192
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	36,388	36,388	0	36,388
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	36,388	36,388	0	36,388
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,284,779	36,388	1,321,167	159,413	1,480,580
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	22,709	22,709	0	22,709
30.00	Administrative Costs	226,223	351,217	577,440	0	577,440
31.00	Total Facility Overhead (sum of lines 29 and 30)	226,223	373,926	600,149	0	600,149
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,511,002	410,314	1,921,316	159,413	2,080,729

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1319

Period:

Worksheet M-1

Component CCN: 14-8576

From 06/01/2018
To 05/31/2019Date/Time Prepared:
10/25/2019 8:36 am

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	887,337	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	253,165	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	200,351	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	103,339	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,444,192	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	36,388	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	36,388	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,480,580	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	22,709	29.00
30.00	Administrative Costs	0	577,440	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	600,149	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,080,729	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1319

Period:

Worksheet M-1

Component CCN: 14-8577

From 06/01/2018
To 05/31/2019Date/Time Prepared:
10/25/2019 8:36 am

		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	14,998	0	14,998	22,298	37,296
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	82,688	0	82,688	0	82,688
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	29,601	0	29,601	0	29,601
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	10,731	0	10,731	-1,772	8,959
10.00	Subtotal (sum of lines 1 through 9)	138,018	0	138,018	20,526	158,544
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	19,770	19,770	0	19,770
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	19,770	19,770	0	19,770
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	138,018	19,770	157,788	20,526	178,314
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	9,968	9,968	0	9,968
30.00	Administrative Costs	36,693	88,785	125,478	0	125,478
31.00	Total Facility Overhead (sum of lines 29 and 30)	36,693	98,753	135,446	0	135,446
32.00	Total facility costs (sum of lines 22, 28 and 31)	174,711	118,523	293,234	20,526	313,760

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1319

Period:

Worksheet M-1

Component CCN: 14-8577

From 06/01/2018
To 05/31/2019Date/Time Prepared:
10/25/2019 8:36 am

		RHC II		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	37,296	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	82,688	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	29,601	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	8,959	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	158,544	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	19,770	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	19,770	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	178,314	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	9,968	29.00
30.00	Administrative Costs	0	125,478	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	135,446	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	313,760	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1319

Period:

Worksheet M-1

Component CCN: 14-8587

From 06/01/2018
To 05/31/2019Date/Time Prepared:
10/25/2019 8:36 am

		RHC III		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	262,380	0	262,380	114,124	376,504
2.00	Physician Assistant	2,886	0	2,886	0	2,886
3.00	Nurse Practitioner	232,451	0	232,451	0	232,451
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	98,804	0	98,804	0	98,804
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	44,643	0	44,643	-277	44,366
10.00	Subtotal (sum of lines 1 through 9)	641,164	0	641,164	113,847	755,011
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	40,964	40,964	0	40,964
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	40,964	40,964	0	40,964
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	641,164	40,964	682,128	113,847	795,975
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0
30.00	Administrative Costs	102,990	39,434	142,424	0	142,424
31.00	Total Facility Overhead (sum of lines 29 and 30)	102,990	39,434	142,424	0	142,424
32.00	Total facility costs (sum of lines 22, 28 and 31)	744,154	80,398	824,552	113,847	938,399

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1319

Period:

Worksheet M-1

Component CCN: 14-8587

From 06/01/2018
To 05/31/2019Date/Time Prepared:
10/25/2019 8:36 am

		RHC III		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	376,504	1.00
2.00	Physician Assistant	0	2,886	2.00
3.00	Nurse Practitioner	0	232,451	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	98,804	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	44,366	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	755,011	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	40,964	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	40,964	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	795,975	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	0	142,424	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	142,424	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	938,399	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1319

Period:

Worksheet M-2

Component CCN: 14-8576

From 06/01/2018
To 05/31/2019Date/Time Prepared:
10/25/2019 8:36 am

		RHC I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	1.21	6,724	4,200	5,082	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	1.56	6,219	2,100	3,276	3.00
4.00	Subtotal (sum of lines 1 through 3)	2.77	12,943	8,358	12,943	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.77	12,943		12,943	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				1,480,580	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				1,480,580	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)				600,149	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,205,521	15.00
16.00	Total overhead (sum of lines 14 and 15)				1,805,670	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				1,805,670	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				1,805,670	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				3,286,250	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES			Provider CCN: 14-1319 Component CCN: 14-8577		Period: From 06/01/2018 To 05/31/2019		Worksheet M-2 Date/Time Prepared: 10/25/2019 8:36 am	
			RHC II		Cost			
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4			
	1.00	2.00	3.00	4.00	5.00			
VISITS AND PRODUCTIVITY								
Positions								
1.00	Physician	0.07	177	4,200	294			1.00
2.00	Physician Assistant	0.00	0	2,100	0			2.00
3.00	Nurse Practitioner	0.45	1,934	2,100	945			3.00
4.00	Subtotal (sum of lines 1 through 3)	0.52	2,111		1,239		2,111	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)	0.52	2,111				2,111	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)						178,314	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)						178,314	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)						135,446	14.00
15.00	Parent provider overhead allocated to facility (see instructions)						98,986	15.00
16.00	Total overhead (sum of lines 14 and 15)						234,432	16.00
17.00	Allowable GME overhead (see instructions)						0	17.00
18.00	Enter the amount from line 16						234,432	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)						234,432	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)						412,746	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1319

Period:

Worksheet M-2

Component CCN: 14-8587

From 06/01/2018
To 05/31/2019Date/Time Prepared:
10/25/2019 8:36 am

				RHC III		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.71	1,771	4,200	2,982		1.00
2.00	Physician Assistant	0.02	10	2,100	42		2.00
3.00	Nurse Practitioner	1.70	2,797	2,100	3,570		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.43	4,578		6,594	6,594	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.43	4,578			6,594	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)					795,975	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)					795,975	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)					142,424	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					521,866	15.00
16.00	Total overhead (sum of lines 14 and 15)					664,290	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					664,290	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					664,290	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,460,265	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN:14-1319 Component CCN:14-8576	Period: From 06/01/2018 To 05/31/2019	Worksheet M-3 Date/Time Prepared: 10/25/2019 8:36 am		
			Title XVIII	RHC I	Cost	
					1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			3,286,250	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			352,817	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,933,433	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			12,943	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)			12,943	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			226.64	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			83.45	83.45	8.00
9.00	Rate for Program covered visits (see instructions)			226.64	226.64	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	2,624	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	594,703	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	594,703	16.00
16.01	Total program charges (see instructions)(from contractor's records)				521,064	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				52,575	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				60,005	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.)				393,670	16.04
16.05	Total program cost (see instructions)			0	453,675	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				42,610	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				85,176	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				453,675	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				137,454	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				591,129	22.00
23.00	Allowable bad debts (see instructions)				0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)				0	25.50
25.99	Demonstration payment adjustment amount before sequestration				0	25.99
26.00	Net reimbursable amount (see instructions)				591,129	26.00
26.01	Sequestration adjustment (see instructions)				11,823	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				308,361	27.00
28.00	Tentative settlement (for contractor use only)				0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)				270,945	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:14-1319 Component CCN:14-8577	Period: From 06/01/2018 To 05/31/2019	Worksheet M-3 Date/Time Prepared: 10/25/2019 8:36 am		
			Title XVIII	RHC II	Cost	
				1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			412,746	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			64,939	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			347,807	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,111	4.00	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00	
6.00	Total adjusted visits (line 4 plus line 5)			2,111	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			164.76	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			83.45	83.45	8.00
9.00	Rate for Program covered visits (see instructions)			164.76	164.76	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	535	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	88,147	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	88,147	16.00
16.01	Total program charges (see instructions)(from contractor's records)				97,731	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				5,455	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				4,920	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.)				58,932	16.04
16.05	Total program cost (see instructions)			0	63,852	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				9,562	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				16,543	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				63,852	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				39,614	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				103,466	22.00
23.00	Allowable bad debts (see instructions)				0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)				0	25.50
25.99	Demonstration payment adjustment amount before sequestration				0	25.99
26.00	Net reimbursable amount (see instructions)				103,466	26.00
26.01	Sequestration adjustment (see instructions)				2,069	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				56,450	27.00
28.00	Tentative settlement (for contractor use only)				0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)				44,947	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: 14-1319 Component CCN: 14-8587	Period: From 06/01/2018 To 05/31/2019	Worksheet M-3 Date/Time Prepared: 10/25/2019 8:36 am		
		Title XVIII	RHC III	Cost		
				1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,460,265	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			144,398	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,315,867	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			6,594	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)			6,594	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			199.56	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			83.45	83.45	8.00
9.00	Rate for Program covered visits (see instructions)			199.56	199.56	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)		0	1,150	10.00	
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	229,494	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	229,494	16.00	
16.01	Total program charges (see instructions)(from contractor's records)			228,567	16.01	
16.02	Total program preventive charges (see instructions)(from provider's records)			10,967	16.02	
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			11,012	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.)			160,678	16.04	
16.05	Total program cost (see instructions)		0	171,690	16.05	
17.00	Primary payer amounts			0	17.00	
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			17,635	18.00	
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			39,993	19.00	
20.00	Net Medicare cost excluding vaccines (see instructions)			171,690	20.00	
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			64,843	21.00	
22.00	Total reimbursable Program cost (line 20 plus line 21)			236,533	22.00	
23.00	Allowable bad debts (see instructions)			0	23.00	
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01	
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00	
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00	
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50	
25.99	Demonstration payment adjustment amount before sequestration			0	25.99	
26.00	Net reimbursable amount (see instructions)			236,533	26.00	
26.01	Sequestration adjustment (see instructions)			4,731	26.01	
26.02	Demonstration payment adjustment amount after sequestration			0	26.02	
27.00	Interim payments			218,934	27.00	
28.00	Tentative settlement (for contractor use only)			0	28.00	
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			12,868	29.00	
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00	

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN:14-1319 Component CCN:14-8576	Period: From 06/01/2018 To 05/31/2019	Worksheet M-4 Date/Time Prepared: 10/25/2019 8:36 am	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1,444,192	1,444,192	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000378	0.000609	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		546	880	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		67,359	90,172	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		67,905	91,052	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,480,580	1,480,580	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,805,670	1,805,670	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.045864	0.061498	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		82,815	111,045	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		150,720	202,097	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		201	324	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		749.85	623.76	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		76	129	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		56,989	80,465	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)			352,817	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)			137,454	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN:14-1319 Component CCN:14-8577	Period: From 06/01/2018 To 05/31/2019	Worksheet M-4 Date/Time Prepared: 10/25/2019 8:36 am	
		Title XVIII	RHC II	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		158,544	158,544	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000202	0.001102	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		32	175	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		5,027	22,821	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		5,059	22,996	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		178,314	178,314	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		234,432	234,432	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.028371	0.128964	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		6,651	30,233	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		11,710	53,229	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		15	82	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		780.67	649.13	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		10	49	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		7,807	31,807	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)			64,939	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)			39,614	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN:14-1319 Component CCN:14-8587	Period: From 06/01/2018 To 05/31/2019	Worksheet M-4 Date/Time Prepared: 10/25/2019 8:36 am	
		Title XVIII	RHC III	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		755,011	755,011	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000328	0.000895	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		248	676	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		23,794	53,992	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		24,042	54,668	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		795,975	795,975	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		664,290	664,290	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.030204	0.068681	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		20,064	45,624	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		44,106	100,292	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		71	194	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		621.21	516.97	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		17	105	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		10,561	54,282	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)			144,398	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			64,843	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN:14-1319 Component CCN:14-8576	Period: From 06/01/2018 To 05/31/2019	Worksheet M-5 Date/Time Prepared: 10/25/2019 8:36 am	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		308,361	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00	
Program to Provider					
3.01			0	3.01	
3.02			0	3.02	
3.03			0	3.03	
3.04			0	3.04	
3.05			0	3.05	
Provider to Program					
3.50			0	3.50	
3.51			0	3.51	
3.52			0	3.52	
3.53			0	3.53	
3.54			0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		308,361	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		270,945	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		579,306	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00 2.00		
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1319 Component CCN: 14-8577	Period: From 06/01/2018 To 05/31/2019	Worksheet M-5 Date/Time Prepared: 10/25/2019 8:36 am	
			RHC II	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			56,450	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			56,450	4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01				0	5.01
5.02				0	5.02
5.03				0	5.03
Provider to Program					
5.50				0	5.50
5.51				0	5.51
5.52				0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER			44,947	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			101,397	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN:14-1319 Component CCN:14-8587	Period: From 06/01/2018 To 05/31/2019	Worksheet M-5 Date/Time Prepared: 10/25/2019 8:36 am	
			RHC III	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			218,934	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			218,934	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			12,868	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			231,802	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00