

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 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1319	Period: From 06/01/2019 To 05/31/2020	Worksheet S Parts I-III Date/Time Prepared: 10/19/2020 4:22 pm
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 2. ☐ Manually prepared cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.	Date:	Time:
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.	

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HAMMOND-HENRY HOSPITAL (14-1319) for the cost reporting period beginning 06/01/2019 and ending 05/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
			Part A 2.00	Part B 3.00			
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	85,652	493,090	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	50,674	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	-142	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	-2		0	9.00
10.00	KEWANEE RHC I	0		72,512		0	10.00
10.01	WYOMING RHC II	0		8,648		0	10.01
10.02	GENESEO RHC III	0		56,394		0	10.02
200.00	Total	0	136,184	630,642	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 06/01/2019 To 05/31/2020		Worksheet S-2 Part I Date/Time Prepared: 10/19/2020 4:22 pm	
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
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			HAMMOND-HENRY HOSPITAL	141319	19340	1	06/04/2002	N
4.00	Subprovider - IPF							O	O
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF			HAMMOND-HENRY SWING BED	142319	99914		05/21/2003	N
8.00	Swing Beds - NF							O	N
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)						06/01/2019	05/31/2020	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 06/01/2019
To 05/31/2020Worksheet S-2
Part I
Date/Time Prepared:
10/19/2020 4:22 pm

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
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	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	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	47.00
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					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 in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		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

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			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00

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

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			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			Y	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	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	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1319		Period: From 06/01/2019 To 05/31/2020		Worksheet S-2 Part I Date/Time Prepared: 10/19/2020 4:22 pm	
				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N			108.00
				Physical	Occupational	Speech	Respiratory
				1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			N	N	N	N
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N			110.00
				1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N			111.00
				1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.			N			112.00
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.			N			0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.			Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1			118.00
				Premiums	Losses	Insurance	
				1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:			490,791	0	0	118.01
				1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N			118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.			N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.			Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.			N			122.00
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.			N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1319		Period: From 06/01/2019 To 05/31/2020		Worksheet S-2 Part I Date/Time Prepared: 10/19/2020 4:22 pm	
				1.00			2.00		
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							132.00	
133.00	Removed and reserved							133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.							134.00	
All Providers									
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)			N				140.00	
				1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:			Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:			PO Box:				142.00	
143.00	City:			State:		Zip Code:		143.00	
						1.00			
144.00	Are provider based physicians' costs included in Worksheet A?					Y		144.00	
						1.00		2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.			N				146.00	
						1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N		149.00	
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			Y	Y	N	N	155.00	
156.00	Subprovider - IPF			N	N	N	N	156.00	
157.00	Subprovider - IRF			N	N	N	N	157.00	
158.00	SUBPROVIDER							158.00	
159.00	SNF			N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY			N	N	N	N	160.00	
161.00	CMHC				N	N	N	161.00	
161.10	CORF				N	N	N	161.10	
						1.00			
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N		165.00	
				Name	County	State	Zip Code	CBSA	FTE/Campus
				0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00
						1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.00		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1319	Period: From 06/01/2019 To 05/31/2020	Worksheet S-2 Part I Date/Time Prepared: 10/19/2020 4:22 pm
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1319	Period: From 06/01/2019 To 05/31/2020	Worksheet S-2 Part II Date/Time Prepared: 10/19/2020 4:22 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	09/15/2020	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
				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	10/19/2020	Y	10/19/2020
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020Worksheet S-2
Part II
Date/Time Prepared:
10/19/2020 4:22 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		Y		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		Y		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		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 06/01/2019 To 05/31/2020	Worksheet S-2 Part II Date/Time Prepared: 10/19/2020 4:22 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CPA		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

HFS Supplemental Information		Provider CCN: 14-1319	Period: From 06/01/2019 To 05/31/2020	Worksheet S-2 Part IX Date/Time Prepared: 10/19/2020 4:22 pm
			Title V 1.00	Title XIX 2.00
TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)	Y	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?	N	N	3.01
			Inpatient 1.00	Outpatient 2.00
CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	5.00
			Title V 1.00	Title XIX 2.00
RCE DISALLOWANCE				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)	Y	Y	6.00
PASS THROUGH COST				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)	Y	Y	7.00
RHC				
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00
FQHC				
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	9.00
			State 1.00	
STATE MEDICAID FORMS				
10.00	Select the state when using state Medicaid forms.			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020Worksheet S-3
Part I
Date/Time Prepared:
10/19/2020 4:22 pm

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	9,150	55,680.00	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	9,150	55,680.00	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	9,150	55,680.00	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	13,542		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 06/01/2019
To 05/31/2020Worksheet S-3
Part I
Date/Time Prepared:
10/19/2020 4:22 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,245	11	2,320		1.00
2.00	HMO and other (see instructions)	370	93			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	506	0	633		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	37		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,751	11	2,990		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)	1,751	11	2,990	0.00	253.88
15.00	CAH visits	0	0	0		14.00
16.00	SUBPROVIDER - IPF					15.00
17.00	SUBPROVIDER - IRF					16.00
18.00	SUBPROVIDER					17.00
19.00	SKILLED NURSING FACILITY	354	0	13,508	0.00	26.67
20.00	NURSING FACILITY					18.00
21.00	OTHER LONG TERM CARE			0	0.00	19.00
22.00	HOME HEALTH AGENCY	3,795	0	8,657	0.00	0.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					9.15
24.00	HOSPICE					23.00
24.10	HOSPICE (non-distinct part)			0		24.00
25.00	CMHC - CMHC					24.10
25.10	CMHC - CORF	0	0	0	0.00	25.00
26.00	KEWANEE RHC	2,900	0	15,177	0.00	0.00
26.01	WYOMING RHC	215	0	798	0.00	22.40
26.02	GENESEO RHC	1,538	0	6,683	0.00	1.23
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	11.11
27.00	Total (sum of lines 14-26)				0.00	0.00
28.00	Observation Bed Days		0	1,275	0.00	0.00
29.00	Ambulance Trips	0				324.44
30.00	Employee discount days (see instruction)			0		27.00
31.00	Employee discount days - IRF			0		28.00
32.00	Labor & delivery days (see instructions)	0	0	0		29.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		30.00
33.00	LTCH non-covered days	0				31.00
33.01	LTCH site neutral days and discharges	0				32.00
						32.01
						33.00
						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020Worksheet S-3
Part I
Date/Time Prepared:
10/19/2020 4:22 pm

Component		Full Time Equivalents	Discharges			Total All Patients	
		Nonpaid Workers	Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	342	2	635	1.00
2.00	HMO and other (see instructions)			93	23		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	342	2	635	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 06/01/2019 To 05/31/2020		Worksheet S-4 Date/Time Prepared: 10/19/2020 4:22 pm	
				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	15,009	0	0	15,009	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	176.00	33.00	56.00	265.00	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			0.91	0.00	0.91	5.00
6.00	Direct Nursing Service			0.00	0.00	0.00	6.00
7.00	Nursing Supervisor			1.02	0.00	1.02	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			7.22	0.00	7.22	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	1,709	272	48	35	2,064	21.00
22.00	Skilled Nursing Visit Charges	292,068	46,485	8,203	5,982	352,738	22.00
23.00	Physical Therapy Visits	721	146	9	17	893	23.00
24.00	Physical Therapy Visit Charges	151,410	30,660	1,890	3,570	187,530	24.00
25.00	Occupational Therapy Visits	329	86	3	19	437	25.00
26.00	Occupational Therapy Visit Charges	69,090	18,060	630	3,990	91,770	26.00
27.00	Speech Pathology Visits	17	28	0	0	45	27.00
28.00	Speech Pathology Visit Charges	3,570	5,880	0	0	9,450	28.00
29.00	Medical Social Service Visits	4	0	0	1	5	29.00
30.00	Medical Social Service Visit Charges	1,040	0	0	260	1,300	30.00
31.00	Home Health Aide Visits	303	48	0	0	351	31.00
32.00	Home Health Aide Visit Charges	28,785	4,560	0	0	33,345	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,083	580	60	72	3,795	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)	545,963	105,645	10,723	13,802	676,133	35.00
36.00	Total Number of Episodes (standard/non outlier)	223		22	3	248	36.00
37.00	Total Number of Outlier Episodes		22		1	23	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1319 Component CCN: 14-8576		Period: From 06/01/2019 To 05/31/2020		Worksheet S-8 Date/Time Prepared: 10/19/2020 4:22 pm	
				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	
				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	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1319 Component CCN: 14-8576	Period: From 06/01/2019 To 05/31/2020	Worksheet S-8 Date/Time Prepared: 10/19/2020 4:22 pm	
			RHC I		Cost	
			Friday		Saturday	
			from	to	from	to
			11.00	12.00	13.00	14.00
Facility hours of operations (1)						
11.00	CLINIC	07:30	18:00			11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1319 Component CCN: 14-8577		Period: From 06/01/2019 To 05/31/2020		Worksheet S-8 Date/Time Prepared: 10/19/2020 4:22 pm		
				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 06/01/2019 To 05/31/2020	Worksheet S-8 Date/Time Prepared: 10/19/2020 4:22 pm	
			RHC II		Cost	
			Friday		Saturday	
			from	to	from	to
			11.00	12.00	13.00	14.00
Facility hours of operations (1)						
11.00	CLINIC	08:30	17:00			11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1319 Component CCN: 14-8587		Period: From 06/01/2019 To 05/31/2020		Worksheet S-8 Date/Time Prepared: 10/19/2020 4:22 pm	
				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 06/01/2019 To 05/31/2020	Worksheet S-8 Date/Time Prepared: 10/19/2020 4:22 pm	
			RHC III		Cost	
			Friday		Saturday	
			from	to	from	to
			11.00	12.00	13.00	14.00
Facility hours of operations (1)						
11.00	CLINIC	08:30	17:00			11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1319	Period: From 06/01/2019 To 05/31/2020	Worksheet S-10 Date/Time Prepared: 10/19/2020 4:22 pm
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.352039 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	12,481,309		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	15,759,445		6.00
7.00	Medicaid cost (line 1 times line 6)	5,547,939		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)	149,422	0	149,422 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	52,602	0	52,602 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)	52,602	0	52,602 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)	2,032,774		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	48,653		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	74,851		27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,957,923		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	715,463		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	768,065		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	768,065		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020

Worksheet A

Date/Time Prepared:
10/19/2020 4:22 pm

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		1,997,415	1,997,415	379,169	2,376,584	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,202,829	1,202,829	4,730	1,207,559	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	371,539	4,658,074	5,029,613	-987,905	4,041,708	4.00
5.01	00550	DATA PROCESSING	298,175	1,215,415	1,513,590	0	1,513,590	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	138,565	4,513	143,078	0	143,078	5.02
5.03	00570	ADMITTING	189,889	46,769	236,658	0	236,658	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	476,315	410,381	886,696	0	886,696	5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	631,521	2,355,749	2,987,270	-93,767	2,893,503	5.05
7.00	00700	OPERATION OF PLANT	262,645	912,212	1,174,857	0	1,174,857	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,123	90,664	118,787	0	118,787	8.00
9.00	00900	HOUSEKEEPING	424,196	168,817	593,013	0	593,013	9.00
10.00	01000	DIETARY	502,929	451,759	954,688	0	954,688	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	178,854	1,028	179,882	0	179,882	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	27,860	27,860	0	27,860	14.00
15.00	01500	PHARMACY	248,627	193,124	441,751	0	441,751	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	445,956	72,337	518,293	0	518,293	16.00
17.00	01700	SOCIAL SERVICE	111,292	1,946	113,238	0	113,238	17.00
18.00	01080	INSERVICE EDUCATION	167,304	44,971	212,275	0	212,275	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,263,227	312,989	2,576,216	94,863	2,671,079	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,065,249	170,115	1,235,364	288,670	1,524,034	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	1,255,828	3,137,884	4,393,712	-1,294,314	3,099,398	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	846,073	0	846,073	83,141	929,214	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	883,060	1,199,884	2,082,944	61,785	2,144,729	54.00
60.00	06000	LABORATORY	709,627	1,294,515	2,004,142	3,056	2,007,198	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	111,224	111,224	0	111,224	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,326,360	63,214	1,389,574	0	1,389,574	66.00
67.00	06700	OCCUPATIONAL THERAPY	388,244	22,998	411,242	0	411,242	67.00
68.00	06800	SPEECH PATHOLOGY	130,179	9,177	139,356	0	139,356	68.00
69.00	06900	ELECTROCARDIOLOGY	211,236	209,355	420,591	0	420,591	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	1,335,885	1,335,885	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,194,975	1,194,975	0	1,194,975	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	73,133	58,355	131,488	0	131,488	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	KEWANEE RHC	1,646,804	495,859	2,142,663	179,754	2,322,417	88.00
88.01	08801	WYOMING RHC	64,039	63,857	127,896	8,513	136,409	88.01
88.02	08802	GENESEO RHC	1,007,712	122,198	1,129,910	151,938	1,281,848	88.02
90.00	09000	CLINIC	652,563	234,009	886,572	142,167	1,028,739	90.00
90.01	09001	PAIN CLINIC	65,733	199,326	265,059	1,102	266,161	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	34,379	1,319,626	1,354,005	0	1,354,005	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	1,686,128	1,097,561	2,783,689	156,735	2,940,424	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	580,418	144,240	724,658	0	724,658	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		621,655	621,655	-621,655	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,365,922	25,938,879	45,304,801	-106,133	45,198,668	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	1,311	1,311	0	1,311	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	121,963	92,613	214,576	0	214,576	192.03
192.04	19204	ANNAWAN CLINIC	314,926	134,737	449,663	41,680	491,343	192.04
192.05	19205	CAMBRIDGE CLINIC	233,594	71,775	305,369	25,474	330,843	192.05
192.06	19206	PORT BYRON CLINIC	174,706	52,883	227,589	38,979	266,568	192.06
194.00	07955	FOUNDATION	0	0	0	0	0	194.00
194.01	07950	SPORTS MEDICINE	110,612	22,151	132,763	0	132,763	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020

Worksheet A

Date/Time Prepared:
10/19/2020 4:22 pm

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	
194.03	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	4,589	4,589	0	4,589	194.07
200.00		TOTAL (SUM OF LINES 118 through 199)	20,321,723	26,318,938	46,640,661	0	46,640,661	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020

Worksheet A

Date/Time Prepared:
10/19/2020 4:22 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	30,033	2,406,617	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,207,559	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-65,564	3,976,144	4.00
5.01	00550	DATA PROCESSING	0	1,513,590	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-202,333	-59,255	5.02
5.03	00570	ADMITTING	0	236,658	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	-101,577	785,119	5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	-91,540	2,801,963	5.05
7.00	00700	OPERATION OF PLANT	0	1,174,857	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	118,787	8.00
9.00	00900	HOUSEKEEPING	0	593,013	9.00
10.00	01000	DIETARY	-198,347	756,341	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	179,882	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	27,860	14.00
15.00	01500	PHARMACY	0	441,751	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-120	518,173	16.00
17.00	01700	SOCIAL SERVICE	0	113,238	17.00
18.00	01800	INSERVICE EDUCATION	0	212,275	18.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-558,328	2,112,751	30.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	-1,182	1,522,852	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-116,288	2,983,110	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-929,214	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,144,729	54.00
60.00	06000	LABORATORY	-1,350	2,005,848	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	111,224	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
66.00	06600	PHYSICAL THERAPY	-19,338	1,370,236	66.00
67.00	06700	OCCUPATIONAL THERAPY	-168	411,074	67.00
68.00	06800	SPEECH PATHOLOGY	0	139,356	68.00
69.00	06900	ELECTROCARDIOLOGY	-17,677	402,914	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,335,885	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,194,975	73.00
76.00	03020	ACUPUNCTURE	0	0	76.00
76.01	03610	SLEEP LAB	-337	131,151	76.01
76.02	03950	IV THERAPY	0	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	KEWANEE RHC	0	2,322,417	88.00
88.01	08801	WYOMING RHC	0	136,409	88.01
88.02	08802	GENESE0 RHC	0	1,281,848	88.02
90.00	09000	CLINIC	-592,661	436,078	90.00
90.01	09001	PAIN CLINIC	-192,710	73,451	90.01
90.02	09002	SPECIALTY CLINIC	0	0	90.02
90.03	09003	SURGICAL CLINIC	-718,650	635,355	90.03
90.04	09004	GENESE0 CLINIC	0	0	90.04
91.00	09100	EMERGENCY	-683,510	2,256,914	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	-4,271	720,387	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,465,132	40,733,536	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	1,311	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	192.02
192.03	19202	LEASED SPACE	0	214,576	192.03
192.04	19204	ANNAWAN CLINIC	0	491,343	192.04
192.05	19205	CAMBRIDGE CLINIC	0	330,843	192.05
192.06	19206	PORT BYRON CLINIC	0	266,568	192.06
194.00	07955	FOUNDATION	0	0	194.00
194.01	07950	SPORTS MEDICINE	0	132,763	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	194.02
194.03	07952	ANESTHESIA BILLING	0	0	194.03

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020

Worksheet A

Date/Time Prepared:
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Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
194.04	07953 SPECIALTY CLINIC	0	0	194.04
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	4,589	194.07
200.00	TOTAL (SUM OF LINES 118 through 199)	-4,465,132	42,175,529	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020Worksheet Non-CMS W
Date/Time Prepared:
10/19/2020 4:22 pm

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.01	DATA PROCESSING	00550	DATA PROCESSING	5.01
5.02	PURCHASING RECEIVING AND STORES	00560	PURCHASING RECEIVING AND STORES	5.02
5.03	ADMITTING	00570	ADMITTING	5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.04
5.05	ALL OTHER ADMINISTRATIVE AND GE	00590		5.05
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
18.00	INSERVICE EDUCATION	01080	INSERVICE EDUCATION	18.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
43.00	NURSERY	04300		43.00
44.00	SKILLED NURSING FACILITY	04400		44.00
46.00	OTHER LONG TERM CARE	04600		46.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD	06200		62.00
64.00	INTRAVENOUS THERAPY	06400		64.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PAT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.00	ACUPUNCTURE	03020	ACUPUNCTURE	76.00
76.01	SLEEP LAB	03610	SLEEP LAB	76.01
76.02	IV THERAPY	03950		76.02
OUTPATIENT SERVICE COST CENTERS				
88.00	KEWANEE RHC	08800		88.00
88.01	WYOMING RHC	08801		88.01
88.02	GENESEO RHC	08802		88.02
90.00	CLINIC	09000		90.00
90.01	PAIN CLINIC	09001		90.01
90.02	SPECIALTY CLINIC	09002		90.02
90.03	SURGICAL CLINIC	09003		90.03
90.04	GENESEO CLINIC	09004		90.04
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT	09200		92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	CORF	09910		99.10
101.00	HOME HEALTH AGENCY	10100		101.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT FLOWER COFFEE SHOP & CAN	19000		190.00
192.00	PHYSICIANS PRIVATE OFFICES	19200		192.00
192.01	MUSCATINE CLINIC	19203		192.01
192.02	CARDIOLOGY CLINIC	19201		192.02
192.03	LEASED SPACE	19202		192.03
192.04	ANNAWAN CLINIC	19204		192.04
192.05	CAMBRIDGE CLINIC	19205		192.05
192.06	PORT BYRON CLINIC	19206		192.06
194.00	FOUNDATION	07955		194.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020Worksheet Non-CMS W
Date/Time Prepared:
10/19/2020 4:22 pm

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
194.01	SPORTS MEDICINE	07950		194.01
194.02	KELLY MEDICAL RENTAL AREA	07951		194.02
194.03	ANESTHESIA BILLING	07952		194.03
194.04	SPECIALTY CLINIC	07953		194.04
194.05	COLONA CLINIC	07954		194.05
194.06	TRINITY/DIALYSIS LEASED SPACE	07956		194.06
194.07	COMMUNITY HEALTH	07957		194.07
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020

Worksheet A-6

Date/Time Prepared:
10/19/2020 4:22 pm

	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	40,870	1.00
	TOTALS		0	40,870	
	C - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	621,655	1.00
	TOTALS		0	621,655	
	E - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	69,356	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	22,428	2.00
3.00	CLINIC	90.00	0	1,983	3.00
	TOTALS		0	93,767	
	H - IMPLANT EXP RECLASS				
1.00	IMPL. DEV. CHARGED TO	72.00	0	1,335,885	1.00
	PATIENTS				
	TOTALS		0	1,335,885	
	I - RECLASS PROVIDER BENEFITS				
1.00	ANESTHESIOLOGY	53.00	0	124,712	1.00
2.00	CLINIC	90.00	0	99,314	2.00
3.00	PAIN CLINIC	90.01	0	1,102	3.00
4.00	CAMBRIDGE CLINIC	192.05	0	25,474	4.00
5.00	ANNAWAN CLINIC	192.04	0	41,680	5.00
6.00	PORT BYRON CLINIC	192.06	0	38,979	6.00
7.00	KEWANEE RHC	88.00	0	242,993	7.00
8.00	WYOMING RHC	88.01	0	9,086	8.00
9.00	GENESEO RHC	88.02	0	152,967	9.00
10.00	EMERGENCY	91.00	0	156,735	10.00
11.00	ADULTS & PEDIATRICS	30.00	0	94,863	11.00
	TOTALS		0	987,905	
	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	92,324	2.00
3.00	SKILLED NURSING FACILITY	44.00	0	17,698	3.00
	TOTALS		0	288,670	
	K - TO CLOSE ANESTHESIA TO OR				
1.00	OPERATING ROOM	50.00	0	41,571	1.00
	TOTALS		0	41,571	
	L - RHC LAB AND RADIOLOGY COSTS				
1.00	LABORATORY	60.00	3,056	0	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	61,785	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		64,841	0	
500.00	Grand Total: Increases		64,841	3,410,323	500.00

RECLASSIFICATIONS

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020

Worksheet A-6

Date/Time Prepared:
10/19/2020 4:22 pm

	Decreases				Wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00	10.00	
1.00	A - COLONA CLINIC BUILDING DEPRECIATION					1.00
	CAP REL COSTS-BLDG & FIXT	1.00	0	40,870	9	
	TOTALS		0	40,870		
1.00	C - INTEREST EXPENSE					1.00
	INTEREST EXPENSE	113.00	0	621,655	11	
	TOTALS		0	621,655		
1.00	E - OTHER CAPITAL COSTS					1.00
	ALL OTHER ADMINISTRATIVE AND GE	5.05	0	93,767	12	
	TOTALS		0	93,767		
2.00		0.00	0	0	12	2.00
3.00		0.00	0	0	0	3.00
1.00	H - IMPLANT EXP RECLASS					1.00
	OPERATING ROOM	50.00	0	1,335,885	0	
	TOTALS		0	1,335,885		
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	I - RECLASS PROVIDER BENEFITS					1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	987,905	0	
		0.00	0	0	0	
		0.00	0	0	0	
		0.00	0	0	0	
		0.00	0	0	0	
		0.00	0	0	0	
		0.00	0	0	0	
		0.00	0	0	0	
		0.00	0	0	0	
		0.00	0	0	0	
		0.00	0	0	0	
1.00 2.00 3.00	J - RECLASS SNF DEPRECIATION AND INTERST					1.00 2.00 3.00
	CAP REL COSTS-BLDG & FIXT	1.00	0	178,648	9	
	CAP REL COSTS-BLDG & FIXT	1.00	0	92,324	11	
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	17,698	9	1.00
	TOTALS		0	288,670		
	K - TO CLOSE ANESTHESIA TO OR					
1.00	ANESTHESIOLOGY	53.00	0	41,571	0	1.00
	TOTALS		0	41,571		
	L - RHC LAB AND RADIOLOGY COSTS					
1.00	KEWANEE RHC	88.00	63,239	0	0	1.00
2.00	WYOMING RHC	88.01	573	0	0	2.00
3.00	GENESEO RHC	88.02	1,029	0	0	3.00
500.00	TOTALS		64,841	0		
Grand Total: Decreases			64,841	3,410,323		500.00

RECLASSIFICATIONS

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
10/19/2020 4:22 pm

Increases					Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
A - COLONA CLINIC BUILDING DEPRECIATION									
1.00	CLINIC	90.00	0	40,870	CAP REL COSTS-BLDG & FIXT	1.00	0	40,870	1.00
	TOTALS		0	40,870	TOTALS		0	40,870	
C - INTEREST EXPENSE									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	621,655	INTEREST EXPENSE	113.00	0	621,655	1.00
	TOTALS		0	621,655	TOTALS		0	621,655	
E - OTHER CAPITAL COSTS									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	69,356	ALL OTHER ADMINISTRATIVE AND GE	5.05	0	93,767	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	22,428		0.00	0	0	2.00
3.00	CLINIC	90.00	0	1,983		0.00	0	0	3.00
	TOTALS		0	93,767	TOTALS		0	93,767	
H - IMPLANT EXP RECLASS									
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,335,885	OPERATING ROOM	50.00	0	1,335,885	1.00
	TOTALS		0	1,335,885	TOTALS		0	1,335,885	
I - RECLASS PROVIDER BENEFITS									
1.00	ANESTHESIOLOGY	53.00	0	124,712	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	987,905	1.00
2.00	CLINIC	90.00	0	99,314		0.00	0	0	2.00
3.00	PAIN CLINIC	90.01	0	1,102		0.00	0	0	3.00
4.00	CAMBRIDGE CLINIC	192.05	0	25,474		0.00	0	0	4.00
5.00	ANNAWAN CLINIC	192.04	0	41,680		0.00	0	0	5.00
6.00	PORT BYRON CLINIC	192.06	0	38,979		0.00	0	0	6.00
7.00	KEWANEE RHC	88.00	0	242,993		0.00	0	0	7.00
8.00	WYOMING RHC	88.01	0	9,086		0.00	0	0	8.00
9.00	GENESEO RHC	88.02	0	152,967		0.00	0	0	9.00
10.00	EMERGENCY	91.00	0	156,735		0.00	0	0	10.00
11.00	ADULTS & PEDIATRICS	30.00	0	94,863		0.00	0	0	11.00
	TOTALS		0	987,905	TOTALS		0	987,905	
J - RECLASS SNF DEPRECIATION AND INTERST									
1.00	SKILLED NURSING FACILITY	44.00	0	178,648	CAP REL COSTS-BLDG & FIXT	1.00	0	178,648	1.00
2.00	SKILLED NURSING FACILITY	44.00	0	92,324	CAP REL COSTS-BLDG & FIXT	1.00	0	92,324	2.00
3.00	SKILLED NURSING FACILITY	44.00	0	17,698	CAP REL COSTS-MVBLE EQUIP	2.00	0	17,698	3.00
	TOTALS		0	288,670	TOTALS		0	288,670	
K - TO CLOSE ANESTHESIA TO OR									
1.00	OPERATING ROOM	50.00	0	41,571	ANESTHESIOLOGY	53.00	0	41,571	1.00
	TOTALS		0	41,571	TOTALS		0	41,571	
L - RHC LAB AND RADIOLOGY COSTS									
1.00	LABORATORY	60.00	3,056	0	KEWANEE RHC	88.00	63,239	0	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	61,785	0	WYOMING RHC	88.01	573	0	2.00
3.00		0.00	0	0	GENESEO RHC	88.02	1,029	0	3.00
	TOTALS		64,841	0	TOTALS		64,841	0	
500.00	Grand Total: Increases		64,841	3,410,323	Grand Total: Decreases		64,841	3,410,323	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020Worksheet A-7
Part I
Date/Time Prepared:
10/19/2020 4:22 pm

		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	1,335,569	0	0	0	0	1.00
2.00	Land Improvements	1,658,717	0	0	0	0	2.00
3.00	Buildings and Fixtures	45,044,295	1,624,333	0	1,624,333	26,100	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	14,183,345	2,215,513	0	2,215,513	1,213,399	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	62,221,926	3,839,846	0	3,839,846	1,239,499	8.00
9.00	Reconciling Items	-617,009	-1,579,196	0	-1,579,196	-2,191,434	9.00
10.00	Total (line 8 minus line 9)	62,838,935	5,419,042	0	5,419,042	3,430,933	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	46,642,528	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	15,185,459	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	64,822,273	0				8.00
9.00	Reconciling Items	-4,771	0				9.00
10.00	Total (line 8 minus line 9)	64,827,044	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020Worksheet A-7
Part II
Date/Time Prepared:
10/19/2020 4:22 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,997,415	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,202,829	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,200,244	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	1,997,415				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,202,829				2.00
3.00	Total (sum of lines 1-2)	0	3,200,244				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020Worksheet A-7
Part III
Date/Time Prepared:
10/19/2020 4:22 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	46,456,714	0	46,456,714	0.753651	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15,185,460	0	15,185,460	0.246349	0	2.00
3.00	Total (sum of lines 1-2)	61,642,174	0	61,642,174	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Relat ed Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,777,897	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,185,131	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,963,028	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	559,364	69,356	0	0	2,406,617	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	22,428	0	0	1,207,559	2.00
3.00	Total (sum of lines 1-2)	559,364	91,784	0	0	3,614,176	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020

Worksheet A-8

Date/Time Prepared:
10/19/2020 4:22 pm

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	-202,333	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	-3,375	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	-2,871,405			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	-198,345	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	-120	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	B	-2	DIETARY	10.00	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 06/01/2019
To 05/31/2020

Worksheet A-8

Date/Time Prepared:
10/19/2020 4:22 pm

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	-71,072	ALL OTHER ADMINISTRATIVE AND GE	5.05	0	33.00
33.01	PART B BILLING	A	-101,577	CASHIERING/ACCOUNTS RECEIVABLE	5.04	0	33.01
33.02	PHYSICIAN RECRUITING	A	-5,865	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	-4,209	ADULTS & PEDIATRICS	30.00	0	33.04
33.05	TV SERVICE - CARDIAC	A	-337	ELECTROCARDIOLOGY	69.00	0	33.05
33.06	TV SERVICE - LTC	A	-6,903	SKILLED NURSING FACILITY	44.00	0	33.06
33.07	TV SERVICE - OR	A	-2,694	OPERATING ROOM	50.00	0	33.07
33.08	TV SERVICE - ER	A	-1,179	EMERGENCY	91.00	0	33.08
33.09	TV SERVICE - PT	A	-505	PHYSICAL THERAPY	66.00	0	33.09
33.10	TV SERVICE - OT	A	-168	OCCUPATIONAL THERAPY	67.00	0	33.10
33.11	TV SERVICE - SLEEP	A	-337	SLEEP LAB	76.01	0	33.11
33.12	CRNA EXPENSES	A	-929,214	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	-11,228	ALL OTHER ADMINISTRATIVE AND GE	5.05	0	33.14
33.15	EMPLOYEE LAB TEST REVENUE	B	-1,350	LABORATORY	60.00	0	33.15
33.16	PT SPECIAL EDUCATION REVENUE	B	-18,833	PHYSICAL THERAPY	66.00	0	33.16
33.17	LIFELINE REVENUE	B	-4,271	HOME HEALTH AGENCY	101.00	0	33.17
33.18	SUMMIT WELLNESS REVENUE	B	-65,564	EMPLOYEE BENEFITS DEPARTMENT	4.00	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.)		-4,465,132				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 06/01/2019
To 05/31/2020

Worksheet A-8-2

Date/Time Prepared:
10/19/2020 4:22 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	17,678	0	17,678	0	0	1.00
2.00	91.00	EMERGENCY	1,754,967	682,331	1,072,636	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	17,340	17,340	0	0	0	3.00
4.00	90.00	CLINIC	592,661	592,661	0	0	0	4.00
5.00	90.03	SURGICAL CLINIC	718,650	718,650	0	0	0	5.00
6.00	50.00	OPERATING ROOM	113,594	113,594	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	77,015	77,015	0	0	0	7.00
8.00	30.00	ADULTS & PEDIATRICS	477,104	477,104	0	0	0	8.00
9.00	90.01	PAIN CLINIC	192,710	192,710	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,961,719	2,871,405	1,090,314		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	682,331		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	17,340		3.00
4.00	90.00	CLINIC	0	0	0	592,661		4.00
5.00	90.03	SURGICAL CLINIC	0	0	0	718,650		5.00
6.00	50.00	OPERATING ROOM	0	0	0	113,594		6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	77,015		7.00
8.00	30.00	ADULTS & PEDIATRICS	0	0	0	477,104		8.00
9.00	90.01	PAIN CLINIC	0	0	0	192,710		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,871,405		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020Worksheet B
Part I
Date/Time Prepared:
10/19/2020 4:22 pm

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	2,406,617	2,406,617			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,207,559		1,207,559		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,976,144	11,098	0	3,987,242	4.00
5.01	00550	DATA PROCESSING	1,513,590	45,662	178,910	77,232	1,815,394
5.02	00560	PURCHASING RECEIVING AND STORES	-59,255	69,307	0	35,890	3,543
5.03	00570	ADMITTING	236,658	30,063	21,499	49,184	28,020
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	785,119	38,308	2,372	110,795	36,716
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	2,801,963	88,494	13,353	157,427	137,847
7.00	00700	OPERATION OF PLANT	1,174,857	181,557	7,353	68,029	35,750
8.00	00800	LAUNDRY & LINEN SERVICE	118,787	17,271	1,386	7,284	0
9.00	00900	HOUSEKEEPING	593,013	31,088	0	109,873	10,628
10.00	01000	DIETARY	756,341	78,756	4,696	130,266	19,002
11.00	01100	CAFETERIA	0	52,014	0	0	3,221
13.00	01300	NURSING ADMINISTRATION	179,882	13,549	13,984	46,326	0
14.00	01400	CENTRAL SERVICES & SUPPLY	27,860	0	0	0	0
15.00	01500	PHARMACY	441,751	37,350	6,635	64,398	87,604
16.00	01600	MEDICAL RECORDS & LIBRARY	518,173	36,525	6,102	115,509	100,165
17.00	01700	SOCIAL SERVICE	113,238	0	1,668	28,826	2,899
18.00	01080	INSERVICE EDUCATION	212,275	0	0	43,334	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,112,751	303,100	94,614	483,230	186,802
43.00	04300	NURSERY	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	1,522,852	0	0	275,915	52,820
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,983,110	339,336	303,875	325,278	79,552
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	2,144,729	199,608	249,104	243,525	117,234
60.00	06000	LABORATORY	2,005,848	54,710	60,632	184,596	86,960
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	111,224	2,028	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	1,370,236	298,264	26,097	343,547	44,446
67.00	06700	OCCUPATIONAL THERAPY	411,074	15,132	901	100,561	10,950
68.00	06800	SPEECH PATHOLOGY	139,356	3,610	0	33,718	12,239
69.00	06900	ELECTROCARDIOLOGY	402,914	27,299	5,202	54,713	14,493
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,335,885	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,194,975	0	0	0	0
76.00	03020	ACUPUNCTURE	0	0	0	0	0
76.01	03610	SLEEP LAB	131,151	16,647	0	18,943	0
76.02	03950	IV THERAPY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	KEWANEE RHC	2,322,417	0	100,500	147,583	262,167
88.01	08801	WYOMING RHC	136,409	0	0	6,575	11,595
88.02	08802	GENESEO RHC	1,281,848	72,650	26,347	94,689	125,157
90.00	09000	CLINIC	436,078	0	2,925	61,210	86,960
90.01	09001	PAIN CLINIC	73,451	579	0	15,829	15,782
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0
90.03	09003	SURGICAL CLINIC	635,355	5,839	611	8,905	32,529
90.04	09004	GENESEO CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	2,256,914	205,803	43,521	261,365	93,723
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	720,387	25,115	4,153	150,337	20,291
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,733,536	2,300,762	1,176,440	3,854,892	1,719,095
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	22,018	0	0	0
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0
192.01	19203	MUSCATINE CLINIC	1,311	0	0	0	0
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0
192.03	19202	LEASED SPACE	214,576	17,271	2,997	31,590	0
192.04	19204	ANNAWAN CLINIC	491,343	0	9,918	36,324	52,820
192.05	19205	CAMBRIDGE CLINIC	330,843	0	14,322	32,850	19,324
192.06	19206	PORT BYRON CLINIC	266,568	0	3,663	2,936	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020Worksheet B
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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	
194.00	07955	FOUNDATION	0	8,847	0	0	24,155	194.00
194.01	07950	SPORTS MEDICINE	132,763	0	219	28,650	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	57,719	0	0	0	194.06
194.07	07957	COMMUNITY HEALTH	4,589	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)	42,175,529	2,406,617	1,207,559	3,987,242	1,815,394	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1319

Period:
From 06/01/2019
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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	49,485					5.02
5.03	00570	ADMITTING	48	365,472				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	82	0	973,392			5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	84	0	0	3,199,168	3,199,168	5.05
7.00	00700	OPERATION OF PLANT	644	0	0	1,468,190	120,687	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28	0	0	144,756	11,899	8.00
9.00	00900	HOUSEKEEPING	657	0	0	745,259	61,261	9.00
10.00	01000	DIETARY	445	0	0	989,506	81,338	10.00
11.00	01100	CAFETERIA	0	0	0	55,235	4,540	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	253,741	20,858	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	480	0	0	28,340	2,330	14.00
15.00	01500	PHARMACY	157	0	0	637,895	52,436	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	30	0	0	776,504	63,829	16.00
17.00	01700	SOCIAL SERVICE	2	0	0	146,633	12,053	17.00
18.00	01080	INSERVICE EDUCATION	93	0	0	255,702	21,019	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,629	17,320	40,685	3,240,131	266,342	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	499	0	23,174	1,875,260	154,148	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	11,246	89,164	209,435	4,340,996	356,853	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	3,889	81,252	190,854	3,230,195	265,525	54.00
60.00	06000	LABORATORY	8,872	72,145	169,462	2,643,225	217,276	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	960	2,255	116,467	9,574	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	170	24,691	57,997	2,165,448	178,002	66.00
67.00	06700	OCCUPATIONAL THERAPY	70	7,439	17,473	563,600	46,328	67.00
68.00	06800	SPEECH PATHOLOGY	13	1,681	3,948	194,565	15,993	68.00
69.00	06900	ELECTROCARDIOLOGY	125	16,326	38,348	559,420	45,985	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,493	3,506	4,999	411	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,032	10,809	25,390	1,387,116	114,022	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	21,593	50,720	1,267,288	104,172	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	83	3,123	7,335	177,282	14,573	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	KEWANEE RHC	987	0	43,959	2,877,613	236,543	88.00
88.01	08801	WYOMING RHC	9	0	1,741	156,329	12,850	88.01
88.02	08802	GENESE0 RHC	481	0	14,882	1,616,054	132,841	88.02
90.00	09000	CLINIC	622	0	7,579	595,374	48,940	90.00
90.01	09001	PAIN CLINIC	136	0	274	106,051	8,717	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	299	0	2,911	686,449	56,427	90.03
90.04	09004	GENESE0 CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	1,076	17,476	41,049	2,920,927	240,103	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	737	0	7,859	928,879	76,355	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	48,725	365,472	960,836	40,354,597	3,054,230	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	22,018	1,810	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	8	0	0	1,319	108	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	40	0	0	266,474	21,904	192.03
192.04	19204	ANNAWAN CLINIC	314	0	6,648	597,367	49,104	192.04
192.05	19205	CAMBRIDGE CLINIC	87	0	4,817	402,243	33,065	192.05
192.06	19206	PORT BYRON CLINIC	265	0	1,091	274,523	22,566	192.06
194.00	07955	FOUNDATION	0	0	0	33,002	2,713	194.00
194.01	07950	SPORTS MEDICINE	40	0	0	161,672	13,290	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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1319

Period:
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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	
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	0	0	57,719	194.06
194.07	07957	COMMUNITY HEALTH	6	0	0	4,595	194.07
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	49,485	365,472	973,392	42,175,529	3,199,168

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020Worksheet 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	1,588,877					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,014	168,669				8.00
9.00	00900	HOUSEKEEPING	21,625	1,266	829,411			9.00
10.00	01000	DIETARY	54,785	1,133	25,486	1,152,248		10.00
11.00	01100	CAFETERIA	36,182	0	24,450	737,409	857,816	11.00
13.00	01300	NURSING ADMINISTRATION	9,425	0	0	0	14,516	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	25,982	0	3,108	0	15,059	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25,408	0	2,176	0	53,543	16.00
17.00	01700	SOCIAL SERVICE	0	0	932	0	8,728	17.00
18.00	01800	INSERVICE EDUCATION	0	0	0	0	11,079	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	210,845	41,058	205,031	96,188	138,244	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	278,031	43,874	203,994	318,651	120,607	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	236,051	26,146	160,895	0	84,339	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	138,853	18,623	34,500	0	63,582	54.00
60.00	06000	LABORATORY	38,058	0	19,788	0	65,301	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	1,411	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	207,481	14,247	24,658	0	89,811	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,526	0	5,595	0	23,470	67.00
68.00	06800	SPEECH PATHOLOGY	2,511	0	0	0	7,597	68.00
69.00	06900	ELECTROCARDIOLOGY	18,990	0	9,117	0	15,556	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	11,580	1,210	1,727	0	5,698	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	50,537	286	7,977	0	50,242	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PAIN CLINIC	403	577	0	0	4,115	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	4,062	0	14,401	0	4,794	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	143,162	20,249	32,117	0	71,134	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	17,471	0	3,626	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,555,393	168,669	779,578	1,152,248	847,415	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	15,316	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	12,014	0	35,018	0	3,120	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
192.06	19206	PORT BYRON CLINIC	0	0	0	0	0	192.06
194.00	07955	FOUNDATION	6,154	0	0	0	7,281	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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020Worksheet B
Part I
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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	
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	14,815	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)	1,588,877	168,669	829,411	1,152,248	857,816	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020Worksheet B
Part I
Date/Time Prepared:
10/19/2020 4:22 pm

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	298,540					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	30,670				14.00
15.00	01500	PHARMACY	9,621	0	744,101			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	921,460		16.00
17.00	01700	SOCIAL SERVICE	5,576	0	0	0	173,922	17.00
18.00	01080	INSERVICE EDUCATION	7,079	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	88,323	0	0	39,725	100,460	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	1,389	65,258	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	53,883	0	0	204,438	298	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	40,622	0	0	186,351	0	54.00
60.00	06000	LABORATORY	41,720	0	0	165,464	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	2,202	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	56,628	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	17,061	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,855	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	37,443	597	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	30,670	0	3,423	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	24,791	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	744,101	49,524	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	3,640	0	0	7,162	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	42,922	0	88.00
88.01	08801	WYOMING RHC	0	0	0	1,700	0	88.01
88.02	08802	GENESE0 RHC	0	0	0	14,531	0	88.02
90.00	09000	CLINIC	0	0	0	7,400	0	90.00
90.01	09001	PAIN CLINIC	2,629	0	0	267	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	0	2,842	0	90.03
90.04	09004	GENESE0 CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	45,447	0	0	40,081	7,309	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)	298,540	30,670	744,101	909,199	173,922	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	6,491	0	192.04
192.05	19205	CAMBRIDGE CLINIC	0	0	0	4,704	0	192.05
192.06	19206	PORT BYRON CLINIC	0	0	0	1,066	0	192.06
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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020Worksheet B
Part I
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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	
194.04	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	0	0	0	194.06
194.07	07957	COMMUNITY HEALTH	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)	298,540	30,670	744,101	921,460	173,922

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020Worksheet B
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
OTHER GENERAL SERVICE 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	294,879			18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,425	4,438,772	0	30.00
43.00	04300	NURSERY	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	7,077	3,068,289	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	63,969	5,527,868	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	58,286	4,036,537	0	54.00
60.00	06000	LABORATORY	51,753	3,242,585	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	689	130,343	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	17,712	2,753,987	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,336	671,916	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,206	225,727	0	68.00
69.00	06900	ELECTROCARDIOLOGY	11,711	698,819	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,071	40,574	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,754	1,533,683	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,490	2,180,575	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	76.00
76.01	03610	SLEEP LAB	2,240	225,112	0	76.01
76.02	03950	IV THERAPY	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	13,425	3,170,503	0	88.00
88.01	08801	WYOMING RHC	532	171,411	0	88.01
88.02	08802	GENESEO RHC	4,545	1,877,013	0	88.02
90.00	09000	CLINIC	2,315	654,029	0	90.00
90.01	09001	PAIN CLINIC	84	122,843	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	889	769,864	0	90.03
90.04	09004	GENESEO CLINIC	0	0	0	90.04
91.00	09100	EMERGENCY	12,536	3,533,065	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	1,026,331	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	291,045	40,099,846	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	39,144	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	1,427	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	192.02
192.03	19202	LEASED SPACE	0	338,530	0	192.03
192.04	19204	ANNAWAN CLINIC	2,030	654,992	0	192.04
192.05	19205	CAMBRIDGE CLINIC	1,471	441,483	0	192.05
192.06	19206	PORT BYRON CLINIC	333	298,488	0	192.06

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020Worksheet 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		
194.00	07955	FOUNDATION	0	49,150	0	49,150		194.00
194.01	07950	SPORTS MEDICINE	0	174,962	0	174,962		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	72,534	0	72,534		194.06
194.07	07957	COMMUNITY HEALTH	0	4,973	0	4,973		194.07
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	294,879	42,175,529	0	42,175,529		202.00

COST ALLOCATION STATISTICS

Provider CCN: 14-1319

Period:

From 06/01/2019

To 05/31/2020

Worksheet Non-CMS W

Date/Time Prepared:
10/19/2020 4:22 pm

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
1.00	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	3	GROSS SALARIES	4.00
5.01	DATA PROCESSING	4	TIME SPENT	5.01
5.02	PURCHASING RECEIVING AND STORES	5	SUPPLY COS T	5.02
5.03	ADMITTING	6	GROSS CHAR GES	5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE	7	GROSS CHAR GES	5.04
5.05	ALL OTHER ADMINISTRATIVE AND GE	-1	ACCUM. COST	5.05
7.00	OPERATION OF PLANT	8	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	9	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	10	HOURS OF SERVICE	9.00
10.00	DIETARY	11	MEALS SERVED	10.00
11.00	CAFETERIA	12	FTES	11.00
13.00	NURSING ADMINISTRATION	13	FTES	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQ UIS	14.00
15.00	PHARMACY	15	COSTED REQ UIS	15.00
16.00	MEDICAL RECORDS & LIBRARY	16	GROSS PT. CHARGES	16.00
17.00	SOCIAL SERVICE	17	TIME SPENT	17.00
18.00	INSERVICE EDUCATION	18	GROSS CHAR GES	18.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020Worksheet B
Part II
Date/Time Prepared:
10/19/2020 4:22 pm

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	11,098	0	11,098	4.00
5.01	00550	DATA PROCESSING	0	45,662	178,910	224,572	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	69,307	0	69,307	5.02
5.03	00570	ADMITTING	0	30,063	21,499	51,562	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	38,308	2,372	40,680	5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	0	88,494	13,353	101,847	5.05
7.00	00700	OPERATION OF PLANT	0	181,557	7,353	188,910	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	17,271	1,386	18,657	8.00
9.00	00900	HOUSEKEEPING	0	31,088	0	31,088	9.00
10.00	01000	DIETARY	0	78,756	4,696	83,452	10.00
11.00	01100	CAFETERIA	0	52,014	0	52,014	11.00
13.00	01300	NURSING ADMINISTRATION	0	13,549	13,984	27,533	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	37,350	6,635	43,985	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	36,525	6,102	42,627	16.00
17.00	01700	SOCIAL SERVICE	0	0	1,668	1,668	17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	303,100	94,614	397,714	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	339,336	303,875	643,211	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	199,608	249,104	448,712	54.00
60.00	06000	LABORATORY	0	54,710	60,632	115,342	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	2,028	0	2,028	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	298,264	26,097	324,361	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	15,132	901	16,033	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,610	0	3,610	68.00
69.00	06900	ELECTROCARDIOLOGY	0	27,299	5,202	32,501	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	16,647	0	16,647	76.01
76.02	03950	IV THERAPY	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	KEWANEE RHC	0	0	100,500	100,500	88.00
88.01	08801	WYOMING RHC	0	0	0	0	88.01
88.02	08802	GENESE0 RHC	0	72,650	26,347	98,997	88.02
90.00	09000	CLINIC	0	0	2,925	2,925	90.00
90.01	09001	PAIN CLINIC	0	579	0	579	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	5,839	611	6,450	90.03
90.04	09004	GENESE0 CLINIC	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	205,803	43,521	249,324	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	25,115	4,153	29,268	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,300,762	1,176,440	3,477,202	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	22,018	0	22,018	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	17,271	2,997	20,268	192.03
192.04	19204	ANNAWAN CLINIC	0	0	9,918	9,918	192.04
192.05	19205	CAMBRIDGE CLINIC	0	0	14,322	14,322	192.05
192.06	19206	PORT BYRON CLINIC	0	0	3,663	3,663	192.06
194.00	07955	FOUNDATION	0	8,847	0	8,847	194.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020Worksheet B
Part II
Date/Time Prepared:
10/19/2020 4:22 pm

Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
				0	1.00	2.00	2A	4.00
194.01	07950	SPORTS MEDICINE	0	0	219	219	80	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	57,719	0	57,719	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,406,617	1,207,559	3,614,176	11,098	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1319

Period:
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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	224,787					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	439	31,785				5.02
5.03	00570	ADMITTING	3,470	31	55,200			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	4,546	53	0	45,587		5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	17,069	54	0	0	119,408	5.05
7.00	00700	OPERATION OF PLANT	4,427	414	0	0	4,504	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18	0	0	444	8.00
9.00	00900	HOUSEKEEPING	1,316	422	0	0	2,286	9.00
10.00	01000	DIETARY	2,353	286	0	0	3,036	10.00
11.00	01100	CAFETERIA	399	0	0	0	169	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	778	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	308	0	0	87	14.00
15.00	01500	PHARMACY	10,847	101	0	0	1,957	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,403	19	0	0	2,382	16.00
17.00	01700	SOCIAL SERVICE	359	1	0	0	450	17.00
18.00	01080	INSERVICE EDUCATION	0	60	0	0	784	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	23,130	1,047	2,614	1,905	9,941	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	6,540	320	0	1,085	5,753	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	9,850	7,224	13,496	9,812	13,326	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	14,516	2,498	12,264	8,937	9,910	54.00
60.00	06000	LABORATORY	10,768	5,699	10,889	7,936	8,109	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	145	106	357	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	5,503	109	3,727	2,716	6,644	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,356	45	1,123	818	1,729	67.00
68.00	06800	SPEECH PATHOLOGY	1,515	8	254	185	597	68.00
69.00	06900	ELECTROCARDIOLOGY	1,795	80	2,464	1,796	1,716	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	225	164	15	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,652	1,631	1,189	4,256	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,259	2,375	3,888	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	54	471	343	544	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	KEWANEE RHC	32,462	634	0	2,059	8,829	88.00
88.01	08801	WYOMING RHC	1,436	6	0	82	480	88.01
88.02	08802	GENESE0 RHC	15,497	309	0	697	4,958	88.02
90.00	09000	CLINIC	10,768	399	0	355	1,827	90.00
90.01	09001	PAIN CLINIC	1,954	88	0	13	325	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	4,028	192	0	136	2,106	90.03
90.04	09004	GENESE0 CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	11,605	691	2,638	1,922	8,961	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	2,512	474	0	368	2,850	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	212,863	31,296	55,200	44,999	113,998	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	68	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	5	0	0	4	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	26	0	0	818	192.03
192.04	19204	ANNAWAN CLINIC	6,540	202	0	311	1,833	192.04
192.05	19205	CAMBRIDGE CLINIC	2,393	56	0	226	1,234	192.05
192.06	19206	PORT BYRON CLINIC	0	170	0	51	842	192.06
194.00	07955	FOUNDATION	2,991	0	0	0	101	194.00
194.01	07950	SPORTS MEDICINE	0	26	0	0	496	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

ALLOCATION OF CAPITAL RELATED COSTS

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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	
194.04	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	0	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	4	0	14	194.07
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	38,061	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	224,787	69,846	55,200	45,587	119,408

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1319

Period:
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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	198,444					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,501	20,640				8.00
9.00	00900	HOUSEKEEPING	2,701	155	38,274			9.00
10.00	01000	DIETARY	6,842	139	1,176	97,647		10.00
11.00	01100	CAFETERIA	4,519	0	1,128	62,492	120,721	11.00
13.00	01300	NURSING ADMINISTRATION	1,177	0	0	0	2,043	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	3,245	0	143	0	2,119	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,173	0	100	0	7,535	16.00
17.00	01700	SOCIAL SERVICE	0	0	43	0	1,228	17.00
18.00	01800	INSERVICE EDUCATION	0	0	0	0	1,559	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	26,334	5,024	9,461	8,151	19,455	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	34,725	5,369	9,414	27,004	16,973	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	29,482	3,199	7,425	0	11,869	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	17,342	2,279	1,592	0	8,948	54.00
60.00	06000	LABORATORY	4,753	0	913	0	9,190	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	176	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	25,913	1,743	1,138	0	12,639	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,315	0	258	0	3,303	67.00
68.00	06800	SPEECH PATHOLOGY	314	0	0	0	1,069	68.00
69.00	06900	ELECTROCARDIOLOGY	2,372	0	421	0	2,189	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	1,446	148	80	0	802	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	6,312	35	368	0	7,071	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PAIN CLINIC	50	71	0	0	579	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	507	0	665	0	675	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	17,880	2,478	1,482	0	10,011	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	2,182	0	167	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	194,261	20,640	35,974	97,647	119,257	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	1,913	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	1,501	0	1,616	0	439	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
192.06	19206	PORT BYRON CLINIC	0	0	0	0	0	192.06
194.00	07955	FOUNDATION	769	0	0	0	1,025	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			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	684	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)	198,444	20,640	38,274	97,647	120,721	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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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	31,660					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	395				14.00
15.00	01500	PHARMACY	1,020	0	63,596			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	68,561		16.00
17.00	01700	SOCIAL SERVICE	591	0	0	0	4,420	17.00
18.00	01080	INSERVICE EDUCATION	751	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,367	0	0	2,957	2,553	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	103	1,658	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	5,714	0	0	15,192	8	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	4,308	0	0	13,870	0	54.00
60.00	06000	LABORATORY	4,424	0	0	12,315	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	164	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,215	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,270	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	287	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,787	15	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	395	0	255	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,845	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	63,596	3,686	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	386	0	0	533	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	3,195	0	88.00
88.01	08801	WYOMING RHC	0	0	0	127	0	88.01
88.02	08802	GENESE0 RHC	0	0	0	1,082	0	88.02
90.00	09000	CLINIC	0	0	0	551	0	90.00
90.01	09001	PAIN CLINIC	279	0	0	20	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	0	212	0	90.03
90.04	09004	GENESE0 CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	4,820	0	0	2,983	186	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)	31,660	395	63,596	67,649	4,420	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	483	0	192.04
192.05	19205	CAMBRIDGE CLINIC	0	0	0	350	0	192.05
192.06	19206	PORT BYRON CLINIC	0	0	0	79	0	192.06
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

ALLOCATION OF CAPITAL RELATED COSTS

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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	
194.04	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	0	0	0	194.06
194.07	07957	COMMUNITY HEALTH	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)	31,660	395	63,596	68,561	4,420

ALLOCATION OF CAPITAL RELATED COSTS

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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	3,275				18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	140	521,138	0	521,138	30.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	80	109,792	0	109,792	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	675	771,388	0	771,388	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	656	546,510	0	546,510	54.00
60.00	06000	LABORATORY	583	191,435	0	191,435	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	8	2,984	0	2,984	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	199	389,863	0	389,863	66.00
67.00	06700	OCCUPATIONAL THERAPY	60	27,590	0	27,590	67.00
68.00	06800	SPEECH PATHOLOGY	14	7,947	0	7,947	68.00
69.00	06900	ELECTROCARDIOLOGY	132	48,420	0	48,420	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	12	1,066	0	1,066	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	87	18,660	0	18,660	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	174	76,978	0	76,978	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03610	SLEEP LAB	25	21,532	0	21,532	76.01
76.02	03950	IV THERAPY	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	KEWANEE RHC	151	148,241	0	148,241	88.00
88.01	08801	WYOMING RHC	6	2,155	0	2,155	88.01
88.02	08802	GENESEO RHC	51	135,641	0	135,641	88.02
90.00	09000	CLINIC	26	17,021	0	17,021	90.00
90.01	09001	PAIN CLINIC	1	4,003	0	4,003	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	10	15,006	0	15,006	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	90.04
91.00	09100	EMERGENCY	141	315,850	0	315,850	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	38,239	0	38,239	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,231	3,411,459	0	3,411,459	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	23,999	0	23,999	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	9	0	9	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	24,756	0	24,756	192.03
192.04	19204	ANNAWAN CLINIC	23	19,411	0	19,411	192.04
192.05	19205	CAMBRIDGE CLINIC	17	18,689	0	18,689	192.05
192.06	19206	PORT BYRON CLINIC	4	4,817	0	4,817	192.06

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020Worksheet B
Part II
Date/Time Prepared:
10/19/2020 4:22 pm

Cost Center Description			OTHER GENERAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			INSERVICE EDUCATION					
			18.00	24.00	25.00	26.00		
194.00	07955	FOUNDATION	0	13,733	0	13,733		194.00
194.01	07950	SPORTS MEDICINE	0	821	0	821		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	58,403	0	58,403		194.06
194.07	07957	COMMUNITY HEALTH	0	18	0	18		194.07
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	38,061	0	38,061		201.00
202.00		TOTAL (sum lines 118 through 201)	3,275	3,614,176	0	3,614,176		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020

Worksheet B-1

Date/Time Prepared:
10/19/2020 4:22 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (TIME SPENT)	PURCHASING RECEIVING AND STORES (SUPPLY COST)	
			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	107,992					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,181,923				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	498	0	15,393,868			4.00
5.01	00550	DATA PROCESSING	2,049	175,112	298,175	140,915		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	3,110	0	138,565	275	4,398,126	5.02
5.03	00570	ADMITTING	1,349	21,043	189,889	2,175	4,239	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,719	2,322	427,754	2,850	7,272	5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	3,971	13,070	607,791	10,700	7,455	5.05
7.00	00700	OPERATION OF PLANT	8,147	7,197	262,645	2,775	57,228	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	775	1,357	28,123	0	2,485	8.00
9.00	00900	HOUSEKEEPING	1,395	0	424,196	825	58,431	9.00
10.00	01000	DIETARY	3,534	4,596	502,929	1,475	39,543	10.00
11.00	01100	CAFETERIA	2,334	0	0	250	0	11.00
13.00	01300	NURSING ADMINISTRATION	608	13,687	178,854	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	42,648	14.00
15.00	01500	PHARMACY	1,676	6,494	248,627	6,800	13,943	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,639	5,972	445,956	7,775	2,688	16.00
17.00	01700	SOCIAL SERVICE	0	1,633	111,292	225	207	17.00
18.00	01800	INSERVICE EDUCATION	0	0	167,304	0	8,247	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,601	92,605	1,865,640	14,500	144,828	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	1,065,249	4,100	44,321	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	297,423	1,255,828	6,175	999,550	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	8,957	243,816	940,198	9,100	345,651	54.00
60.00	06000	LABORATORY	2,455	59,345	712,683	6,750	788,542	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	13,384	25,543	1,326,360	3,450	15,085	66.00
67.00	06700	OCCUPATIONAL THERAPY	679	882	388,244	850	6,263	67.00
68.00	06800	SPEECH PATHOLOGY	162	0	130,179	950	1,171	68.00
69.00	06900	ELECTROCARDIOLOGY	1,225	5,092	211,236	1,125	11,124	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	1,335,885	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	73,133	0	7,420	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	KEWANEE RHC	0	98,366	569,785	20,350	87,710	88.00
88.01	08801	WYOMING RHC	0	0	25,383	900	838	88.01
88.02	08802	GENESEO RHC	3,260	25,788	365,573	9,715	42,793	88.02
90.00	09000	CLINIC	0	2,863	236,320	6,750	55,242	90.00
90.01	09001	PAIN CLINIC	26	0	61,113	1,225	12,110	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	262	598	34,379	2,525	26,593	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	9,235	42,597	1,009,071	7,275	95,648	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	580,418	1,575	65,537	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	103,242	1,151,466	14,882,892	133,440	4,330,697	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	679	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	775	2,933	121,963	0	3,563	192.03
192.04	19204	ANNAWAN CLINIC	0	9,707	140,238	4,100	27,885	192.04
192.05	19205	CAMBRIDGE CLINIC	0	14,018	126,827	1,500	7,734	192.05
192.06	19206	PORT BYRON CLINIC	0	3,585	11,336	0	23,530	192.06

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020

Worksheet B-1

Date/Time Prepared:
10/19/2020 4:22 pm

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	
194.00	07955	FOUNDATION	397	0	0	1,875	0	194.00
194.01	07950	SPORTS MEDICINE	0	214	110,612	0	3,537	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	501	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)	2,406,617	1,207,559	3,987,242	1,815,394	49,485	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.285141	1.021690	0.259015	12.882901	0.011251	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			11,098	224,787	69,846	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000721	1.595196	0.007227	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 06/01/2019
To 05/31/2020

Worksheet B-1

Date/Time Prepared:
10/19/2020 4:22 pm

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	101,770,116					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	115,396,035				5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	0	0	-3,199,168	38,918,642		5.05
7.00	00700	OPERATION OF PLANT	0	0	0	1,468,190	102,494	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	144,756	775	8.00
9.00	00900	HOUSEKEEPING	0	0	0	745,259	1,395	9.00
10.00	01000	DIETARY	0	0	0	989,506	3,534	10.00
11.00	01100	CAFETERIA	0	0	0	55,235	2,334	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	253,741	608	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	28,340	0	14.00
15.00	01500	PHARMACY	0	0	0	637,895	1,676	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	776,504	1,639	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	146,633	0	17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	255,702	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,823,303	4,823,303	0	3,240,131	13,601	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	2,747,357	0	1,875,260	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	24,826,216	24,826,216	0	4,340,996	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	22,626,437	22,626,437	0	3,230,195	8,957	54.00
60.00	06000	LABORATORY	20,090,385	20,090,385	0	2,643,225	2,455	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	267,350	267,350	0	116,467	91	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	6,875,717	6,875,717	0	2,165,448	13,384	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,071,485	2,071,485	0	563,600	679	67.00
68.00	06800	SPEECH PATHOLOGY	468,048	468,048	0	194,565	162	68.00
69.00	06900	ELECTROCARDIOLOGY	4,546,253	4,546,253	0	559,420	1,225	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	415,635	415,635	0	4,999	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,010,086	3,010,086	0	1,387,116	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,013,060	6,013,060	0	1,267,288	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	869,594	869,594	0	177,282	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	5,211,456	0	2,877,613	0	88.00
88.01	08801	WYOMING RHC	0	206,434	0	156,329	0	88.01
88.02	08802	GENESEO RHC	0	1,764,292	0	1,616,054	3,260	88.02
90.00	09000	CLINIC	0	898,495	0	595,374	0	90.00
90.01	09001	PAIN CLINIC	0	32,439	0	106,051	26	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	345,091	0	686,449	262	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	4,866,547	4,866,547	0	2,920,927	9,235	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	931,741	0	928,879	1,127	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	101,770,116	113,907,421	-3,199,168	37,155,429	100,334	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	22,018	988	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	1,319	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	0	0	266,474	775	192.03
192.04	19204	ANNAWAN CLINIC	0	788,108	0	597,367	0	192.04
192.05	19205	CAMBRIDGE CLINIC	0	571,124	0	402,243	0	192.05
192.06	19206	PORT BYRON CLINIC	0	129,382	0	274,523	0	192.06
194.00	07955	FOUNDATION	0	0	0	33,002	397	194.00
194.01	07950	SPORTS MEDICINE	0	0	0	161,672	0	194.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020

Worksheet B-1

Date/Time Prepared:
10/19/2020 4:22 pm

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	
194.02	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
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	-57,719	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	4,595	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)	365,472	973,392		3,199,168	1,588,877	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.003591	0.008435		0.082201	15.502146	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	55,200	45,587		119,408	198,444	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000542	0.000395		0.003068	1.936152	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 06/01/2019
To 05/31/2020

Worksheet B-1

Date/Time Prepared:
10/19/2020 4:22 pm

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	214,603				8.00
9.00	00900	HOUSEKEEPING	1,611	240,170			9.00
10.00	01000	DIETARY	1,441	7,380	149,895		10.00
11.00	01100	CAFETERIA	0	7,080	95,929	18,969	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	321	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	900	0	333	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	630	0	1,184	16.00
17.00	01700	SOCIAL SERVICE	0	270	0	193	17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	245	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	52,239	59,370	12,513	3,057	30.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	55,824	59,070	41,453	2,667	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	33,266	46,590	0	1,865	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	23,695	9,990	0	1,406	54.00
60.00	06000	LABORATORY	0	5,730	0	1,444	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	18,127	7,140	0	1,986	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,620	0	519	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	168	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,640	0	344	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	1,539	500	0	126	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	364	2,310	0	1,111	88.02
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	PAIN CLINIC	734	0	0	91	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	4,170	0	106	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	90.04
91.00	09100	EMERGENCY	25,763	9,300	0	1,573	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)	214,603	225,740	149,895	18,739	118.00
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	69	192.03
192.04	19204	ANNAWAN CLINIC	0	0	0	0	192.04
192.05	19205	CAMBRIDGE CLINIC	0	0	0	0	192.05
192.06	19206	PORT BYRON CLINIC	0	0	0	0	192.06
194.00	07955	FOUNDATION	0	0	0	161	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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020

Worksheet B-1

Date/Time Prepared:
10/19/2020 4:22 pm

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	
194.03	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	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)	168,669	829,411	1,152,248	857,816	298,540	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.785958	3.453433	7.687034	45.221994	28.891900	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	20,640	38,274	97,647	120,721	31,660	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.096178	0.159362	0.651436	6.364120	3.063970	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 06/01/2019
To 05/31/2020

Worksheet B-1

Date/Time Prepared:
10/19/2020 4:22 pm

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 CHA RGES)	
			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	111,885,634			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	58,300		17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	0	114,464,294	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	4,823,303	33,675	4,823,303	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	168,697	21,875	2,747,357	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	24,826,216	100	24,826,216	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	22,626,437	0	22,626,437	54.00
60.00	06000	LABORATORY	0	0	20,090,385	0	20,090,385	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	267,350	0	267,350	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	6,875,717	0	6,875,717	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,071,485	0	2,071,485	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	468,048	0	468,048	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	4,546,253	200	4,546,253	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	100	0	415,635	0	415,635	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	3,010,086	0	3,010,086	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	6,013,060	0	6,013,060	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	869,594	0	869,594	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	5,211,456	0	5,211,456	88.00
88.01	08801	WYOMING RHC	0	0	206,434	0	206,434	88.01
88.02	08802	GENESEO RHC	0	0	1,764,292	0	1,764,292	88.02
90.00	09000	CLINIC	0	0	898,495	0	898,495	90.00
90.01	09001	PAIN CLINIC	0	0	32,439	0	32,439	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	345,091	0	345,091	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	4,866,547	2,450	4,866,547	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	110,397,020	58,300	112,975,680	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	788,108	0	788,108	192.04
192.05	19205	CAMBRIDGE CLINIC	0	0	571,124	0	571,124	192.05
192.06	19206	PORT BYRON CLINIC	0	0	129,382	0	129,382	192.06

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020

Worksheet B-1

Date/Time Prepared:
10/19/2020 4:22 pm

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	
194.00	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
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)	30,670	744,101	921,460	173,922	294,879	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	306.700000	7,441.010000	0.008236	2.983225	0.002576	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	395	63,596	68,561	4,420	3,275	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.950000	635.960000	0.000613	0.075815	0.000029	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 06/01/2019
To 05/31/2020Worksheet C
Part I
Date/Time Prepared:
10/19/2020 4:22 pm

			Title XVIII	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Total Costs
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,438,772		4,438,772	0
43.00	04300	NURSERY	0		0	0
44.00	04400	SKILLED NURSING FACILITY	3,068,289		3,068,289	0
46.00	04600	OTHER LONG TERM CARE	0		0	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,527,868		5,527,868	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0
53.00	05300	ANESTHESIOLOGY	0		0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,036,537		4,036,537	0
60.00	06000	LABORATORY	3,242,585		3,242,585	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	130,343		130,343	0
64.00	06400	INTRAVENOUS THERAPY	0		0	0
66.00	06600	PHYSICAL THERAPY	2,753,987	0	2,753,987	0
67.00	06700	OCCUPATIONAL THERAPY	671,916	0	671,916	0
68.00	06800	SPEECH PATHOLOGY	225,727	0	225,727	0
69.00	06900	ELECTROCARDIOLOGY	698,819		698,819	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	40,574		40,574	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,533,683		1,533,683	0
73.00	07300	DRUGS CHARGED TO PATIENTS	2,180,575		2,180,575	0
76.00	03020	ACUPUNCTURE	0		0	0
76.01	03610	SLEEP LAB	225,112		225,112	0
76.02	03950	IV THERAPY	0		0	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	3,170,503		3,170,503	0
88.01	08801	WYOMING RHC	171,411		171,411	0
88.02	08802	GENESEO RHC	1,877,013		1,877,013	0
90.00	09000	CLINIC	654,029		654,029	0
90.01	09001	PAIN CLINIC	122,843		122,843	0
90.02	09002	SPECIALTY CLINIC	0		0	0
90.03	09003	SURGICAL CLINIC	769,864		769,864	0
90.04	09004	GENESEO CLINIC	0		0	0
91.00	09100	EMERGENCY	3,533,065		3,533,065	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1,337,067		1,337,067	0
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0	0
101.00	10100	HOME HEALTH AGENCY	1,026,331		1,026,331	0
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
200.00		Subtotal (see instructions)	41,436,913	0	41,436,913	0
201.00		Less Observation Beds	1,337,067		1,337,067	0
202.00		Total (see instructions)	40,099,846	0	40,099,846	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020Worksheet C
Part I
Date/Time Prepared:
10/19/2020 4:22 pm

			Title XVIII			Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	3,337,977		3,337,977			30.00	
43.00	04300	NURSERY	0		0			43.00	
44.00	04400	SKILLED NURSING FACILITY	2,747,357		2,747,357			44.00	
46.00	04600	OTHER LONG TERM CARE	0		0			46.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	7,023,643	17,802,573	24,826,216	0.222663	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	981,383	21,645,054	22,626,437	0.178399	0.000000	54.00	
60.00	06000	LABORATORY	1,519,417	18,570,968	20,090,385	0.161400	0.000000	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	117,310	150,040	267,350	0.487537	0.000000	62.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00	
66.00	06600	PHYSICAL THERAPY	613,907	6,261,810	6,875,717	0.400538	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	304,957	1,766,528	2,071,485	0.324364	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	60,615	407,433	468,048	0.482273	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	590,794	3,955,459	4,546,253	0.153713	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	317,260	98,375	415,635	0.097619	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,956,319	1,053,767	3,010,086	0.509515	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	2,126,833	3,886,227	6,013,060	0.362640	0.000000	73.00	
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00	
76.01	03610	SLEEP LAB	0	869,594	869,594	0.258870	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	5,211,456	5,211,456			88.00	
88.01	08801	WYOMING RHC	0	206,434	206,434			88.01	
88.02	08802	GENESE0 RHC	0	1,764,292	1,764,292			88.02	
90.00	09000	CLINIC	0	898,495	898,495	0.727916	0.000000	90.00	
90.01	09001	PAIN CLINIC	0	32,439	32,439	3.786892	0.000000	90.01	
90.02	09002	SPECIALTY CLINIC	0	0	0	0.000000	0.000000	90.02	
90.03	09003	SURGICAL CLINIC	28,885	316,206	345,091	2.230901	0.000000	90.03	
90.04	09004	GENESE0 CLINIC	0	0	0	0.000000	0.000000	90.04	
91.00	09100	EMERGENCY	108,065	4,758,482	4,866,547	0.725990	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	139,334	1,345,992	1,485,326	0.900184	0.000000	92.00	
OTHER REIMBURSABLE COST CENTERS									
99.10	09910	CORF	0	0	0			99.10	
101.00	10100	HOME HEALTH AGENCY	0	931,741	931,741			101.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	21,974,056	91,933,365	113,907,421			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	21,974,056	91,933,365	113,907,421			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-1319	Period: From 06/01/2019 To 05/31/2020	Worksheet C Part I Date/Time Prepared: 10/19/2020 4:22 pm
			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	0.222663		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	0.178399		54.00
60.00	06000	LABORATORY	0.161400		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.487537		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600	PHYSICAL THERAPY	0.400538		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.324364		67.00
68.00	06800	SPEECH PATHOLOGY	0.482273		68.00
69.00	06900	ELECTROCARDIOLOGY	0.153713		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.097619		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.509515		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.362640		73.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.258870		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	0.727916		90.00
90.01	09001	PAIN CLINIC	3.786892		90.01
90.02	09002	SPECIALTY CLINIC	0.000000		90.02
90.03	09003	SURGICAL CLINIC	2.230901		90.03
90.04	09004	GENESE0 CLINIC	0.000000		90.04
91.00	09100	EMERGENCY	0.725990		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.900184		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 06/01/2019
To 05/31/2020Worksheet C
Part I
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			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance		Total Costs
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,438,772		4,438,772	0	4,438,772	30.00
43.00	04300	NURSERY	0		0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	3,068,289		3,068,289	0	3,068,289	44.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,527,868		5,527,868	0	5,527,868	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	4,036,537		4,036,537	0	4,036,537	54.00
60.00	06000	LABORATORY	3,242,585		3,242,585	0	3,242,585	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	130,343		130,343	0	130,343	62.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	2,753,987	0	2,753,987	0	2,753,987	66.00
67.00	06700	OCCUPATIONAL THERAPY	671,916	0	671,916	0	671,916	67.00
68.00	06800	SPEECH PATHOLOGY	225,727	0	225,727	0	225,727	68.00
69.00	06900	ELECTROCARDIOLOGY	698,819		698,819	0	698,819	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	40,574		40,574	0	40,574	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,533,683		1,533,683	0	1,533,683	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,180,575		2,180,575	0	2,180,575	73.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	225,112		225,112	0	225,112	76.01
76.02	03950	IV THERAPY	0		0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	KEWANEE RHC	3,170,503		3,170,503	0	3,170,503	88.00
88.01	08801	WYOMING RHC	171,411		171,411	0	171,411	88.01
88.02	08802	GENESEO RHC	1,877,013		1,877,013	0	1,877,013	88.02
90.00	09000	CLINIC	654,029		654,029	0	654,029	90.00
90.01	09001	PAIN CLINIC	122,843		122,843	0	122,843	90.01
90.02	09002	SPECIALTY CLINIC	0		0	0	0	90.02
90.03	09003	SURGICAL CLINIC	769,864		769,864	0	769,864	90.03
90.04	09004	GENESEO CLINIC	0		0	0	0	90.04
91.00	09100	EMERGENCY	3,533,065		3,533,065	0	3,533,065	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1,337,067		1,337,067	0	1,337,067	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	1,026,331		1,026,331		1,026,331	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	41,436,913	0	41,436,913	0	41,436,913	200.00
201.00		Less Observation Beds	1,337,067		1,337,067		1,337,067	201.00
202.00		Total (see instructions)	40,099,846	0	40,099,846	0	40,099,846	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020Worksheet C
Part I
Date/Time Prepared:
10/19/2020 4:22 pm

			Title XIX			Hospital	Cost
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS			9.00	10.00			
30.00	03000	ADULTS & PEDIATRICS	3,337,977		3,337,977		30.00
43.00	04300	NURSERY	0		0		43.00
44.00	04400	SKILLED NURSING FACILITY	2,747,357		2,747,357		44.00
46.00	04600	OTHER LONG TERM CARE	0		0		46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,023,643	17,802,573	24,826,216	0.222663	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	981,383	21,645,054	22,626,437	0.178399	54.00
60.00	06000	LABORATORY	1,519,417	18,570,968	20,090,385	0.161400	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	117,310	150,040	267,350	0.487537	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	613,907	6,261,810	6,875,717	0.400538	66.00
67.00	06700	OCCUPATIONAL THERAPY	304,957	1,766,528	2,071,485	0.324364	67.00
68.00	06800	SPEECH PATHOLOGY	60,615	407,433	468,048	0.482273	68.00
69.00	06900	ELECTROCARDIOLOGY	590,794	3,955,459	4,546,253	0.153713	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	317,260	98,375	415,635	0.097619	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,956,319	1,053,767	3,010,086	0.509515	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,126,833	3,886,227	6,013,060	0.362640	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	869,594	869,594	0.258870	76.01
76.02	03950	IV THERAPY	0	0	0	0.000000	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	KEWANEE RHC	0	5,211,456	5,211,456	0.608372	88.00
88.01	08801	WYOMING RHC	0	206,434	206,434	0.830343	88.01
88.02	08802	GENESE0 RHC	0	1,764,292	1,764,292	1.063890	88.02
90.00	09000	CLINIC	0	898,495	898,495	0.727916	90.00
90.01	09001	PAIN CLINIC	0	32,439	32,439	3.786892	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0.000000	90.02
90.03	09003	SURGICAL CLINIC	28,885	316,206	345,091	2.230901	90.03
90.04	09004	GENESE0 CLINIC	0	0	0	0.000000	90.04
91.00	09100	EMERGENCY	108,065	4,758,482	4,866,547	0.725990	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	139,334	1,345,992	1,485,326	0.900184	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	931,741	931,741		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	21,974,056	91,933,365	113,907,421		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	21,974,056	91,933,365	113,907,421		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020Worksheet C
Part I
Date/Time Prepared:
10/19/2020 4:22 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
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 06/01/2019
To 05/31/2020Worksheet D
Part II
Date/Time Prepared:
10/19/2020 4:22 pm

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	771,388	24,826,216	0.031072	3,377,956	104,960	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	546,510	22,626,437	0.024154	351,727	8,496	54.00
60.00	06000 LABORATORY	191,435	20,090,385	0.009529	659,974	6,289	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD	2,984	267,350	0.011161	54,987	614	62.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
66.00	06600 PHYSICAL THERAPY	389,863	6,875,717	0.056701	169,909	9,634	66.00
67.00	06700 OCCUPATIONAL THERAPY	27,590	2,071,485	0.013319	91,708	1,221	67.00
68.00	06800 SPEECH PATHOLOGY	7,947	468,048	0.016979	16,055	273	68.00
69.00	06900 ELECTROCARDIOLOGY	48,420	4,546,253	0.010651	305,117	3,250	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	1,066	415,635	0.002565	197,984	508	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	18,660	3,010,086	0.006199	1,093,133	6,776	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	76,978	6,013,060	0.012802	892,518	11,426	73.00
76.00	03020 ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610 SLEEP LAB	21,532	869,594	0.024761	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	148,241	5,211,456	0.028445	0	0	88.00
88.01	08801 WYOMING RHC	2,155	206,434	0.010439	0	0	88.01
88.02	08802 GENESEO RHC	135,641	1,764,292	0.076881	0	0	88.02
90.00	09000 CLINIC	17,021	898,495	0.018944	0	0	90.00
90.01	09001 PAIN CLINIC	4,003	32,439	0.123401	0	0	90.01
90.02	09002 SPECIALTY CLINIC	0	0	0.000000	0	0	90.02
90.03	09003 SURGICAL CLINIC	15,006	345,091	0.043484	0	0	90.03
90.04	09004 GENESEO CLINIC	0	0	0.000000	0	0	90.04
91.00	09100 EMERGENCY	315,850	4,866,547	0.064902	8,387	544	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	156,980	1,485,326	0.105687	9,556	1,010	92.00
200.00	Total (lines 50 through 199)	2,899,270	106,890,346		7,229,011	155,001	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020Worksheet D
Part IV
Date/Time Prepared:
10/19/2020 4:22 pm

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	GENESE0 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	GENESE0 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 06/01/2019
To 05/31/2020Worksheet D
Part IV
Date/Time Prepared:
10/19/2020 4:22 pm

Cost Center Description			Title XVIII		Hospital	Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
			4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	24,826,216	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	22,626,437	0.000000
60.00	06000	LABORATORY	0	0	0	20,090,385	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	267,350	0.000000
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	6,875,717	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,071,485	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	468,048	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,546,253	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	415,635	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,010,086	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,013,060	0.000000
76.00	03020	ACUPUNCTURE	0	0	0	0	0.000000
76.01	03610	SLEEP LAB	0	0	0	869,594	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	5,211,456	0.000000
88.01	08801	WYOMING RHC	0	0	0	206,434	0.000000
88.02	08802	GENESEO RHC	0	0	0	1,764,292	0.000000
90.00	09000	CLINIC	0	0	0	898,495	0.000000
90.01	09001	PAIN CLINIC	0	0	0	32,439	0.000000
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0.000000
90.03	09003	SURGICAL CLINIC	0	0	0	345,091	0.000000
90.04	09004	GENESEO CLINIC	0	0	0	0	0.000000
91.00	09100	EMERGENCY	0	0	0	4,866,547	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	1,485,326	0.000000
200.00		Total (lines 50 through 199)	0	0	0	106,890,346	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020Worksheet D
Part IV
Date/Time Prepared:
10/19/2020 4:22 pm

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	3,377,956	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	351,727	0	0	0 54.00
60.00	06000	LABORATORY	0.000000	659,974	0	0	0 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.000000	54,987	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	169,909	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	91,708	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	16,055	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	305,117	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	197,984	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,093,133	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	892,518	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	8,387	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000	9,556	0	0	0 92.00
200.00		Total (lines 50 through 199)		7,229,011	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020Worksheet D
Part IV
Date/Time Prepared:
10/19/2020 4:22 pm

				Title XVIII	Hospital	Cost
Cost Center Description			PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
	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		Total (lines 50 through 199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020Worksheet D
Part V
Date/Time Prepared:
10/19/2020 4:22 pm

			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	0.222663	0	5,064,577	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	0.178399	0	6,679,132	0	0	54.00
60.00	06000	LABORATORY	0.161400	0	5,583,138	333	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.487537	0	79,520	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.400538	0	2,267,493	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.324364	0	541,213	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.482273	0	107,491	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.153713	0	1,494,970	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.097619	0	43,295	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.509515	0	134,903	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.362640	0	1,741,569	3,756	0	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.258870	0	223,213	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	0.727916	0	33,203	1,440	0	90.00
90.01	09001	PAIN CLINIC	3.786892	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	2.230901	0	58,464	0	0	90.03
90.04	09004	GENESE0 CLINIC	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.725990	0	1,330,799	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.900184	0	492,057	0	0	92.00
200.00		Subtotal (see instructions)		0	25,875,037	5,529	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	25,875,037	5,529	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-1319		Period: From 06/01/2019 To 05/31/2020		Worksheet D Part V Date/Time Prepared: 10/19/2020 4:22 pm	
			Title XVIII		Hospital		Cost	
Cost Center Description			Costs					
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
			6.00	7.00				
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,127,694	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	1,191,550	0				54.00
60.00	06000	LABORATORY	901,118	54				60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	38,769	0				62.00
64.00	06400	INTRAVENOUS THERAPY	0	0				64.00
66.00	06600	PHYSICAL THERAPY	908,217	0				66.00
67.00	06700	OCCUPATIONAL THERAPY	175,550	0				67.00
68.00	06800	SPEECH PATHOLOGY	51,840	0				68.00
69.00	06900	ELECTROCARDIOLOGY	229,796	0				69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	4,226	0				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	68,735	0				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	631,563	1,362				73.00
76.00	03020	ACUPUNCTURE	0	0				76.00
76.01	03610	SLEEP LAB	57,783	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	24,169	1,048				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	130,427	0				90.03
90.04	09004	GENESE0 CLINIC	0	0				90.04
91.00	09100	EMERGENCY	966,147	0				91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	442,942	0				92.00
200.00		Subtotal (see instructions)	6,950,526	2,464				200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0					201.00
202.00		Net Charges (line 200 - line 201)	6,950,526	2,464				202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1319

Period:

Worksheet D

Component CCN:14-Z319

From 06/01/2019
To 05/31/2020Part V
Date/Time Prepared:
10/19/2020 4:22 pm

			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	0.222663	0	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	0.178399	0	0	0	0	54.00
60.00	06000	LABORATORY	0.161400	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.487537	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.400538	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.324364	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.482273	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.153713	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.097619	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.509515	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.362640	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.258870	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	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	0.727916	0	0	0	0	90.00
90.01	09001	PAIN CLINIC	3.786892	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	2.230901	0	0	0	0	90.03
90.04	09004	GENESEO CLINIC	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.725990	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.900184	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN:14-1319	Period: From 06/01/2019	Worksheet D
		Component CCN:14-Z319	To 05/31/2020	Part V
		Title XVIII	Swing Beds - SNF	Date/Time Prepared: 10/19/2020 4:22 pm
		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	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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1319 Component CCN: 14-5464		Period: From 06/01/2019 To 05/31/2020		Worksheet D Part IV Date/Time Prepared: 10/19/2020 4:22 pm	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
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	GENESE0 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	GENESE0 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 Component CCN: 14-5464		Period: From 06/01/2019 To 05/31/2020		Worksheet D Part IV Date/Time Prepared: 10/19/2020 4:22 pm	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	24,826,216	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	22,626,437	0.000000	54.00
60.00	06000	LABORATORY		0	0	0	20,090,385	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD		0	0	0	267,350	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	6,875,717	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	2,071,485	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	468,048	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	4,546,253	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT		0	0	0	415,635	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	3,010,086	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	6,013,060	0.000000	73.00
76.00	03020	ACUPUNCTURE		0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB		0	0	0	869,594	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	5,211,456	0.000000	88.00
88.01	08801	WYOMING RHC		0	0	0	206,434	0.000000	88.01
88.02	08802	GENESE0 RHC		0	0	0	1,764,292	0.000000	88.02
90.00	09000	CLINIC		0	0	0	898,495	0.000000	90.00
90.01	09001	PAIN CLINIC		0	0	0	32,439	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	345,091	0.000000	90.03
90.04	09004	GENESE0 CLINIC		0	0	0	0	0.000000	90.04
91.00	09100	EMERGENCY		0	0	0	4,866,547	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		0	0	0	1,485,326	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	106,890,346		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1319 Component CCN: 14-5464		Period: From 06/01/2019 To 05/31/2020		Worksheet D Part IV Date/Time Prepared: 10/19/2020 4:22 pm	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
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	0.000000	8,618	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	16,881	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.000000	2,220	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	0.000000	88,345	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	35,309	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	6,463	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,040	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	67,387	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	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	0	0	0	0	88.00
88.01	08801	WYOMING RHC	0.000000	0	0	0	0	0	88.01
88.02	08802	GENESEO RHC	0.000000	0	0	0	0	0	88.02
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
90.01	09001	PAIN CLINIC	0.000000	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	0.000000	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	0.000000	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			227,263	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 06/01/2019 To 05/31/2020		Worksheet D Part IV Date/Time Prepared: 10/19/2020 4:22 pm	
			Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description			PSA Adj. Non Physician Anesthetist Cost 21.00	PSA Adj. All Other Medical Education Cost 24.00				
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		Total (lines 50 through 199)	0	0				200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN:14-1319 Component CCN:14-5464	Period: From 06/01/2019 To 05/31/2020	Worksheet D Part V Date/Time Prepared: 10/19/2020 4:22 pm	
				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	0.222663	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	0.178399	0	0	0	54.00
60.00	06000	LABORATORY	0.161400	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.487537	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.400538	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.324364	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.482273	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.153713	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.097619	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.509515	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.362640	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	76.00
76.01	03610	SLEEP LAB	0.258870	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	GENESEO RHC	0.000000			0	88.02
90.00	09000	CLINIC	0.727916	0	0	0	90.00
90.01	09001	PAIN CLINIC	3.786892	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.000000	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	2.230901	0	0	0	90.03
90.04	09004	GENESEO CLINIC	0.000000	0	0	0	90.04
91.00	09100	EMERGENCY	0.725990	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.900184	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 Component CCN:14-5464		Period: From 06/01/2019 To 05/31/2020		Worksheet D Part V Date/Time Prepared: 10/19/2020 4:22 pm		
			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 06/01/2019
To 05/31/2020

Worksheet D-1

Date/Time Prepared:
10/19/2020 4:22 pm

Title XVIII		Hospital	Cost
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,265	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,595	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)	2,320	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	369	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)	264	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	21	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)	16	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,245	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)	295	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)	211	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)	4,438,772	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)	2,803	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)	2,136	25.00
26.00	Total swing-bed cost (see instructions)	668,753	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,770,019	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)	3,770,019	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,048.68	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,305,607	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)	1,305,607	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020

Worksheet D-1

Date/Time Prepared:
10/19/2020 4:22 pm

		Title XVIII		Hospital	Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		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)					2,015,316
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,320,923
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)					309,361
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					221,271
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					530,632
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)					1,275
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,048.68
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,337,067

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020

Worksheet D-1

Date/Time Prepared:
10/19/2020 4:22 pm

		Title XVIII		Hospital	Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	521,138	4,438,772	0.117406	1,337,067	156,980
91.00	Nursing School cost	0	4,438,772	0.000000	1,337,067	0
92.00	Allied health cost	0	4,438,772	0.000000	1,337,067	0
93.00	All other Medical Education	0	4,438,772	0.000000	1,337,067	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1319 Component CCN: 14-5464	Period: From 06/01/2019 To 05/31/2020	Worksheet D-1 Date/Time Prepared: 10/19/2020 4:22 pm
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		13,508	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		13,508	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)		13,508	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		354	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)		3,068,289	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)		3,068,289	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)		3,068,289	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	Period: From 06/01/2019 To 05/31/2020	Worksheet D-1
				Component CCN: 14-5464		Date/Time Prepared: 10/19/2020 4:22 pm
				Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT						43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges						54.00
55.00 Target amount per discharge						55.00
56.00 Target amount (line 54 x line 55)						56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00 Bonus payment (see instructions)						58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00 Relief payment (see instructions)						62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					3,068,289	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					227.15	71.00
72.00 Program routine service cost (line 9 x line 71)					80,411	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)					80,411	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)					80,411	83.00
84.00 Program inpatient ancillary services (see instructions)					80,051	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)					160,462	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 06/01/2019 To 05/31/2020		Worksheet D-1 Date/Time Prepared: 10/19/2020 4:22 pm
			Title XVIII		Skilled Nursing Facility		PPS
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1319	Period: From 06/01/2019 To 05/31/2020	Worksheet D-3 Date/Time Prepared: 10/19/2020 4:22 pm	
			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		1,586,939		30.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.222663	3,377,956	752,146	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	0.178399	351,727	62,748	54.00
60.00	06000	LABORATORY	0.161400	659,974	106,520	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.487537	54,987	26,808	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.400538	169,909	68,055	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.324364	91,708	29,747	67.00
68.00	06800	SPEECH PATHOLOGY	0.482273	16,055	7,743	68.00
69.00	06900	ELECTROCARDIOLOGY	0.153713	305,117	46,900	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.097619	197,984	19,327	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.509515	1,093,133	556,968	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.362640	892,518	323,663	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.258870	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	0.727916	0	0	90.00
90.01	09001	PAIN CLINIC	3.786892	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.000000	0	0	90.02
90.03	09003	SURGICAL CLINIC	2.230901	0	0	90.03
90.04	09004	GENESEO CLINIC	0.000000	0	0	90.04
91.00	09100	EMERGENCY	0.725990	8,387	6,089	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.900184	9,556	8,602	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,229,011	2,015,316	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)		7,229,011		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1319 Component CCN: 14-Z319	Period: From 06/01/2019 To 05/31/2020	Worksheet D-3 Date/Time Prepared: 10/19/2020 4:22 pm	
Cost Center Description			Title XVIII	Swing Beds - SNF	Cost	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.222663	95,206	21,199	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	0.178399	18,669	3,331	54.00
60.00	06000	LABORATORY	0.161400	80,407	12,978	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.487537	6,270	3,057	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.400538	163,701	65,568	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.324364	81,916	26,571	67.00
68.00	06800	SPEECH PATHOLOGY	0.482273	8,855	4,271	68.00
69.00	06900	ELECTROCARDIOLOGY	0.153713	28,282	4,347	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.097619	459	45	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.509515	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.362640	121,251	43,970	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.258870	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	0.727916	0	0	90.00
90.01	09001	PAIN CLINIC	3.786892	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.000000	0	0	90.02
90.03	09003	SURGICAL CLINIC	2.230901	0	0	90.03
90.04	09004	GENESEO CLINIC	0.000000	0	0	90.04
91.00	09100	EMERGENCY	0.725990	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.900184	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		605,016	185,337	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)		605,016		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1319 Component CCN: 14-5464	Period: From 06/01/2019 To 05/31/2020	Worksheet D-3 Date/Time Prepared: 10/19/2020 4:22 pm	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.222663	0	0	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	0.178399	8,618	1,537	54.00
60.00	06000 LABORATORY	0.161400	16,881	2,725	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD	0.487537	2,220	1,082	62.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
66.00	06600 PHYSICAL THERAPY	0.400538	88,345	35,386	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.324364	35,309	11,453	67.00
68.00	06800 SPEECH PATHOLOGY	0.482273	6,463	3,117	68.00
69.00	06900 ELECTROCARDIOLOGY	0.153713	2,040	314	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.097619	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.509515	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.362640	67,387	24,437	73.00
76.00	03020 ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610 SLEEP LAB	0.258870	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	0.727916	0	0	90.00
90.01	09001 PAIN CLINIC	3.786892	0	0	90.01
90.02	09002 SPECIALTY CLINIC	0.000000	0	0	90.02
90.03	09003 SURGICAL CLINIC	2.230901	0	0	90.03
90.04	09004 GENESEO CLINIC	0.000000	0	0	90.04
91.00	09100 EMERGENCY	0.725990	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0.900184	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		227,263	80,051	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)		227,263		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1319	Period: From 06/01/2019 To 05/31/2020	Worksheet E Part B Date/Time Prepared: 10/19/2020 4:22 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		6,952,990	1.00
2.00	Medical and other services reimbursed under OPPI (see instructions)		0	2.00
3.00	OPPI 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)		6,952,990	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)		7,022,520	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)		73,963	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		4,026,140	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)		2,922,417	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)		2,922,417	30.00
31.00	Primary payer payments		21	31.00
32.00	Subtotal (line 30 minus line 31)		2,922,396	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)		64,335	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		41,818	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		2,964,214	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)		2,964,214	40.00
40.01	Sequestration adjustment (see instructions)		59,284	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		2,411,840	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		493,090	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1319	Period: From 06/01/2019 To 05/31/2020	Worksheet E Part B Date/Time Prepared: 10/19/2020 4:22 pm
		Title XVIII	Hospital	Cost
				Overrides
				1.00
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0 112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1319 Component CCN: 14-5464	Period: From 06/01/2019 To 05/31/2020	Worksheet E Part B Date/Time Prepared: 10/19/2020 4:22 pm
		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)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		0	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		0	37.00
38.00	MSP-LCC reconciliation amount from PS&R			38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		0	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		0	41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		0	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1319 Component CCN: 14-5464	Period: From 06/01/2019 To 05/31/2020	Worksheet E Part B Date/Time Prepared: 10/19/2020 4:22 pm
		Title XVIII	Skilled Nursing Facility	PPS
				Overrides
				1.00
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020Worksheet E-1
Part I
Date/Time Prepared:
10/19/2020 4:22 pm

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,873,259		2,734,809	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	11/27/2019	24,464	11/27/2019	322,969	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)		-24,464		-322,969	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)		2,848,795		2,411,840	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		85,652		493,090	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,934,447		2,904,930	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 06/01/2019

Part I

To 05/31/2020

Date/Time Prepared:

10/19/2020 4:22 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		670,971		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	11/27/2019	17,200		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)		-17,200		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)		653,771		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		50,674		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		704,445		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 06/01/2019 To 05/31/2020	Worksheet E-1 Part I Date/Time Prepared: 10/19/2020 4:22 pm	
		Title XVIII	Skilled Nursing Facility	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider		122,596		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)		122,596		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		142		0 6.02
7.00	Total Medicare program liability (see instructions)		122,454		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 06/01/2019 To 05/31/2020	Worksheet E-1 Part II Date/Time Prepared: 10/19/2020 4:22 pm
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN:14-1319 Component CCN:14-Z319	Period: From 06/01/2019 To 05/31/2020	Worksheet E-2 Date/Time Prepared: 10/19/2020 4:22 pm	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		535,938	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		187,190	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)				3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		506	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)		723,128	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		723,128	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)		723,128	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		4,307	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		718,821	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)		718,821	0	19.00
19.01	Sequestration adjustment (see instructions)		14,376	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
20.00	Interim payments		653,771	0	20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		50,674	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-1319	Period: From 06/01/2019 To 05/31/2020	Worksheet E-3 Part V Date/Time Prepared: 10/19/2020 4:22 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		3,320,923	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)		3,320,923	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		3,354,132	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)		3,354,132	19.00
20.00	Deductibles (exclude professional component)		366,633	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		2,987,499	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		2,987,499	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		10,516	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		6,835	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)		2,994,334	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)		2,994,334	30.00
30.01	Sequestration adjustment (see instructions)		59,887	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM		0	30.03
31.00	Interim payments		2,848,795	31.00
31.01	Interim payments-PARHM		0	31.01
32.00	Tentative settlement (for contractor use only)		0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		0	32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		85,652	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1319 Component CCN: 14-5464	Period: From 06/01/2019 To 05/31/2020	Worksheet E-3 Part VI Date/Time Prepared: 10/19/2020 4:22 pm
		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)			167,380 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)			167,380 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			42,427 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)			124,953 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)			124,953 15.00
15.01	Sequestration adjustment (see instructions)			2,499 15.01
15.02	Demonstration payment adjustment amount after sequestration			0 15.02
16.00	Interim payments			122,596 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)			-142 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 06/01/2019
To 05/31/2020

Worksheet G

Date/Time Prepared:
10/19/2020 4:22 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	19,039,435	0	0	0	1.00
2.00	Temporary investments	28,610,189	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	26,627,526	0	0	0	4.00
5.00	Other receivable	1,006,416	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-24,234,996	0	0	0	6.00
7.00	Inventory	770,562	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	1,454,981	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)	53,274,113	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	-1,115,255	0	0	0	14.00
15.00	Buildings	44,797,997	0	0	0	15.00
16.00	Accumulated depreciation	-25,782,216	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	15,185,459	0	0	0	19.00
20.00	Accumulated depreciation	-10,840,878	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	-1,019,268	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	4,771	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	26,069,427	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	7,266,573	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	7,266,573	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	86,610,113	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	0	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,785,315	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	1,582,435	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	1,628,773	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,996,523	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	10,581,837	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	24,319,286	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	34,901,123	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	40,897,646	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	45,712,467	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)	45,712,467	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	86,610,113	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020

Worksheet G-1

Date/Time Prepared:
10/19/2020 4:22 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		38,340,743		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		6,804,564				2.00
3.00	Total (sum of line 1 and line 2)		45,145,307		0		3.00
4.00	NET INCOME FROM FOUNDATION	567,160		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)		567,160		0		10.00
11.00	Subtotal (line 3 plus line 10)		45,712,467		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)		45,712,467		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 06/01/2019
To 05/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
10/19/2020 4:22 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,337,977		3,337,977	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	2,747,357		2,747,357	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)	6,085,334		6,085,334	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,085,334		6,085,334	17.00
18.00	Ancillary services	15,859,837	82,572,302	98,432,139	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	KEWANEE RHC	0	5,211,456	5,211,456	20.00
20.01	WYOMING RHC	0	206,434	206,434	20.01
20.02	GENESEO RHC	0	1,764,292	1,764,292	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		931,741	931,741	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	898,495	898,495	27.00
27.01	PAIN CLINIC	0	32,439	32,439	27.01
27.02	SURGICAL CLINIC	28,885	316,206	345,091	27.02
27.03	PROFESSIONAL FEES	1,688,987	11,118,010	12,806,997	27.03
27.04	CAMBRIDGE CLINIC	0	571,124	571,124	27.04
27.05	ANNAWAN CLINIC	0	788,108	788,108	27.05
27.06	PORT BYRON CLINIC	0	129,382	129,382	27.06
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	23,663,043	104,539,989	128,203,032	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		46,640,661		29.00
30.00	PROVISION FOR BAD DEBT	2,032,774			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)		2,032,774		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)		48,673,435		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1319

Period:
From 06/01/2019
To 05/31/2020

Worksheet G-3

Date/Time Prepared:
10/19/2020 4:22 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	128,203,032	1.00
2.00	Less contractual allowances and discounts on patients' accounts	80,955,736	2.00
3.00	Net patient revenues (line 1 minus line 2)	47,247,296	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	48,673,435	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,426,139	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	67,906	6.00
7.00	Income from investments	916,224	7.00
8.00	Revenues from telephone and other miscellaneous communication services	194	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	202,333	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	198,917	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	120	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	127,412	24.00
24.01	RENTAL INCOME	425,083	24.01
24.02	PROPERTY INCOME	792,118	24.02
24.03	340B PHARMACY REVENUE	1,798,083	24.03
24.04	CARES ACT FUNDING	4,178,119	24.04
24.05	OTHER OPERATING REVENUE	143,744	24.05
25.00	Total other income (sum of lines 6-24)	8,850,253	25.00
26.00	Total (line 5 plus line 25)	7,424,114	26.00
27.00	340B PHARMACY EXPENSES	576,910	27.00
27.02	LOSS ON SALE OF FIXED ASSETS	42,640	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	619,550	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	6,804,564	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-1319

Period:

Worksheet H

HHA CCN: 14-7450

From 06/01/2019

Date/Time Prepared:

To 05/31/2020

10/19/2020 4:22 pm

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	0	3.00
4.00 Transportation	0	0	0	0	0	0	4.00
5.00 Administrative and General	118,794	0	700	13,570	6,780	139,844	5.00
HHA REIMBURSABLE SERVICES							
6.00 Skilled Nursing Care	417,873	0	57,696	0	2,200	477,769	6.00
7.00 Physical Therapy	0	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	0	8.00
9.00 Speech Pathology	0	0	0	0	0	0	9.00
10.00 Medical Social Services	0	0	0	0	0	0	10.00
11.00 Home Health Aide	43,751	0	258	0	0	44,009	11.00
12.00 Supplies (see instructions)	0	0	0	0	63,036	63,036	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)	580,418	0	58,654	13,570	72,016	724,658	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	139,844	-4,271	135,573			5.00
HHA REIMBURSABLE SERVICES							
6.00 Skilled Nursing Care	0	477,769	0	477,769			6.00
7.00 Physical Therapy	0	0	0	0			7.00
8.00 Occupational Therapy	0	0	0	0			8.00
9.00 Speech Pathology	0	0	0	0			9.00
10.00 Medical Social Services	0	0	0	0			10.00
11.00 Home Health Aide	0	44,009	0	44,009			11.00
12.00 Supplies (see instructions)	0	63,036	0	63,036			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	724,658	-4,271	720,387			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 06/01/2019
To 05/31/2020Part I
Date/Time Prepared:
10/19/2020 4:22 pmHome Health
Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportatio n			
			Bldgs & Fixtures	Movable Equipment			Subtotal (cols. 0-4)		
									0
	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	135,573	0	0	0	0	135,573	5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	477,769	0	0	0	0	477,769	6.00	
7.00	Physical Therapy	0	0	0	0	0	0	7.00	
8.00	Occupational Therapy	0	0	0	0	0	0	8.00	
9.00	Speech Pathology	0	0	0	0	0	0	9.00	
10.00	Medical Social Services	0	0	0	0	0	0	10.00	
11.00	Home Health Aide	44,009	0	0	0	0	44,009	11.00	
12.00	Supplies (see instructions)	63,036	0	0	0	0	63,036	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)	720,387	0	0	0	0	720,387	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	135,573							5.00
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	110,758	588,527						6.00
7.00	Physical Therapy	0	0						7.00
8.00	Occupational Therapy	0	0						8.00
9.00	Speech Pathology	0	0						9.00
10.00	Medical Social Services	0	0						10.00
11.00	Home Health Aide	10,202	54,211						11.00
12.00	Supplies (see instructions)	14,613	77,649						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)		720,387						24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-1319

Period:

Worksheet H-1

HHA CCN: 14-7450

From 06/01/2019

Part II

To 05/31/2020

Date/Time Prepared:

10/19/2020 4:22 pm

Home Health
Agency I

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
	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	-135,573	584,814	5.00		
	HHA REIMBURSABLE SERVICES									
6.00	Skilled Nursing Care	0	0	0	0	0	477,769	6.00		
7.00	Physical Therapy	0	0	0	0	0	0	7.00		
8.00	Occupational Therapy	0	0	0	0	0	0	8.00		
9.00	Speech Pathology	0	0	0	0	0	0	9.00		
10.00	Medical Social Services	0	0	0	0	0	0	10.00		
11.00	Home Health Aide	0	0	0	0	0	44,009	11.00		
12.00	Supplies (see instructions)	0	0	0	0	0	63,036	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	-135,573	584,814	24.00		
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		135,573	25.00		
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.231822	26.00		

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1319

Period:

Worksheet H-2

HHA CCN: 14-7450

From 06/01/2019
To 05/31/2020Part I
Date/Time Prepared:
10/19/2020 4:22 pmHome 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	25,115	4,153	150,337	20,291	737	1.00
2.00	Skilled Nursing Care	588,527	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	54,211	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	77,649	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)	720,387	25,115	4,153	150,337	20,291	737	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	7,859	208,492	17,138	17,471	0	1.00
2.00	Skilled Nursing Care	0	0	588,527	48,378	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	54,211	4,456	0	0	7.00
8.00	Supplies (see instructions)	0	0	77,649	6,383	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	7,859	928,879	76,355	17,471	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 06/01/2019
To 05/31/2020Part I
Date/Time Prepared:
10/19/2020 4:22 pmHome 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	3,626	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)	3,626	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	246,727	0	246,727	1.00
2.00	Skilled Nursing Care	0	0	0	636,905	0	636,905	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	58,667	0	58,667	7.00
8.00	Supplies (see instructions)	0	0	0	84,032	0	84,032	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	1,026,331	0	1,026,331	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 06/01/2019
To 05/31/2020Part I
Date/Time Prepared:
10/19/2020 4:22 pmHome 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	201,566	838,471		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	18,567	77,234		7.00
8.00	Supplies (see instructions)	26,594	110,626		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)	246,727	1,026,331		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.	0.316477			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 06/01/2019

Worksheet H-2

HHA CCN: 14-7450

To 05/31/2020

Part II

Date/Time Prepared: 10/19/2020 4:22 pm

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	580,418	1,575	65,537	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	580,418	1,575	65,537	0	20.00
21.00	Total cost to be allocated	25,115	4,153	150,337	20,291	737	0	21.00
22.00	Unit cost multiplier	22.284827	1.021648	0.259015	12.883175	0.011246	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	931,741	0	208,492	1,127	0	1,050	1.00
2.00	Skilled Nursing Care	0	0	588,527	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	54,211	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	77,649	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)	931,741	0	928,879	1,127	0	1,050	20.00
21.00	Total cost to be allocated	7,859	0	76,355	17,471	0	3,626	21.00
22.00	Unit cost multiplier	0.008435	0	0.082201	15.502218	0.000000	3.453333	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 06/01/2019
To 05/31/2020Part II
Date/Time Prepared:
10/19/2020 4:22 pm

Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATIO N (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQ UIS)	PHARMACY (COSTED REQ UIS)	MEDICAL RECORDS & LIBRARY (GROSS PT. CHARGES)	PPS
		10.00	11.00	13.00	14.00	15.00	16.00	
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 CHAR GES)					
		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 06/01/2019

Part I

To 05/31/2020

Date/Time Prepared:

10/19/2020 4:22 pm

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	838,471		838,471	5,072	165.31	1.00
2.00	Physical Therapy	3.00	0	122,210	122,210	1,797	68.01	2.00
3.00	Occupational Therapy	4.00	0	49,883	49,883	900	55.43	3.00
4.00	Speech Pathology	5.00	0	18,235	18,235	69	264.28	4.00
5.00	Medical Social Services	6.00	0		0	80	0.00	5.00
6.00	Home Health Aide	7.00	77,234		77,234	739	104.51	6.00
7.00	Total (sum of lines 1-6)		915,705	190,328	1,106,033	8,657		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	1,779			8.00
8.01	Skilled Nursing Care		99914	0	285			8.01
9.00	Physical Therapy		19340	0	739			9.00
9.01	Physical Therapy		99914	0	154			9.01
10.00	Occupational Therapy		19340	0	343			10.00
10.01	Occupational Therapy		99914	0	94			10.01
11.00	Speech Pathology		19340	0	17			11.00
11.01	Speech Pathology		99914	0	28			11.01
12.00	Medical Social Services		19340	0	5			12.00
12.01	Medical Social Services		99914	0	0			12.01
13.00	Home Health Aide		19340	0	303			13.00
13.01	Home Health Aide		99914	0	48			13.01
14.00	Total (sum of lines 8-13)			0	3,795			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	110,626	0	110,626	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00
Program Visits								
Cost Center Description		Part A	Part B		Cost of Services	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	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	2,064		0	341,200		1.00
2.00	Physical Therapy	0	893		0	60,733		2.00
3.00	Occupational Therapy	0	437		0	24,223		3.00
4.00	Speech Pathology	0	45		0	11,893		4.00
5.00	Medical Social Services	0	5		0	0		5.00
6.00	Home Health Aide	0	351		0	36,683		6.00
7.00	Total (sum of lines 1-6)	0	3,795		0	474,732		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1319

Period:

Worksheet H-3

HHA CCN: 14-7450

From 06/01/2019
To 05/31/2020Part I
Date/Time Prepared:
10/19/2020 4:22 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description						Agency 1			
		6.00	7.00	8.00	9.00	10.00	11.00		
Limitation Cost Computation									
8.00	Skilled Nursing Care								8.00
8.01	Skilled Nursing Care								8.01
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	341,200							1.00
2.00	Physical Therapy	60,733							2.00
3.00	Occupational Therapy	24,223							3.00
4.00	Speech Pathology	11,893							4.00
5.00	Medical Social Services	0							5.00
6.00	Home Health Aide	36,683							6.00
7.00	Total (sum of lines 1-6)	474,732							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 06/01/2019

Part II

To 05/31/2020

Date/Time Prepared:

10/19/2020 4:22 pm

Title XVIII

Home Health

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	0.400538	305,114	122,210	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.324364	153,788	49,883	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.482273	37,810	18,235	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.097619	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.362640	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1319 HHA CCN: 14-7450	Period: From 06/01/2019 To 05/31/2020	Worksheet H-4 Part I-II Date/Time Prepared: 10/19/2020 4:22 pm
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0 1.00
2.00	Total charges	0	0	0 2.00
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0 3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0 4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000 5.00
6.00	Total customary charges (see instructions)	0	0	0 6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0 7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0 8.00
9.00	Primary payer amounts	0	0	0 9.00
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0 10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	529,018 11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	53,623 12.00
13.00	Total PPS Reimbursement - LUPA Episodes		0	9,785 13.00
14.00	Total PPS Reimbursement - PEP Episodes		0	5,950 14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	11,000 15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	896 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	610,272 22.00
23.00	Excess reasonable cost (from line 8)		0	0 23.00
24.00	Subtotal (line 22 minus line 23)		0	610,272 24.00
25.00	Coinsurance billed to program patients (from your records)		0	0 25.00
26.00	Net cost (line 24 minus line 25)		0	610,272 26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	610,272 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	610,272 31.00
31.01	Sequestration adjustment (see instructions)		0	11,084 31.01
31.02	Demonstration payment adjustment amount after sequestration		0	0 31.02
32.00	Interim payments (see instructions)		0	599,190 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	-2 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 06/01/2019 To 05/31/2020	Worksheet H-5 Date/Time Prepared: 10/19/2020 4:22 pm	
		Home Health Agency I		PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider		0		599,190
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
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)				
Program to Provider					
3.01			0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50			0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
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		599,190
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)				
Program to Provider					
5.01			0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50			0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		0		0
6.02	SETTLEMENT TO PROGRAM		0		2
7.00	Total Medicare program liability (see instructions)		0		599,188
				Contractor Number	NPR Date (Mo/Day/Yr)
		0		1.00	2.00
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.		06101	

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1319

Period:

Worksheet M-1

Component CCN: 14-8576

From 06/01/2019
To 05/31/2020Date/Time Prepared:
10/19/2020 4:22 pm

		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	632,005	0	632,005	242,993	874,998
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	397,904	0	397,904	0	397,904
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	174,720	0	174,720	0	174,720
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	218,645	0	218,645	-63,239	155,406
10.00	Subtotal (sum of lines 1 through 9)	1,423,274	0	1,423,274	179,754	1,603,028
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	174,319	174,319	0	174,319
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	174,319	174,319	0	174,319
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,423,274	174,319	1,597,593	179,754	1,777,347
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	10,856	10,856	0	10,856
30.00	Administrative Costs	223,529	310,685	534,214	0	534,214
31.00	Total Facility Overhead (sum of lines 29 and 30)	223,529	321,541	545,070	0	545,070
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,646,803	495,860	2,142,663	179,754	2,322,417

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1319

Period:

Worksheet M-1

Component CCN: 14-8576

From 06/01/2019
To 05/31/2020Date/Time Prepared:
10/19/2020 4:22 pm

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	874,998	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	397,904	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	174,720	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	155,406	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,603,028	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	174,319	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	174,319	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,777,347	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	10,856	29.00
30.00	Administrative Costs	0	534,214	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	545,070	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,322,417	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1319

Period:

Worksheet M-1

Component CCN: 14-8577

From 06/01/2019
To 05/31/2020Date/Time Prepared:
10/19/2020 4:22 pm

		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	3,295	0	3,295	9,086	12,381
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	31,161	0	31,161	0	31,161
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	10,584	0	10,584	0	10,584
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	4,880	0	4,880	-573	4,307
10.00	Subtotal (sum of lines 1 through 9)	49,920	0	49,920	8,513	58,433
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	2,640	2,640	0	2,640
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	2,640	2,640	0	2,640
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	49,920	2,640	52,560	8,513	61,073
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	2,859	2,859	0	2,859
30.00	Administrative Costs	14,119	58,358	72,477	0	72,477
31.00	Total Facility Overhead (sum of lines 29 and 30)	14,119	61,217	75,336	0	75,336
32.00	Total facility costs (sum of lines 22, 28 and 31)	64,039	63,857	127,896	8,513	136,409

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1319

Period:

Worksheet M-1

Component CCN: 14-8577

From 06/01/2019
To 05/31/2020Date/Time Prepared:
10/19/2020 4:22 pm

		RHC II		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	12,381	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	31,161	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	10,584	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	4,307	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	58,433	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	2,640	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	2,640	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	61,073	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	2,859	29.00
30.00	Administrative Costs	0	72,477	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	75,336	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	136,409	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1319

Period:

Worksheet M-1

Component CCN: 14-8587

From 06/01/2019
To 05/31/2020Date/Time Prepared:
10/19/2020 4:22 pm

		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	453,518	0	453,518	152,967	606,485
2.00	Physician Assistant	2,094	0	2,094	0	2,094
3.00	Nurse Practitioner	244,135	0	244,135	0	244,135
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	138,144	0	138,144	0	138,144
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	55,447	0	55,447	-1,029	54,418
10.00	Subtotal (sum of lines 1 through 9)	893,338	0	893,338	151,938	1,045,276
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	70,007	70,007	0	70,007
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	70,007	70,007	0	70,007
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	893,338	70,007	963,345	151,938	1,115,283
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	60	60	0	60
30.00	Administrative Costs	114,374	52,131	166,505	0	166,505
31.00	Total Facility Overhead (sum of lines 29 and 30)	114,374	52,191	166,565	0	166,565
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,007,712	122,198	1,129,910	151,938	1,281,848

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1319

Period:

Worksheet M-1

Component CCN: 14-8587

From 06/01/2019
To 05/31/2020Date/Time Prepared:
10/19/2020 4:22 pm

		RHC III		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	606,485	1.00
2.00	Physician Assistant	0	2,094	2.00
3.00	Nurse Practitioner	0	244,135	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	138,144	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	54,418	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,045,276	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	70,007	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	70,007	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,115,283	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	60	29.00
30.00	Administrative Costs	0	166,505	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	166,565	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,281,848	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1319

Period:

Worksheet M-2

Component CCN: 14-8576

From 06/01/2019
To 05/31/2020Date/Time Prepared:
10/19/2020 4:22 pm

		RHC I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	1.53	6,073	4,200	6,426	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	2.56	9,104	2,100	5,376	3.00
4.00	Subtotal (sum of lines 1 through 3)	4.09	15,177		11,802	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)	4.09	15,177		15,177	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)				1,777,347	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)				1,777,347	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)				545,070	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				848,086	15.00
16.00	Total overhead (sum of lines 14 and 15)				1,393,156	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				1,393,156	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				1,393,156	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				3,170,503	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1319

Period:

Worksheet M-2

Component CCN: 14-8577

From 06/01/2019
To 05/31/2020Date/Time Prepared:
10/19/2020 4:22 pm

		RHC II		Cost	
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
	1.00	2.00	3.00	4.00	5.00
VISITS AND PRODUCTIVITY					
Positions					
1.00	Physician	0.01	66	4,200	42
2.00	Physician Assistant	0.00	0	2,100	0
3.00	Nurse Practitioner	0.19	732	2,100	399
4.00	Subtotal (sum of lines 1 through 3)	0.20	798		441
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	0.00	0		0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.20	798		798
9.00	Physician Services Under Agreements		0		0
					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)				61,073
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				61,073
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				75,336
15.00	Parent provider overhead allocated to facility (see instructions)				35,002
16.00	Total overhead (sum of lines 14 and 15)				110,338
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				110,338
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				110,338
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				171,411

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1319 Component CCN: 14-8587		Period: From 06/01/2019 To 05/31/2020		Worksheet M-2 Date/Time Prepared: 10/19/2020 4:22 pm	
		RHC III		Cost			
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4		
	1.00	2.00	3.00	4.00	5.00		
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.95	3,001	4,200	3,990		1.00
2.00	Physician Assistant	0.01	10	2,100	21		2.00
3.00	Nurse Practitioner	1.69	3,672	2,100	3,549		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.65	6,683		7,560	7,560	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)	2.65	6,683			7,560	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)					1,115,283	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)					1,115,283	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)					166,565	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					595,165	15.00
16.00	Total overhead (sum of lines 14 and 15)					761,730	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					761,730	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					761,730	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,877,013	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1319 Component CCN: 14-8576	Period: From 06/01/2019 To 05/31/2020	Worksheet M-3 Date/Time Prepared: 10/19/2020 4:22 pm		
		Title XVIII	RHC I	Cost		
				1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			3,170,503	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			243,844	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,926,659	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			15,177	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)			15,177	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			192.84	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)			192.84	192.84	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)		0	2,900	10.00	
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	559,236	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	559,236	16.00	
16.01	Total program charges (see instructions)(from contractor's records)			690,256	16.01	
16.02	Total program preventive charges (see instructions)(from provider's records)			67,597	16.02	
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			54,766	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.)			369,666	16.04	
16.05	Total program cost (see instructions)		0	424,432	16.05	
17.00	Primary payer amounts			0	17.00	
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			42,387	18.00	
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			116,601	19.00	
20.00	Net Medicare cost excluding vaccines (see instructions)			424,432	20.00	
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			140,514	21.00	
22.00	Total reimbursable Program cost (line 20 plus line 21)			564,946	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)			564,946	26.00	
26.01	Sequestration adjustment (see instructions)			11,299	26.01	
26.02	Demonstration payment adjustment amount after sequestration			0	26.02	
27.00	Interim payments			481,135	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)			72,512	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 06/01/2019 To 05/31/2020	Worksheet M-3 Date/Time Prepared: 10/19/2020 4:22 pm		
		Title XVIII	RHC II	Cost		
				1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			171,411	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			0	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			171,411	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			798	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)			798	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			214.80	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			83.45	83.45	8.00
9.00	Rate for Program covered visits (see instructions)			214.80	214.80	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)		0	215	10.00	
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	46,182	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	46,182	16.00	
16.01	Total program charges (see instructions)(from contractor's records)			48,756	16.01	
16.02	Total program preventive charges (see instructions)(from provider's records)			3,672	16.02	
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			3,478	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.)			33,116	16.04	
16.05	Total program cost (see instructions)		0	36,594	16.05	
17.00	Primary payer amounts			0	17.00	
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			1,309	18.00	
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			8,755	19.00	
20.00	Net Medicare cost excluding vaccines (see instructions)			36,594	20.00	
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			0	21.00	
22.00	Total reimbursable Program cost (line 20 plus line 21)			36,594	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)			36,594	26.00	
26.01	Sequestration adjustment (see instructions)			732	26.01	
26.02	Demonstration payment adjustment amount after sequestration			0	26.02	
27.00	Interim payments			27,214	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)			8,648	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 06/01/2019 To 05/31/2020	Worksheet M-3 Date/Time Prepared: 10/19/2020 4:22 pm		
			Title XVIII	RHC III	Cost	
				1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,877,013	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			135,836	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,741,177	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			7,560	4.00	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00	
6.00	Total adjusted visits (line 4 plus line 5)			7,560	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			230.31	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)			230.31	230.31	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	1,538	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	354,217	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	354,217	16.00
16.01	Total program charges (see instructions)(from contractor's records)				339,757	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				27,284	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				28,445	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.)				237,530	16.04
16.05	Total program cost (see instructions)			0	265,975	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				28,860	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				56,723	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				265,975	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				31,538	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				297,513	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)				297,513	26.00
26.01	Sequestration adjustment (see instructions)				5,950	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				235,169	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)				56,394	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 06/01/2019 To 05/31/2020	Worksheet M-4 Date/Time Prepared: 10/19/2020 4:22 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1,603,028	1,603,028	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000488	0.000283	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		782	454	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		91,488	43,973	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		92,270	44,427	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,777,347	1,777,347	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,393,156	1,393,156	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.051914	0.024996	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		72,324	34,823	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		164,594	79,250	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		273	158	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		602.91	501.58	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		169	77	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		101,892	38,622	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)			243,844	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)			140,514	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN:14-1319 Component CCN:14-8577	Period: From 06/01/2019 To 05/31/2020	Worksheet M-4 Date/Time Prepared: 10/19/2020 4:22 pm	
		Title XVIII	RHC II	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		58,433	58,433	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		0	0	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		61,073	61,073	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		110,338	110,338	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.000000	0.000000	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		0	0	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		0	0	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		0	0	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		0.00	0.00	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		0	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		0	0	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)			0	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)			0	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN:14-1319 Component CCN:14-8587	Period: From 06/01/2019 To 05/31/2020	Worksheet M-4 Date/Time Prepared: 10/19/2020 4:22 pm	
		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)		1,045,276	1,045,276	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000325	0.000642	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		340	671	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		30,161	49,539	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		30,501	50,210	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,115,283	1,115,283	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		761,730	761,730	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.027348	0.045020	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		20,832	34,293	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		51,333	84,503	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		90	178	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		570.37	474.74	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		22	40	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		12,548	18,990	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)			135,836	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)			31,538	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 06/01/2019 To 05/31/2020	Worksheet M-5 Date/Time Prepared: 10/19/2020 4:22 pm	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		443,216	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		11/27/2019	37,919	3.01	
3.02			0	3.02	
3.03			0	3.03	
3.04			0	3.04	
3.05			0	3.05	
Provider to Program					
3.50			0	3.50	
3.51			0	3.51	
3.52			0	3.52	
3.53			0	3.53	
3.54			0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		37,919	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		481,135	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		72,512	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		553,647	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 06/01/2019 To 05/31/2020	Worksheet M-5 Date/Time Prepared: 10/19/2020 4:22 pm	
			RHC II	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			25,772	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			11/27/2019	1,442	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)			1,442	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			27,214	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			8,648	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			35,862	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 06/01/2019 To 05/31/2020	Worksheet M-5 Date/Time Prepared: 10/19/2020 4:22 pm	
			RHC III	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			264,740	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			11/27/2019	29,571	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)			-29,571	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			235,169	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			56,394	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			291,563	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00