

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 06/01/2020 To 05/31/2021	Worksheet S Parts I-III Date/Time Prepared: 10/22/2021 7:54 am
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 2. ☐ Manually prepared cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.	Date: 10/22/2021	Time: 7:54 am
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 06/01/2020 and ending 05/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.	
☐ 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.	
Encryption Information ECR: Date: 10/22/2021 Time: 7:54 am cPwReA:Xt67Fw6G0gh.VJ0ldjf:7R0 vwRXn03Z8Y:.x3tjd8rK.8dbe8Zxqx HUjc1ip35i0gtolr PI: Date: 10/22/2021 Time: 7:54 am bkwJuIr.wogmVwvvtphaS6S1qqWjj0 1l2jk0d0Btkg:Ke2S1VZLIQDNxYzyN vm:E0txt0v0qf:tc	(Signed) _____ Officer or Administrator of Provider(s) Title _____ Date _____

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-106,104	832,325	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	55,126	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	-2	0		0	7.00
9.00 HOME HEALTH AGENCY I	0	0	-1		0	9.00
10.00 KEWANEE RHC I	0		-13,685		0	10.00
10.01 WYOMING RHC II	0		0		0	10.01
10.02 GENESEO RHC III	0		-40,033		0	10.02
10.03 ANNAWAN RHC IV	0		-940		0	10.03
200.00 Total	0	-50,980	777,666	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 06/01/2020 To 05/31/2021		Worksheet S-2 Part I Date/Time Prepared: 10/22/2021 7:54 am		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 600 N. COLLEGE AVENUE			PO Box:		1.00					
2.00	City: GENESEO			State: IL		Zip Code: 61254-1099		County: HENRY			2.00
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
								V	XVIII	XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		HAMMOND-HENRY HOSPITAL	141319	19340	1	06/04/2002	N	O	O	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF		HAMMOND-HENRY SWING BED	142319	99914		05/21/2003	N	O	N	7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF		HAMMOND-HENRY SKILLED NURSING	145464	99914		06/01/1983	N	P	N	9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA		HAMMOND-HENRY HOME HEALTH SERVICES	147450	99914		06/05/1986	N	P	N	12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC		HAMMOND-HENRY HOSPITAL RHP-KEWANEE	148576	99914		05/01/2017	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II		HAMMOND-HENRY HOSPITAL RHP-WYOMING	148577	99914		05/01/2017	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III		HAMMOND-HENRY HOSPITAL RHP-GENESEO	148587	99914		05/16/2018	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV		ANNAWAN URGENT CARE CLINIC	148615	99914		07/28/2020	N	O	N	15.03
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
17.10	Hospital-Based (CORF) I										17.10
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						06/01/2020		05/31/2021		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
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMBdelineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.										22.04

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1319		Period: From 06/01/2020 To 05/31/2021		Worksheet S-2 Part I Date/Time Prepared: 10/22/2021 7:54 am	
		1.00	2.00	3.00			
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N			23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
		1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0
		Urban/Rural S		Date of Geogr			
		1.00		2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00	
		Beginning:		Ending:			
		1.00		2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)					37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N		Y/N			
		1.00		2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N		N		39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N		N		40.00	
		V	XVIII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00	
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1319	Period: From 06/01/2020 To 05/31/2021	Worksheet S-2 Part I Date/Time Prepared: 10/22/2021 7:54 am	
			V 1.00	XVIII 2.00	XIX 3.00
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
		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	
		1.00	2.00	3.00	
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
61.20	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
					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
62.01	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
Teaching Hospitals that Claim Residents in Nonprovider Settings					
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N			63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet S-2
Part I
Date/Time Prepared:
10/22/2021 7:54 am

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

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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 06/01/2020 To 05/31/2021		Worksheet S-2 Part I Date/Time Prepared: 10/22/2021 7:54 am	
				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			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
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.			N			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:			523,750	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
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.			N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1319		Period: From 06/01/2020 To 05/31/2021		Worksheet S-2 Part I Date/Time Prepared: 10/22/2021 7:54 am	
		1.00		2.00			
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00	
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
						1.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	Y		Y		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC			N		N	
161.10	CORF			N		N	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name		County		State	
		0		1.00		2.00	
				3.00		4.00	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.00		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1319	Period: From 06/01/2020 To 05/31/2021	Worksheet S-2 Part I Date/Time Prepared: 10/22/2021 7:54 am
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1319	Period: From 06/01/2020 To 05/31/2021	Worksheet S-2 Part II Date/Time Prepared: 10/22/2021 7:54 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	09/21/2021	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N			14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N			15.00
			Part A		Part B
			Y/N	Date	Y/N
			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	10/08/2021	Y	10/08/2021
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet S-2
Part II
Date/Time Prepared:
10/22/2021 7:54 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		Y		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		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 06/01/2020 To 05/31/2021	Worksheet S-2 Part II Date/Time Prepared: 10/22/2021 7:54 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CPA		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet S-3
Part I
Date/Time Prepared:
10/22/2021 7:54 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	52,176.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	52,176.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,125	52,176.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	37	13,505		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	46.00	0	0			21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 KEWANEE RHC	88.00				0	26.00
26.02 GENESEO RHC	88.02				0	26.02
26.03 ANNAWAN RHC	88.03				0	26.03
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 06/01/2020
To 05/31/2021Worksheet S-3
Part I
Date/Time Prepared:
10/22/2021 7:54 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,065	102	2,174		1.00
2.00	HMO and other (see instructions)	209	70			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	291	0	360		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	14		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,356	102	2,548		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)	1,356	102	2,548	0.00	262.00
15.00	CAH visits	0	0	0		15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY	623	0	12,699	0.00	28.41
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE			0	0.00	0.00
22.00	HOME HEALTH AGENCY	4,739	0	9,953	0.00	9.93
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
24.10	HOSPICE (non-distinct part)			0		24.10
25.00	CMHC - CMHC					25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00
26.00	KEWANEE RHC	2,891	0	16,202	0.00	21.62
26.02	GENESEO RHC	2,676	0	13,154	0.00	18.15
26.03	ANNAWAN RHC	123	0	2,924	0.00	4.98
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				0.00	345.09
28.00	Observation Bed Days		0	1,176		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			0		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	0	0		32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.01
33.00	LTCH non-covered days	0				33.00
33.01	LTCH site neutral days and discharges	0				33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet S-3
Part I
Date/Time Prepared:
10/22/2021 7:54 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	303	5	566	1.00
2.00 HMO and other (see instructions)			62	19		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	303	5	566	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
26.02 GENESEO RHC	0.00					26.02
26.03 ANNAWAN RHC	0.00					26.03
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 06/01/2020 To 05/31/2021		Worksheet S-4 Date/Time Prepared: 10/22/2021 7:54 am	
				Home Health Agency I		PPS	
				1.00			
0.00 County		HENRY				0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	15,977	0	0	15,977	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	187.00	4.00	66.00	257.00	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			1.21	0.00	1.21	5.00
6.00	Direct Nursing Service			0.00	0.00	0.00	6.00
7.00	Nursing Supervisor			1.04	0.00	1.04	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			7.68	0.00	7.68	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	2,305	472	48	12	2,837	21.00
22.00	Skilled Nursing Visit Charges	393,925	80,665	8,203	2,051	484,844	22.00
23.00	Physical Therapy Visits	599	308	6	0	913	23.00
24.00	Physical Therapy Visit Charges	130,553	67,116	1,310	0	198,979	24.00
25.00	Occupational Therapy Visits	284	280	4	0	568	25.00
26.00	Occupational Therapy Visit Charges	61,900	60,950	874	0	123,724	26.00
27.00	Speech Pathology Visits	15	27	0	0	42	27.00
28.00	Speech Pathology Visit Charges	3,276	5,897	0	0	9,173	28.00
29.00	Medical Social Service Visits	2	1	0	0	3	29.00
30.00	Medical Social Service Visit Charges	520	260	0	0	780	30.00
31.00	Home Health Aide Visits	267	109	0	0	376	31.00
32.00	Home Health Aide Visit Charges	25,365	10,355	0	0	35,720	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,472	1,197	58	12	4,739	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)	615,539	225,243	10,387	2,051	853,220	35.00
36.00	Total Number of Episodes (standard/non outlier)	396		43	2	441	36.00
37.00	Total Number of Outlier Episodes		54		0	54	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00

Health Financial Systems		HAMMOND-HENRY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1319 Component CCN: 14-8576		Period: From 06/01/2020 To 05/31/2021 Worksheet S-8 Date/Time Prepared: 10/22/2021 7:54 am	
		RHC I		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	1258 WEST SOUTH STREET #2		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	KEWANEE IL 61443		2.00	
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0		3.00	
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
7.00	Appalachian Regional Commission			7.00	
8.00	Look-Alikes			8.00	
9.00	OTHER (SPECIFY)			9.00	
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0 10.00	
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
		1.00		2.00	
11.00	Facility hours of operations (1)	CLINIC		11.00	
		07:30		18:00	
		07:30		11.00	
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0 13.00	
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			14.00	
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
		Total Visits		5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County		4.00	
2.00	City, State, ZIP Code, County	HENRY		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00			
Facility hours of operations (1)					
11.00	CLINIC	18:00	07:30	18:00	07:30
		18:00		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1319 Component CCN: 14-8576	Period: From 06/01/2020 To 05/31/2021	Worksheet S-8 Date/Time Prepared: 10/22/2021 7:54 am	
			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: 14-8587		Period: From 06/01/2020 To 05/31/2021		Worksheet S-8 Date/Time Prepared: 10/22/2021 7:54 am	
				RHC III		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			600 N. COLLEGE AVENUE			1.00		
			City	State	ZIP Code				
			1.00	2.00	3.00				
2.00	City, State, ZIP Code, County			GENESE0 IL 61254-1099		2.00			
				1.00					
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0		3.00			
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)							4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)							5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)							6.00	
7.00	Appalachian Regional Commission							7.00	
8.00	Look-Alikes							8.00	
9.00	OTHER (SPECIFY)							9.00	
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0		10.00	
				Sunday		Monday		Tuesday	
				from	to	from	to	from	
				1.00	2.00	3.00	4.00	5.00	
Facility hours of operations (1)									
11.00	CLINIC			08:30		17:00		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	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		17:00	
				08:30		17:00		11.00	

Health Financial Systems		HAMMOND-HENRY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1319	Period: From 06/01/2020	Worksheet S-8
			Component CCN: 14-8587	To 05/31/2021	Date/Time Prepared: 10/22/2021 7:54 am
			RHC III		Cost
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
Facility hours of operations (1)					
11.00	CLINIC	08:30	17:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1319 Component CCN: 14-8615		Period: From 06/01/2020 To 05/31/2021		Worksheet S-8 Date/Time Prepared: 10/22/2021 7:54 am	
				RHC IV		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street				203 W FRONT STREET		1.00		
				City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County				ANNAWAN		IL 61234		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				07:00		19:00		07:00
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?				N				12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N		0		13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number								14.00
				Y/N		V		Total Visits	
				1.00		2.00		3.00 4.00 5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)								15.00
				County					
				4.00					
2.00	City, State, ZIP Code, County				HENRY				2.00
				Tuesday		Wednesday		Thursday	
				to		from to		from to	
				6.00		7.00 8.00		9.00 10.00	
Facility hours of operations (1)									
11.00	CLINIC				19:00		07:00		19:00

Health Financial Systems		HAMMOND-HENRY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1319	Period: From 06/01/2020	Worksheet S-8
			Component CCN: 14-8615	To 05/31/2021	Date/Time Prepared: 10/22/2021 7:54 am
			RHC IV		Cost
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
Facility hours of operations (1)					
11.00	CLINIC	07:00	19:00	08:00	14:00
					11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1319	Period: From 06/01/2020 To 05/31/2021	Worksheet S-10 Date/Time Prepared: 10/22/2021 7:54 am
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.358082 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	2,844,810		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	5,792,912		6.00
7.00	Medicaid cost (line 1 times line 6)	2,074,338		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)	92,411	0	92,411 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	33,091	0	33,091 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)	33,091	0	33,091 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)	2,268,411		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	34,473		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	53,035		27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,215,376		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	811,848		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	844,939		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	844,939		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 14-1319		Period: From 06/01/2020 To 05/31/2021		Worksheet A Date/Time Prepared: 10/22/2021 7:54 am	
		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)		
			1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS									
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,992,265	1,992,265	252,569	2,244,834	1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,290,688	1,290,688	4,547	1,295,235	2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	392,579	5,197,861	5,590,440	-1,203,099	4,387,341	4.00	
5.01	00550	DATA PROCESSING	354,091	1,322,318	1,676,409	0	1,676,409	5.01	
5.02	00560	PURCHASING RECEIVING AND STORES	173,044	4,128	177,172	0	177,172	5.02	
5.03	00570	ADMITTING	221,531	44,767	266,298	0	266,298	5.03	
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	482,574	412,971	895,545	0	895,545	5.04	
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	737,428	2,184,824	2,922,252	-96,606	2,825,646	5.05	
7.00	00700	OPERATION OF PLANT	275,019	965,477	1,240,496	0	1,240,496	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	31,218	83,490	114,708	0	114,708	8.00	
9.00	00900	HOUSEKEEPING	426,183	158,110	584,293	0	584,293	9.00	
10.00	01000	DIETARY	502,622	421,750	924,372	0	924,372	10.00	
11.00	01100	CAFETERIA	0	0	0	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	180,354	407	180,761	0	180,761	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	17,807	17,807	0	17,807	14.00	
15.00	01500	PHARMACY	247,253	181,676	428,929	0	428,929	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	488,565	75,838	564,403	0	564,403	16.00	
17.00	01700	SOCIAL SERVICE	118,798	1,829	120,627	0	120,627	17.00	
18.00	01080	INSERVICE EDUCATION	192,431	46,036	238,467	0	238,467	18.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	2,493,553	261,081	2,754,634	108,212	2,862,846	30.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	1,184,956	183,236	1,368,192	269,141	1,637,333	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	1,332,910	4,015,663	5,348,573	-1,453,221	3,895,352	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	423,830	0	423,830	42,383	466,213	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	941,946	1,177,419	2,119,365	117,408	2,236,773	54.00	
60.00	06000	LABORATORY	797,156	4,181,474	4,978,630	2,438	4,981,068	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	120,577	120,577	0	120,577	62.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
66.00	06600	PHYSICAL THERAPY	1,352,464	71,802	1,424,266	0	1,424,266	66.00	
67.00	06700	OCCUPATIONAL THERAPY	421,400	26,351	447,751	0	447,751	67.00	
68.00	06800	SPEECH PATHOLOGY	117,887	5,267	123,154	0	123,154	68.00	
69.00	06900	ELECTROCARDIOLOGY	203,738	189,152	392,890	0	392,890	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	1,474,413	1,474,413	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,279,016	1,279,016	0	1,279,016	73.00	
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00	
76.01	03610	SLEEP LAB	91,823	59,034	150,857	0	150,857	76.01	
76.02	03950	IV THERAPY	0	0	0	0	0	76.02	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	KEWANEE RHC	1,702,355	619,876	2,322,231	217,624	2,539,855	88.00	
88.01	08801	WYOMING RHC	0	0	0	0	0	88.01	
88.02	08802	GENESEO RHC	1,528,692	224,995	1,753,687	237,890	1,991,577	88.02	
88.03	08803	ANNAWAN RHC	348,783	173,867	522,650	-92,660	429,990	88.03	
90.00	09000	CLINIC	663,213	177,551	840,764	135,450	976,214	90.00	
90.01	09001	PAIN CLINIC	59,324	153,928	213,252	1,311	214,563	90.01	
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02	
90.03	09003	SURGICAL CLINIC	440,766	1,452,377	1,893,143	30,426	1,923,569	90.03	
90.04	09004	GENESEO CLINIC	0	0	0	0	0	90.04	
91.00	09100	EMERGENCY	2,027,833	937,839	2,965,672	231,997	3,197,669	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	630,028	158,253	788,281	0	788,281	101.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE		469,303	469,303	-469,303	0	113.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,586,347	30,340,303	51,926,650	-189,080	51,737,570	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	20	20	53,798	53,818	192.01	
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02	
192.03	19202	LEASED SPACE	127,697	93,589	221,286	-62,400	158,886	192.03	
192.04	19204	ANNAWAN CLINIC	0	0	0	90,012	90,012	192.04	
192.05	19205	CAMBRIDGE CLINIC	286,539	100,225	386,764	37,423	424,187	192.05	
192.06	19206	PORT BYRON CLINIC	322,712	92,979	415,691	70,247	485,938	192.06	
194.00	07955	FOUNDATION	0	0	0	0	0	194.00	
194.01	07950	SPORTS MEDICINE	96,116	14,894	111,010	0	111,010	194.01	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021

Worksheet A

Date/Time Prepared:
10/22/2021 7:54 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
194.02	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	16,009	351	16,360	0	16,360	194.07
200.00	TOTAL (SUM OF LINES 118 through 199)	22,435,420	30,642,361	53,077,781	0	53,077,781	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021

Worksheet A

Date/Time Prepared:
10/22/2021 7:54 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	30,033	2,274,867	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,295,235	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,387,341	4.00
5.01	00550	DATA PROCESSING	0	1,676,409	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-176,978	194	5.02
5.03	00570	ADMITTING	0	266,298	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	-88,682	806,863	5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	-116,059	2,709,587	5.05
7.00	00700	OPERATION OF PLANT	0	1,240,496	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	114,708	8.00
9.00	00900	HOUSEKEEPING	0	584,293	9.00
10.00	01000	DIETARY	-185,440	738,932	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	180,761	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	17,807	14.00
15.00	01500	PHARMACY	0	428,929	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-445	563,958	16.00
17.00	01700	SOCIAL SERVICE	0	120,627	17.00
18.00	01800	INSERVICE EDUCATION	0	238,467	18.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-594,618	2,268,228	30.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	-718	1,636,615	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-215,606	3,679,746	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-466,213	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,236,773	54.00
60.00	06000	LABORATORY	-1,000	4,980,068	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	120,577	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
66.00	06600	PHYSICAL THERAPY	-103,194	1,321,072	66.00
67.00	06700	OCCUPATIONAL THERAPY	-157	447,594	67.00
68.00	06800	SPEECH PATHOLOGY	0	123,154	68.00
69.00	06900	ELECTROCARDIOLOGY	-9,134	383,756	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,474,413	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,279,016	73.00
76.00	03020	ACUPUNCTURE	0	0	76.00
76.01	03610	SLEEP LAB	-314	150,543	76.01
76.02	03950	IV THERAPY	0	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	KEWANEE RHC	0	2,539,855	88.00
88.01	08801	WYOMING RHC	0	0	88.01
88.02	08802	GENESEO RHC	0	1,991,577	88.02
88.03	08803	ANNAWAN RHC	0	429,990	88.03
90.00	09000	CLINIC	-535,672	440,542	90.00
90.01	09001	PAIN CLINIC	-150,822	63,741	90.01
90.02	09002	SPECIALTY CLINIC	0	0	90.02
90.03	09003	SURGICAL CLINIC	-864,071	1,059,498	90.03
90.04	09004	GENESEO CLINIC	0	0	90.04
91.00	09100	EMERGENCY	-741,195	2,456,474	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	-14,120	774,161	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,234,405	47,503,165	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	53,818	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	192.02
192.03	19202	LEASED SPACE	0	158,886	192.03
192.04	19204	ANNAWAN CLINIC	0	90,012	192.04
192.05	19205	CAMBRIDGE CLINIC	0	424,187	192.05
192.06	19206	PORT BYRON CLINIC	0	485,938	192.06
194.00	07955	FOUNDATION	0	0	194.00
194.01	07950	SPORTS MEDICINE	0	111,010	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	194.02

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021

Worksheet A

Date/Time Prepared:
10/22/2021 7:54 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
194.03	07952 ANESTHESIA BILLNG	0	0	194.03
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	16,360	194.07
200.00	TOTAL (SUM OF LINES 118 through 199)	-4,234,405	48,843,376	200.00

RECLASSIFICATIONS

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021

Worksheet A-6

Date/Time Prepared:
10/22/2021 7:54 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - COLONA CLINIC BUILDING DEPRECIATION					
1.00	CLINIC	90.00	0	37,635		1.00
	TOTALS		0	37,635		
	C - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	469,303		1.00
	TOTALS		0	469,303		
	E - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	70,635		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	23,954		2.00
3.00	CLINIC	90.00	0	2,017		3.00
	TOTALS		0	96,606		
	H - IMPLANT EXP RECLASS					
1.00	IMPL. DEV. CHARGED TO	72.00	0	1,474,413		1.00
	PATIENTS					
	TOTALS		0	1,474,413		
	I - RECLASS PROVIDER BENEFITS					
1.00	ANESTHESIOLOGY	53.00	0	63,575		1.00
2.00	CLINIC	90.00	0	92,637		2.00
3.00	PAIN CLINIC	90.01	0	1,217		3.00
4.00	CAMBRIDGE CLINIC	192.05	0	33,589		4.00
5.00	ANNAWAN CLINIC	192.04	0	7,828		5.00
6.00	PORT BYRON CLINIC	192.06	0	67,165		6.00
7.00	KEWANEE RHC	88.00	0	251,856		7.00
8.00	GENESEO RHC	88.02	0	223,745		8.00
9.00	ANNAWAN RHC	88.03	0	42,301		9.00
10.00	SURGICAL CLINIC	90.03	0	78,977		10.00
11.00	EMERGENCY	91.00	0	231,997		11.00
12.00	ADULTS & PEDIATRICS	30.00	0	108,212		12.00
	TOTALS		0	1,203,099		
	J - RECLASS SNF DEPRECIATION AND INTERST					
1.00	SKILLED NURSING FACILITY	44.00	0	179,625		1.00
2.00	SKILLED NURSING FACILITY	44.00	0	70,109		2.00
3.00	SKILLED NURSING FACILITY	44.00	0	19,407		3.00
	TOTALS		0	269,141		
	K - TO CLOSE ANESTHESIA TO OR					
1.00	OPERATING ROOM	50.00	0	21,192		1.00
	TOTALS		0	21,192		
	L - RHC LAB AND RADIOLOGY COSTS					
1.00	LABORATORY	60.00	2,438	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	117,408	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		119,846	0		
	M - ANNAWAN NON-RHC COSTS					
1.00	ANNAWAN CLINIC	192.04	54,467	27,152		1.00
	TOTALS		54,467	27,152		
	N - CLINIC ADMIN COSTS					
1.00	KEWANEE RHC	88.00	26,907	0		1.00
2.00	GENESEO RHC	88.02	16,463	0		2.00
3.00	ANNAWAN RHC	88.03	3,047	0		3.00
4.00	CLINIC	90.00	3,161	0		4.00
5.00	PAIN CLINIC	90.01	94	0		5.00
6.00	SURGICAL CLINIC	90.03	4,572	0		6.00
7.00	MUSCATINE CLINIC	192.01	675	0		7.00
8.00	ANNAWAN CLINIC	192.04	565	0		8.00
9.00	CAMBRIDGE CLINIC	192.05	3,834	0		9.00
10.00	PORT BYRON CLINIC	192.06	3,082	0		10.00
	TOTALS		62,400	0		
	O - MUSCATINE CLINIC COSTS					
1.00	MUSCATINE CLINIC	192.01	0	53,123		1.00
	TOTALS		0	53,123		
500.00	Grand Total: Increases		236,713	3,651,664		500.00

RECLASSIFICATIONS

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021

Worksheet A-6

Date/Time Prepared:
10/22/2021 7:54 am

	Decreases							10/22/2021 7:54 am
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
	A - COLONA CLINIC BUILDING DEPRECIATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	37,635	9			1.00
	TOTALS		0	37,635				
	C - INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	469,303	11			1.00
	TOTALS		0	469,303				
	E - OTHER CAPITAL COSTS							
1.00	ALL OTHER ADMINISTRATIVE AND GE	5.05	0	96,606	12			1.00
2.00		0.00	0	0	12			2.00
3.00		0.00	0	0	0			3.00
	TOTALS		0	96,606				
	H - IMPLANT EXP RECLASS							
1.00	OPERATING ROOM	50.00	0	1,474,413	0			1.00
	TOTALS		0	1,474,413				
	I - RECLASS PROVIDER BENEFITS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,203,099	0			1.00
2.00		0.00	0	0	0			2.00
3.00		0.00	0	0	0			3.00
4.00		0.00	0	0	0			4.00
5.00		0.00	0	0	0			5.00
6.00		0.00	0	0	0			6.00
7.00		0.00	0	0	0			7.00
8.00		0.00	0	0	0			8.00
9.00		0.00	0	0	0			9.00
10.00		0.00	0	0	0			10.00
11.00		0.00	0	0	0			11.00
12.00		0.00	0	0	0			12.00
	TOTALS		0	1,203,099				
	J - RECLASS SNF DEPRECIATION AND INTERST							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	179,625	9			1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	70,109	11			2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	19,407	9			3.00
	TOTALS		0	269,141				
	K - TO CLOSE ANESTHESIA TO OR							
1.00	ANESTHESIOLOGY	53.00	0	21,192	0			1.00
	TOTALS		0	21,192				
	L - RHC LAB AND RADIOLOGY COSTS							
1.00	KEWANEE RHC	88.00	61,139	0	0			1.00
2.00	GENESEO RHC	88.02	2,318	0	0			2.00
3.00	ANNAWAN RHC	88.03	56,389	0	0			3.00
	TOTALS		119,846	0				
	M - ANNAWAN NON-RHC COSTS							
1.00	ANNAWAN RHC	88.03	54,467	27,152	0			1.00
	TOTALS		54,467	27,152				
	N - CLINIC ADMIN COSTS							
1.00	LEASED SPACE	192.03	62,400	0	0			1.00
2.00		0.00	0	0	0			2.00
3.00		0.00	0	0	0			3.00
4.00		0.00	0	0	0			4.00
5.00		0.00	0	0	0			5.00
6.00		0.00	0	0	0			6.00
7.00		0.00	0	0	0			7.00
8.00		0.00	0	0	0			8.00
9.00		0.00	0	0	0			9.00
10.00		0.00	0	0	0			10.00
	TOTALS		62,400	0				
	O - MUSCATINE CLINIC COSTS							
1.00	SURGICAL CLINIC	90.03	0	53,123	0			1.00
	TOTALS		0	53,123				
500.00	Grand Total: Decreases		236,713	3,651,664				500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet A-7
Part I
Date/Time Prepared:
10/22/2021 7:54 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	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	46,642,528	57,707	0	57,707	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	15,185,459	1,083,993	0	1,083,993	325,073	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	64,822,273	1,141,700	0	1,141,700	325,073	8.00
9.00	Reconciling Items	-4,771	-219,186	0	-219,186	-223,957	9.00
10.00	Total (line 8 minus line 9)	64,827,044	1,360,886	0	1,360,886	549,030	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	46,700,235	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	15,944,379	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	65,638,900	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	65,638,900	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet A-7
Part II
Date/Time Prepared:
10/22/2021 7:54 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,992,265	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,290,688	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,282,953	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	1,992,265				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,290,688				2.00
3.00	Total (sum of lines 1-2)	0	3,282,953				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet A-7
Part III
Date/Time Prepared:
10/22/2021 7:54 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	48,358,951	0	48,358,951	0.752044	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15,944,380	0	15,944,380	0.247956	0	2.00
3.00	Total (sum of lines 1-2)	64,303,331	0	64,303,331	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	1,775,005	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,271,281	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,046,286	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	429,227	70,635	0	0	2,274,867	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	23,954	0	0	1,295,235	2.00
3.00	Total (sum of lines 1-2)	429,227	94,589	0	0	3,570,102	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021

Worksheet A-8

Date/Time Prepared:
10/22/2021 7:54 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	A	-176,978	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	-3,400	ALL OTHER ADMINISTRATIVE AND GE	5.05	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,103,266			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	-185,080	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	-445	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	-360	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 06/01/2020
To 05/31/2021

Worksheet A-8

Date/Time Prepared:
10/22/2021 7:54 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	ADVERTISING EXPENSE	A	-86,823	ALL OTHER ADMINISTRATIVE AND GE	5.05	0	33.00
33.01	PART B BILLING	A	-88,682	CASHIERING/ACCOUNTS RECEIVABLE	5.04	0	33.01
33.02	PHYSICIAN RECRUITING	A	-13,333	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	-3,926	ADULTS & PEDIATRICS	30.00	0	33.04
33.05	TV SERVICE - CARDIAC	A	-314	ELECTROCARDIOLOGY	69.00	0	33.05
33.06	TV SERVICE - LTC	A	-6,439	SKILLED NURSING FACILITY	44.00	0	33.06
33.07	TV SERVICE - OR	A	-2,513	OPERATING ROOM	50.00	0	33.07
33.08	TV SERVICE - ER	A	-1,099	EMERGENCY	91.00	0	33.08
33.09	TV SERVICE - PT	A	-471	PHYSICAL THERAPY	66.00	0	33.09
33.10	TV SERVICE - OT	A	-157	OCCUPATIONAL THERAPY	67.00	0	33.10
33.11	TV SERVICE - SLEEP	A	-314	SLEEP LAB	76.01	0	33.11
33.12	CRNA EXPENSES	A	-466,213	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	-12,503	ALL OTHER ADMINISTRATIVE AND GE	5.05	0	33.14
33.15	EMPLOYEE LAB TEST REVENUE	B	-1,000	LABORATORY	60.00	0	33.15
33.16	PT SPECIAL EDUCATION REVENUE	B	-45,878	PHYSICAL THERAPY	66.00	0	33.16
33.17	LIFELINE REVENUE	B	-14,120	HOME HEALTH AGENCY	101.00	0	33.17
33.18	SUMMIT WELLNESS REVENUE	B	-56,845	PHYSICAL THERAPY	66.00	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.)		-4,234,405				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 06/01/2020
To 05/31/2021

Worksheet A-8-2

Date/Time Prepared:
10/22/2021 7:54 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	13,244	0	13,244	0	0	1.00
2.00	91.00	EMERGENCY	1,929,344	740,096	1,189,248	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	8,820	8,820	0	0	0	3.00
4.00	90.00	CLINIC	535,672	535,672	0	0	0	4.00
5.00	90.03	SURGICAL CLINIC	864,071	864,071	0	0	0	5.00
6.00	50.00	OPERATING ROOM	213,093	213,093	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	52,966	52,966	0	0	0	7.00
8.00	30.00	ADULTS & PEDIATRICS	537,726	537,726	0	0	0	8.00
9.00	90.01	PAIN CLINIC	150,822	150,822	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,305,758	3,103,266	1,202,492		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	740,096		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	8,820		3.00
4.00	90.00	CLINIC	0	0	0	535,672		4.00
5.00	90.03	SURGICAL CLINIC	0	0	0	864,071		5.00
6.00	50.00	OPERATING ROOM	0	0	0	213,093		6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	52,966		7.00
8.00	30.00	ADULTS & PEDIATRICS	0	0	0	537,726		8.00
9.00	90.01	PAIN CLINIC	0	0	0	150,822		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,103,266		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet B
Part I
Date/Time Prepared:
10/22/2021 7:54 am

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,274,867	2,274,867			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,295,235	1,295,235			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,387,341	10,490	1,232	4,399,063	4.00
5.01	00550	DATA PROCESSING	1,676,409	43,162	153,872	92,693	1,966,136
5.02	00560	PURCHASING RECEIVING AND STORES	194	65,513	0	45,299	4,733
5.03	00570	ADMITTING	266,298	28,417	25,736	57,992	45,753
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	806,863	36,211	2,367	115,198	56,797
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	2,709,587	83,650	28,431	179,128	157,771
7.00	00700	OPERATION OF PLANT	1,240,496	171,618	9,328	71,994	29,450
8.00	00800	LAUNDRY & LINEN SERVICE	114,708	16,325	1,383	8,172	0
9.00	00900	HOUSEKEEPING	584,293	29,386	0	111,565	6,311
10.00	01000	DIETARY	738,932	74,444	3,870	131,575	22,614
11.00	01100	CAFETERIA	0	49,166	0	0	10,518
13.00	01300	NURSING ADMINISTRATION	180,761	12,808	2,060	47,213	0
14.00	01400	CENTRAL SERVICES & SUPPLY	17,807	0	0	0	0
15.00	01500	PHARMACY	428,929	35,305	6,693	64,725	49,961
16.00	01600	MEDICAL RECORDS & LIBRARY	563,958	34,526	3,464	127,896	138,312
17.00	01700	SOCIAL SERVICE	120,627	0	1,664	31,099	3,155
18.00	01080	INSERVICE EDUCATION	238,467	0	411	50,374	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,268,228	286,507	76,544	535,453	207,731
43.00	04300	NURSERY	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	1,636,615	0	0	310,195	26,295
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,679,746	320,759	322,290	348,927	57,849
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	2,236,773	188,680	264,814	261,388	84,144
60.00	06000	LABORATORY	4,980,068	51,715	67,395	209,478	207,731
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	120,577	1,917	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	1,321,072	281,936	24,034	354,045	39,443
67.00	06700	OCCUPATIONAL THERAPY	447,594	14,303	899	110,313	16,303
68.00	06800	SPEECH PATHOLOGY	123,154	3,413	0	30,860	526
69.00	06900	ELECTROCARDIOLOGY	383,756	25,805	9,109	53,334	12,622
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,474,413	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,279,016	0	0	0	0
76.00	03020	ACUPUNCTURE	0	0	0	0	0
76.01	03610	SLEEP LAB	150,543	15,736	0	24,037	2,104
76.02	03950	IV THERAPY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	KEWANEE RHC	2,539,855	0	116,963	157,284	101,289
88.01	08801	WYOMING RHC	0	0	0	0	0
88.02	08802	GENESEO RHC	1,991,577	68,672	42,447	157,364	214,041
88.03	08803	ANNAWAN RHC	429,990	0	27,603	31,190	34,604
90.00	09000	CLINIC	440,542	0	8,106	73,194	89,403
90.01	09001	PAIN CLINIC	63,741	548	207	14,210	12,622
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0
90.03	09003	SURGICAL CLINIC	1,059,498	5,519	196	14,083	17,881
90.04	09004	GENESEO CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	2,456,474	194,537	55,251	279,351	108,336
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	774,161	23,740	1,873	164,927	38,917
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	47,503,165	2,174,808	1,258,242	4,264,556	1,797,216
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	20,812	0	0	0
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0
192.01	19203	MUSCATINE CLINIC	53,818	0	226	15,687	72,049
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0
192.03	19202	LEASED SPACE	158,886	16,325	7,318	33,428	0
192.04	19204	ANNAWAN CLINIC	90,012	0	5,108	5,772	6,416
192.05	19205	CAMBRIDGE CLINIC	424,187	0	14,829	38,598	36,813

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet B
Part I
Date/Time Prepared:
10/22/2021 7:54 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
192.06	19206	PORT BYRON CLINIC	485,938	0	9,312	11,670	43,124	192.06
194.00	07955	FOUNDATION	0	8,363	0	0	10,518	194.00
194.01	07950	SPORTS MEDICINE	111,010	0	200	25,161	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
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	54,559	0	0	0	194.06
194.07	07957	COMMUNITY HEALTH	16,360	0	0	4,191	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)	48,843,376	2,274,867	1,295,235	4,399,063	1,966,136	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet B
Part I
Date/Time Prepared:
10/22/2021 7:54 am

Cost Center Description			PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/AC COUNTS RECEIVABLE	Subtotal	ALL OTHER ADMINISTRATIVE AND GE	
			5.02	5.03	5.04	5A.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	115,739					5.02
5.03	00570	ADMITTING	47	424,243				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	50	0	1,017,486			5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	227	0	0	3,158,794	3,158,794	5.05
7.00	00700	OPERATION OF PLANT	1,237	0	0	1,524,123	105,509	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	60	0	0	140,648	9,736	8.00
9.00	00900	HOUSEKEEPING	1,256	0	0	732,811	50,730	9.00
10.00	01000	DIETARY	1,007	0	0	972,442	67,318	10.00
11.00	01100	CAFETERIA	0	0	0	59,684	4,132	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	242,842	16,811	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,059	0	0	18,866	1,306	14.00
15.00	01500	PHARMACY	222	0	0	585,835	40,555	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	111	0	0	868,267	60,107	16.00
17.00	01700	SOCIAL SERVICE	2	0	0	156,547	10,837	17.00
18.00	01080	INSERVICE EDUCATION	325	0	0	289,577	20,046	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,904	16,239	34,338	3,427,944	237,303	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,328	0	21,205	1,995,638	138,150	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	28,932	97,384	205,920	5,061,807	350,409	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,204	90,086	190,488	3,323,577	230,078	54.00
60.00	06000	LABORATORY	28,546	110,946	234,709	5,890,588	407,792	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	864	1,827	125,185	8,666	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	292	25,842	54,643	2,101,307	145,465	66.00
67.00	06700	OCCUPATIONAL THERAPY	144	7,782	16,455	613,793	42,490	67.00
68.00	06800	SPEECH PATHOLOGY	4	1,034	2,186	161,177	11,158	68.00
69.00	06900	ELECTROCARDIOLOGY	110	15,707	33,213	533,656	36,943	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,487	3,144	4,631	321	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,849	13,995	29,593	1,547,850	107,151	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	22,992	48,616	1,350,624	93,498	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	197	3,272	6,919	202,808	14,040	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	KEWANEE RHC	2,358	0	41,948	2,959,697	204,888	88.00
88.01	08801	WYOMING RHC	0	0	0	0	0	88.01
88.02	08802	GENESE0 RHC	1,438	0	25,667	2,501,206	173,148	88.02
88.03	08803	ANNAWAN RHC	525	0	4,750	528,662	36,597	88.03
90.00	09000	CLINIC	634	0	4,928	616,807	42,699	90.00
90.01	09001	PAIN CLINIC	182	0	147	91,657	6,345	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	376	0	933	1,098,486	76,044	90.03
90.04	09004	GENESE0 CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	2,144	16,613	35,127	3,147,833	217,912	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				0		92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	1,616	0	8,014	1,013,248	70,143	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	114,386	424,243	1,004,770	47,048,617	3,038,327	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	20,812	1,441	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	18	0	1,052	142,850	9,889	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	77	0	0	216,034	14,955	192.03
192.04	19204	ANNAWAN CLINIC	97	0	881	108,286	7,496	192.04
192.05	19205	CAMBRIDGE CLINIC	384	0	5,978	520,789	36,052	192.05
192.06	19206	PORT BYRON CLINIC	758	0	4,805	555,607	38,462	192.06
194.00	07955	FOUNDATION	0	0	0	18,881	1,307	194.00
194.01	07950	SPORTS MEDICINE	19	0	0	136,390	9,442	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet B
Part I
Date/Time Prepared:
10/22/2021 7:54 am

Cost Center Description		PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/AC COUNTS RECEIVABLE	Subtotal	ALL OTHER ADMINISTRATIV E AND GE	
		5.02	5.03	5.04	5A.04	5.05	
194.03	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	54,559	0	194.06
194.07	07957 COMMUNITY HEALTH	0	0	0	20,551	1,423	194.07
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	115,739	424,243	1,017,486	48,843,376	3,158,794	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet B
Part I
Date/Time Prepared:
10/22/2021 7:54 am

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	1,629,632					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,322	162,706				8.00
9.00	00900	HOUSEKEEPING	22,180	769	806,490			9.00
10.00	01000	DIETARY	56,190	871	21,000	1,117,821		10.00
11.00	01100	CAFETERIA	37,110	0	4,954	705,722	811,602	11.00
13.00	01300	NURSING ADMINISTRATION	9,667	0	0	0	15,541	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	26,648	0	3,446	0	13,715	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	26,060	0	3,231	0	46,196	16.00
17.00	01700	SOCIAL SERVICE	0	0	1,938	0	7,537	17.00
18.00	01800	INSERVICE EDUCATION	0	0	0	0	11,656	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	216,253	36,326	200,088	85,556	131,906	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	285,164	36,318	243,272	326,543	110,382	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	242,106	28,986	131,274	0	75,919	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	142,414	19,411	38,984	0	56,492	54.00
60.00	06000	LABORATORY	39,034	0	40,922	0	64,302	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	1,447	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	212,803	14,170	10,769	0	71,762	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,796	0	3,015	0	22,341	67.00
68.00	06800	SPEECH PATHOLOGY	2,576	0	0	0	6,100	68.00
69.00	06900	ELECTROCARDIOLOGY	19,477	0	4,954	0	11,112	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	11,877	2,599	2,154	0	6,178	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	51,833	227	22,507	0	70,518	88.02
88.03	08803	ANNAWAN RHC	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PAIN CLINIC	413	775	0	0	3,303	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	4,166	0	8,184	0	8,664	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	146,834	22,254	32,307	0	68,148	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	17,919	0	1,938	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,595,289	162,706	774,937	1,117,821	801,772	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	15,709	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	12,322	0	17,769	0	1,710	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	6,312	0	0	0	6,488	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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet B
Part I
Date/Time Prepared:
10/22/2021 7:54 am

Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	13,784	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	0	1,632	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)	1,629,632	162,706	806,490	1,117,821	811,602	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet B
Part I
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10/22/2021 7:54 am

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	284,861					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	20,172				14.00
15.00	01500	PHARMACY	8,896	0	679,095			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,003,861		16.00
17.00	01700	SOCIAL SERVICE	4,889	0	0	0	181,748	17.00
18.00	01080	INSERVICE EDUCATION	7,561	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	85,562	0	0	34,798	109,484	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	2,346	67,461	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	49,245	0	0	208,681	1,351	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	36,644	0	0	193,042	0	54.00
60.00	06000	LABORATORY	41,710	0	0	237,856	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	1,851	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	55,375	300	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	16,675	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,215	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	33,658	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	20,172	0	3,186	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	29,990	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	679,095	49,268	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	4,007	0	0	7,012	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	42,511	0	88.00
88.01	08801	WYOMING RHC	0	0	0	0	0	88.01
88.02	08802	GENESE0 RHC	0	0	0	26,011	0	88.02
88.03	08803	ANNAWAN RHC	0	0	0	4,814	0	88.03
90.00	09000	CLINIC	0	0	0	4,994	0	90.00
90.01	09001	PAIN CLINIC	2,142	0	0	149	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	0	946	0	90.03
90.04	09004	GENESE0 CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	44,205	0	0	35,598	3,152	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)	284,861	20,172	679,095	990,976	181,748	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	1,066	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	892	0	192.04
192.05	19205	CAMBRIDGE CLINIC	0	0	0	6,058	0	192.05
192.06	19206	PORT BYRON CLINIC	0	0	0	4,869	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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet B
Part I
Date/Time Prepared:
10/22/2021 7:54 am

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	
194.03	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	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	284,861	20,172	679,095	1,003,861	181,748	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet B
Part I
Date/Time Prepared:
10/22/2021 7:54 am

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	328,840			18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,184	4,576,404	0	30.00
43.00	04300	NURSERY	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	6,907	3,212,181	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	67,067	6,216,845	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	62,041	4,102,683	0	54.00
60.00	06000	LABORATORY	76,502	6,798,706	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	595	137,744	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	17,797	2,629,748	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,359	714,469	0	67.00
68.00	06800	SPEECH PATHOLOGY	712	183,938	0	68.00
69.00	06900	ELECTROCARDIOLOGY	10,817	650,617	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,024	29,334	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,638	1,694,629	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,834	2,188,319	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	76.00
76.01	03610	SLEEP LAB	2,254	252,929	0	76.01
76.02	03950	IV THERAPY	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	13,662	3,220,758	0	88.00
88.01	08801	WYOMING RHC	0	0	0	88.01
88.02	08802	GENESEO RHC	8,360	2,853,810	0	88.02
88.03	08803	ANNAWAN RHC	1,547	571,620	0	88.03
90.00	09000	CLINIC	1,605	666,105	0	90.00
90.01	09001	PAIN CLINIC	48	104,832	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	304	1,196,794	0	90.03
90.04	09004	GENESEO CLINIC	0	0	0	90.04
91.00	09100	EMERGENCY	11,441	3,729,684	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	1,103,248	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	324,698	46,835,397	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	37,962	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	343	154,148	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	192.02
192.03	19202	LEASED SPACE	0	262,790	0	192.03
192.04	19204	ANNAWAN CLINIC	287	116,961	0	192.04
192.05	19205	CAMBRIDGE CLINIC	1,947	564,846	0	192.05

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet B
Part I
Date/Time Prepared:
10/22/2021 7:54 am

Cost Center Description			OTHER GENERAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			INSERVICE EDUCATION					
			18.00	24.00	25.00	26.00		
192.06	19206	PORT BYRON CLINIC	1,565	600,503	0	600,503		192.06
194.00	07955	FOUNDATION	0	32,988	0	32,988		194.00
194.01	07950	SPORTS MEDICINE	0	145,832	0	145,832		194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0		194.02
194.03	07952	ANESTHESIA BILLING	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	68,343	0	68,343		194.06
194.07	07957	COMMUNITY HEALTH	0	23,606	0	23,606		194.07
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	328,840	48,843,376	0	48,843,376		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet B
Part II
Date/Time Prepared:
10/22/2021 7:54 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	10,490	1,232	11,722	4.00
5.01	00550	DATA PROCESSING	0	43,162	153,872	197,034	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	65,513		65,513	5.02
5.03	00570	ADMITTING	0	28,417	25,736	54,153	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	36,211	2,367	38,578	5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	0	83,650	28,431	112,081	5.05
7.00	00700	OPERATION OF PLANT	0	171,618	9,328	180,946	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	16,325	1,383	17,708	8.00
9.00	00900	HOUSEKEEPING	0	29,386	0	29,386	9.00
10.00	01000	DIETARY	0	74,444	3,870	78,314	10.00
11.00	01100	CAFETERIA	0	49,166	0	49,166	11.00
13.00	01300	NURSING ADMINISTRATION	0	12,808	2,060	14,868	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	35,305	6,693	41,998	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	34,526	3,464	37,990	16.00
17.00	01700	SOCIAL SERVICE	0	0	1,664	1,664	17.00
18.00	01080	INSERVICE EDUCATION	0	0	411	411	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	286,507	76,544	363,051	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	320,759	322,290	643,049	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	188,680	264,814	453,494	54.00
60.00	06000	LABORATORY	0	51,715	67,395	119,110	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	1,917	0	1,917	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	281,936	24,034	305,970	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	14,303	899	15,202	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,413	0	3,413	68.00
69.00	06900	ELECTROCARDIOLOGY	0	25,805	9,109	34,914	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	15,736	0	15,736	76.01
76.02	03950	IV THERAPY	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	KEWANEE RHC	0	0	116,963	116,963	88.00
88.01	08801	WYOMING RHC	0	0	0	0	88.01
88.02	08802	GENESE0 RHC	0	68,672	42,447	111,119	88.02
88.03	08803	ANNAWAN RHC	0	0	27,603	27,603	88.03
90.00	09000	CLINIC	0	0	8,106	8,106	90.00
90.01	09001	PAIN CLINIC	0	548	207	755	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	5,519	196	5,715	90.03
90.04	09004	GENESE0 CLINIC	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	194,537	55,251	249,788	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	23,740	1,873	25,613	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,174,808	1,258,242	3,433,050	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	20,812	0	20,812	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	226	226	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	16,325	7,318	23,643	192.03
192.04	19204	ANNAWAN CLINIC	0	0	5,108	5,108	192.04
192.05	19205	CAMBRIDGE CLINIC	0	0	14,829	14,829	192.05
192.06	19206	PORT BYRON CLINIC	0	0	9,312	9,312	192.06

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet B
Part II
Date/Time Prepared:
10/22/2021 7:54 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
194.00	07955	FOUNDATION	0	8,363	0	8,363	0 194.00
194.01	07950	SPORTS MEDICINE	0	0	200	200	67 194.01
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	54,559	0	54,559	0 194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	0	11 194.07
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	2,274,867	1,295,235	3,570,102	11,722 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet B
Part II
Date/Time Prepared:
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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	197,281					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	475	66,109				5.02
5.03	00570	ADMITTING	4,591	27	58,926			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	5,699	29	0	44,613		5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	15,831	130	0	0	128,520	5.05
7.00	00700	OPERATION OF PLANT	2,955	706	0	0	4,293	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	34	0	0	396	8.00
9.00	00900	HOUSEKEEPING	633	718	0	0	2,064	9.00
10.00	01000	DIETARY	2,269	575	0	0	2,739	10.00
11.00	01100	CAFETERIA	1,055	0	0	0	168	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	684	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	605	0	0	53	14.00
15.00	01500	PHARMACY	5,013	127	0	0	1,650	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,878	64	0	0	2,446	16.00
17.00	01700	SOCIAL SERVICE	317	1	0	0	441	17.00
18.00	01080	INSERVICE EDUCATION	0	185	0	0	816	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	20,844	1,659	2,257	1,506	9,657	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,638	759	0	930	5,622	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	5,805	16,526	13,537	9,033	14,259	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	8,443	4,115	12,522	8,356	9,363	54.00
60.00	06000	LABORATORY	20,844	16,306	15,377	10,275	16,577	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	120	80	353	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	3,958	167	3,592	2,397	5,919	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,636	83	1,082	722	1,729	67.00
68.00	06800	SPEECH PATHOLOGY	53	2	144	96	454	68.00
69.00	06900	ELECTROCARDIOLOGY	1,266	63	2,183	1,457	1,503	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	207	138	13	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	17,044	1,945	1,298	4,360	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,196	2,133	3,805	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	211	113	455	304	571	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	KEWANEE RHC	10,163	1,347	0	1,840	8,337	88.00
88.01	08801	WYOMING RHC	0	0	0	0	0	88.01
88.02	08802	GENESE0 RHC	21,477	821	0	1,126	7,046	88.02
88.03	08803	ANNAWAN RHC	3,472	300	0	208	1,489	88.03
90.00	09000	CLINIC	8,971	362	0	216	1,738	90.00
90.01	09001	PAIN CLINIC	1,266	104	0	6	258	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	1,794	215	0	41	3,094	90.03
90.04	09004	GENESE0 CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	10,870	1,225	2,309	1,541	8,867	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	3,905	923	0	352	2,854	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	180,332	65,335	58,926	44,055	123,618	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	59	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	7,229	10	0	46	402	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	44	0	0	609	192.03
192.04	19204	ANNAWAN CLINIC	644	56	0	39	305	192.04
192.05	19205	CAMBRIDGE CLINIC	3,694	220	0	262	1,467	192.05
192.06	19206	PORT BYRON CLINIC	4,327	433	0	211	1,565	192.06
194.00	07955	FOUNDATION	1,055	0	0	0	53	194.00
194.01	07950	SPORTS MEDICINE	0	11	0	0	384	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet B
Part II
Date/Time Prepared:
10/22/2021 7:54 am

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	
194.03	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	58	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)	197,281	66,109	58,926	44,613	128,520	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet B
Part II
Date/Time Prepared:
10/22/2021 7:54 am

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	189,092					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,430	19,590				8.00
9.00	00900	HOUSEKEEPING	2,574	93	35,765			9.00
10.00	01000	DIETARY	6,520	105	931	91,804		10.00
11.00	01100	CAFETERIA	4,306	0	220	57,960	112,875	11.00
13.00	01300	NURSING ADMINISTRATION	1,122	0	0	0	2,161	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	3,092	0	153	0	1,907	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,024	0	143	0	6,425	16.00
17.00	01700	SOCIAL SERVICE	0	0	86	0	1,048	17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	0	1,621	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	25,093	4,374	8,873	7,026	18,347	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	33,088	4,373	10,786	26,818	15,352	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	28,092	3,490	5,822	0	10,559	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	16,525	2,337	1,729	0	7,857	54.00
60.00	06000	LABORATORY	4,529	0	1,815	0	8,943	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	168	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	24,692	1,706	478	0	9,980	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,253	0	134	0	3,107	67.00
68.00	06800	SPEECH PATHOLOGY	299	0	0	0	848	68.00
69.00	06900	ELECTROCARDIOLOGY	2,260	0	220	0	1,545	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	1,378	313	96	0	859	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	6,014	27	998	0	9,807	88.02
88.03	08803	ANNAWAN RHC	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PAIN CLINIC	48	93	0	0	459	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	483	0	363	0	1,205	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	17,038	2,679	1,433	0	9,478	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	2,079	0	86	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	185,107	19,590	34,366	91,804	111,508	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	1,823	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	1,430	0	788	0	238	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	732	0	0	0	902	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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet B
Part II
Date/Time Prepared:
10/22/2021 7:54 am

Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	611	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	0	227	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)	189,092	19,590	35,765	91,804	112,875	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet B
Part II
Date/Time Prepared:
10/22/2021 7:54 am

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	18,961					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	658				14.00
15.00	01500	PHARMACY	592	0	54,705			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	64,311		16.00
17.00	01700	SOCIAL SERVICE	325	0	0	0	3,965	17.00
18.00	01080	INSERVICE EDUCATION	503	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,696	0	0	2,230	2,388	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	150	1,472	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	3,278	0	0	13,376	29	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	2,439	0	0	12,374	0	54.00
60.00	06000	LABORATORY	2,776	0	0	15,213	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	119	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,549	7	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,069	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	142	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,157	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	658	0	204	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,922	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	54,705	3,158	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	267	0	0	449	0	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	KEWANEE RHC	0	0	0	2,725	0	88.00
88.01	08801	WYOMING RHC	0	0	0	0	0	88.01
88.02	08802	GENESE0 RHC	0	0	0	1,667	0	88.02
88.03	08803	ANNAWAN RHC	0	0	0	309	0	88.03
90.00	09000	CLINIC	0	0	0	320	0	90.00
90.01	09001	PAIN CLINIC	143	0	0	10	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	0	61	0	90.03
90.04	09004	GENESE0 CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	2,942	0	0	2,282	69	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)	18,961	658	54,705	63,486	3,965	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	68	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	57	0	192.04
192.05	19205	CAMBRIDGE CLINIC	0	0	0	388	0	192.05
192.06	19206	PORT BYRON CLINIC	0	0	0	312	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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet B
Part II
Date/Time Prepared:
10/22/2021 7:54 am

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	
194.03	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	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	18,961	658	54,705	64,311	3,965	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet B
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	Cost Center Description		OTHER GENERAL	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			SERVICE					
			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	3,670					18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	125	474,546	0	474,546		30.00
43.00	04300	NURSERY	0	0	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	77	102,892	0	102,892		44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0		46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	751	768,536	0	768,536		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	694	540,945	0	540,945		54.00
60.00	06000	LABORATORY	846	233,170	0	233,170		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	7	2,764	0	2,764		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	199	363,558	0	363,558		66.00
67.00	06700	OCCUPATIONAL THERAPY	60	26,371	0	26,371		67.00
68.00	06800	SPEECH PATHOLOGY	8	5,541	0	5,541		68.00
69.00	06900	ELECTROCARDIOLOGY	121	47,831	0	47,831		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	11	1,231	0	1,231		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	108	26,677	0	26,677		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	177	67,174	0	67,174		73.00
76.00	03020	ACUPUNCTURE	0	0	0	0		76.00
76.01	03610	SLEEP LAB	25	20,841	0	20,841		76.01
76.02	03950	IV THERAPY	0	0	0	0		76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	KEWANEE RHC	153	141,947	0	141,947		88.00
88.01	08801	WYOMING RHC	0	0	0	0		88.01
88.02	08802	GENESE0 RHC	94	160,616	0	160,616		88.02
88.03	08803	ANNAWAN RHC	17	33,481	0	33,481		88.03
90.00	09000	CLINIC	18	19,926	0	19,926		90.00
90.01	09001	PAIN CLINIC	1	3,181	0	3,181		90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0		90.02
90.03	09003	SURGICAL CLINIC	3	13,012	0	13,012		90.03
90.04	09004	GENESE0 CLINIC	0	0	0	0		90.04
91.00	09100	EMERGENCY	128	311,394	0	311,394		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	36,252	0	36,252		101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,623	3,401,886	0	3,401,886		118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	22,694	0	22,694		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0		192.00
192.01	19203	MUSCATINE CLINIC	4	8,027	0	8,027		192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0		192.02
192.03	19202	LEASED SPACE	0	26,841	0	26,841		192.03
192.04	19204	ANNAWAN CLINIC	3	6,227	0	6,227		192.04
192.05	19205	CAMBRIDGE CLINIC	22	20,985	0	20,985		192.05

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet B
Part II
Date/Time Prepared:
10/22/2021 7:54 am

Cost Center Description			OTHER GENERAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			INSERVICE EDUCATION					
			18.00	24.00	25.00	26.00		
192.06	19206	PORT BYRON CLINIC	18	16,209	0	16,209		192.06
194.00	07955	FOUNDATION	0	11,105	0	11,105		194.00
194.01	07950	SPORTS MEDICINE	0	662	0	662		194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0		194.02
194.03	07952	ANESTHESIA BILLING	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	55,170	0	55,170		194.06
194.07	07957	COMMUNITY HEALTH	0	296	0	296		194.07
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	3,670	3,570,102	0	3,570,102		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021

Worksheet B-1

Date/Time Prepared:
10/22/2021 7:54 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (TIME SPENT)	PURCHASING RECEIVING AND STORES (SUPPLY COS T)	
		BLDG & FIXT (SQUARE FEET)	MOVBLE 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		1,270,827			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	498	1,209	16,804,567		4.00
5.01	00550	DATA PROCESSING	2,049	150,972	354,091	93,465	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	3,110	0	173,044	225	5.02
5.03	00570	ADMITTING	1,349	25,251	221,531	2,175	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,719	2,322	440,059	2,700	5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	3,971	27,895	684,273	7,500	5.05
7.00	00700	OPERATION OF PLANT	8,147	9,152	275,019	1,400	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	775	1,357	31,218	0	8.00
9.00	00900	HOUSEKEEPING	1,395	0	426,183	300	9.00
10.00	01000	DIETARY	3,534	3,797	502,622	1,075	10.00
11.00	01100	CAFETERIA	2,334	0	0	500	11.00
13.00	01300	NURSING ADMINISTRATION	608	2,021	180,354	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	1,676	6,567	247,253	2,375	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,639	3,399	488,565	6,575	16.00
17.00	01700	SOCIAL SERVICE	0	1,633	118,798	150	17.00
18.00	01800	INSERVICE EDUCATION	0	403	192,431	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,601	75,102	2,045,448	9,875	30.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	1,184,956	1,250	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	15,227	316,216	1,332,910	2,750	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	8,957	259,824	998,511	4,000	54.00
60.00	06000	LABORATORY	2,455	66,125	800,212	9,875	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	91	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	13,384	23,581	1,352,464	1,875	66.00
67.00	06700	OCCUPATIONAL THERAPY	679	882	421,400	775	67.00
68.00	06800	SPEECH PATHOLOGY	162	0	117,887	25	68.00
69.00	06900	ELECTROCARDIOLOGY	1,225	8,937	203,738	600	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	747	0	91,823	100	76.01
76.02	03950	IV THERAPY	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	KEWANEE RHC	0	114,759	600,829	4,815	88.00
88.01	08801	WYOMING RHC	0	0	0	0	88.01
88.02	08802	GENESEO RHC	3,260	41,647	601,134	10,175	88.02
88.03	08803	ANNAWAN RHC	0	27,083	119,148	1,645	88.03
90.00	09000	CLINIC	0	7,953	279,604	4,250	90.00
90.01	09001	PAIN CLINIC	26	203	54,284	600	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	262	192	53,798	850	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	90.04
91.00	09100	EMERGENCY	9,235	54,210	1,067,131	5,150	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	1,127	1,838	630,028	1,850	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	103,242	1,234,530	16,290,746	85,435	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	988	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	222	59,923	3,425	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	192.02
192.03	19202	LEASED SPACE	775	7,180	127,697	0	192.03
192.04	19204	ANNAWAN CLINIC	0	5,012	22,049	305	192.04
192.05	19205	CAMBRIDGE CLINIC	0	14,550	147,447	1,750	192.05

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021

Worksheet B-1

Date/Time Prepared:
10/22/2021 7:54 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (TIME SPENT)	PURCHASING RECEIVING AND STORES (SUPPLY COS T)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5.01	5.02	
192.06	19206	PORT BYRON CLINIC	0	9,137	44,580	2,050	37,424	192.06
194.00	07955	FOUNDATION	397	0	0	500	0	194.00
194.01	07950	SPORTS MEDICINE	0	196	96,116	0	915	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
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	16,009	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)	2,274,867	1,295,235	4,399,063	1,966,136	115,739	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.065144	1.019206	0.261778	21.036067	0.020243	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			11,722	197,281	66,109	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000698	2.110747	0.011563	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 06/01/2020
To 05/31/2021

Worksheet B-1

Date/Time Prepared:

10/22/2021 7:54 am

Cost Center Description			ADMITTING (GROSS CHARGES)	CASHIERING/AC COUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	ALL OTHER ADMINISTRATIVE AND GE (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING	116,789,343					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	132,450,433				5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	0	0	-3,158,794	45,630,023		5.05
7.00	00700	OPERATION OF PLANT	0	0	0	1,524,123	102,494	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	140,648	775	8.00
9.00	00900	HOUSEKEEPING	0	0	0	732,811	1,395	9.00
10.00	01000	DIETARY	0	0	0	972,442	3,534	10.00
11.00	01100	CAFETERIA	0	0	0	59,684	2,334	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	242,842	608	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	18,866	0	14.00
15.00	01500	PHARMACY	0	0	0	585,835	1,676	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	868,267	1,639	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	156,547	0	17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	289,577	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,469,876	4,469,876	0	3,427,944	13,601	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	2,760,402	0	1,995,638	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	26,805,502	26,805,502	0	5,061,807	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	24,796,696	24,796,696	0	3,323,577	8,957	54.00
60.00	06000	LABORATORY	30,552,909	30,552,909	0	5,890,588	2,455	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	237,803	237,803	0	125,185	91	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	7,113,092	7,113,092	0	2,101,307	13,384	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,141,969	2,141,969	0	613,793	679	67.00
68.00	06800	SPEECH PATHOLOGY	284,519	284,519	0	161,177	162	68.00
69.00	06900	ELECTROCARDIOLOGY	4,323,493	4,323,493	0	533,656	1,225	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	409,290	409,290	0	4,631	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,852,228	3,852,228	0	1,547,850	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,328,549	6,328,549	0	1,350,624	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	900,723	900,723	0	202,808	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	5,460,567	0	2,959,697	0	88.00
88.01	08801	WYOMING RHC	0	0	0	0	0	88.01
88.02	08802	GENESEO RHC	0	3,341,144	0	2,501,206	3,260	88.02
88.03	08803	ANNAWAN RHC	0	618,361	0	528,662	0	88.03
90.00	09000	CLINIC	0	641,526	0	616,807	0	90.00
90.01	09001	PAIN CLINIC	0	19,097	0	91,657	26	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	121,495	0	1,098,486	262	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	4,572,694	4,572,694	0	3,147,833	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	1,043,260	0	1,013,248	1,127	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	116,789,343	130,795,195	-3,158,794	43,889,823	100,334	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	20,812	988	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	136,940	0	142,850	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	0	0	216,034	775	192.03
192.04	19204	ANNAWAN CLINIC	0	114,642	0	108,286	0	192.04
192.05	19205	CAMBRIDGE CLINIC	0	778,171	0	520,789	0	192.05
192.06	19206	PORT BYRON CLINIC	0	625,485	0	555,607	0	192.06
194.00	07955	FOUNDATION	0	0	0	18,881	397	194.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021

Worksheet B-1

Date/Time Prepared:
10/22/2021 7:54 am

Cost Center Description			ADMITTING (GROSS CHARGES)	CASHIERING/AC COUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	ALL OTHER ADMINISTRATIVE AND GE (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	7.00	
194.01	07950	SPORTS MEDICINE	0	0	0	136,390	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
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	-54,559	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	20,551	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)	424,243	1,017,486		3,158,794	1,629,632	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.003633	0.007682		0.069226	15.899779	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	58,926	44,613		128,520	189,092	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000505	0.000337		0.002817	1.844908	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 06/01/2020
To 05/31/2021

Worksheet B-1

Date/Time Prepared:
10/22/2021 7:54 am

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATIO N (FTES)	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	DATA PROCESSING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00570	ADMITTING					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE					5.05
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	204,865				8.00
9.00	00900	HOUSEKEEPING	968	187,225			9.00
10.00	01000	DIETARY	1,097	4,875	128,969		10.00
11.00	01100	CAFETERIA	0	1,150	81,423	20,889	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	11,303	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	800	0	353	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	750	0	1,189	16.00
17.00	01700	SOCIAL SERVICE	0	450	0	194	17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	300	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	45,738	46,450	9,871	3,395	30.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	45,728	56,475	37,675	2,841	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	36,497	30,475	0	1,954	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	24,440	9,050	0	1,454	54.00
60.00	06000	LABORATORY	0	9,500	0	1,655	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	17,842	2,500	0	1,847	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	700	0	575	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	157	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,150	0	286	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	3,273	500	0	159	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	GENESE0 RHC	286	5,225	0	1,815	88.02
88.03	08803	ANNANAW RHC	0	0	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	PAIN CLINIC	976	0	0	85	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	1,900	0	223	90.03
90.04	09004	GENESE0 CLINIC	0	0	0	0	90.04
91.00	09100	EMERGENCY	28,020	7,500	0	1,754	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	450	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	204,865	179,900	128,969	20,636	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	4,125	0	44	192.03
192.04	19204	ANNANAW 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	167	194.00
194.01	07950	SPORTS MEDICINE	0	0	0	0	194.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021

Worksheet B-1

Date/Time Prepared:
10/22/2021 7:54 am

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATIO N (FTES)	
		8.00	9.00	10.00	11.00	13.00	
194.02	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	3,200	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	42	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)	162,706	806,490	1,117,821	811,602	284,861 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.794211	4.307598	8.667362	38.853081	25.202247 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	19,590	35,765	91,804	112,875	18,961 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.095624	0.191027	0.711830	5.403562	1.677519 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 06/01/2020
To 05/31/2021

Worksheet B-1

Date/Time Prepared:
10/22/2021 7:54 am

Cost Center Description			CENTRAL SERVICES & SUPPLY (COSTED REQ UIS)	PHARMACY (COSTED REQ UIS)	MEDICAL RECORDS & LIBRARY (GROSS PT. CHARGES)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE INSERVICE EDUCATION (GROSS CHAR GES)	
			14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	100					14.00
15.00	01500	PHARMACY	0	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	128,948,083			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	60,550		17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	0	131,407,173	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	4,469,876	36,475	4,469,876	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	301,312	22,475	2,760,402	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	26,805,502	450	26,805,502	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	24,796,696	0	24,796,696	54.00
60.00	06000	LABORATORY	0	0	30,552,909	0	30,552,909	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	237,803	0	237,803	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	7,113,092	100	7,113,092	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,141,969	0	2,141,969	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	284,519	0	284,519	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	4,323,493	0	4,323,493	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	100	0	409,290	0	409,290	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	3,852,228	0	3,852,228	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	6,328,549	0	6,328,549	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	900,723	0	900,723	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	5,460,567	0	5,460,567	88.00
88.01	08801	WYOMING RHC	0	0	0	0	0	88.01
88.02	08802	GENESEO RHC	0	0	3,341,144	0	3,341,144	88.02
88.03	08803	ANNAWAN RHC	0	0	618,361	0	618,361	88.03
90.00	09000	CLINIC	0	0	641,526	0	641,526	90.00
90.01	09001	PAIN CLINIC	0	0	19,097	0	19,097	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	121,495	0	121,495	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	4,572,694	1,050	4,572,694	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	127,292,845	60,550	129,751,935	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	136,940	0	136,940	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	114,642	0	114,642	192.04
192.05	19205	CAMBRIDGE CLINIC	0	0	778,171	0	778,171	192.05

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021

Worksheet B-1

Date/Time Prepared:
10/22/2021 7:54 am

Cost Center Description			CENTRAL SERVICES & SUPPLY (COSTED REQ UIS)	PHARMACY (COSTED REQ UIS)	MEDICAL RECORDS & LIBRARY (GROSS PT. CHARGES)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE	
							INSERVICE EDUCATION (GROSS CHAR GES)	
			14.00	15.00	16.00	17.00	18.00	
192.06	19206	PORT BYRON CLINIC	0	0	625,485	0	625,485	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 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	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)	20,172	679,095	1,003,861	181,748	328,840	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	201.720000	6,790.950000	0.007785	3.001618	0.002502	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	658	54,705	64,311	3,965	3,670	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.580000	547.050000	0.000499	0.065483	0.000028	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 06/01/2020
To 05/31/2021Worksheet C
Part I
Date/Time Prepared:
10/22/2021 7:54 am

			Title XVIII	Hospital	Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		4,576,404	0	4,576,404
43.00	04300	NURSERY		0	0	0
44.00	04400	SKILLED NURSING FACILITY		3,212,181	0	3,212,181
46.00	04600	OTHER LONG TERM CARE		0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		6,216,845	0	6,216,845
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0
53.00	05300	ANESTHESIOLOGY		0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC		4,102,683	0	4,102,683
60.00	06000	LABORATORY		6,798,706	0	6,798,706
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD		137,744	0	137,744
64.00	06400	INTRAVENOUS THERAPY		0	0	0
66.00	06600	PHYSICAL THERAPY	0	2,629,748	0	2,629,748
67.00	06700	OCCUPATIONAL THERAPY	0	714,469	0	714,469
68.00	06800	SPEECH PATHOLOGY	0	183,938	0	183,938
69.00	06900	ELECTROCARDIOLOGY		650,617	0	650,617
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT		29,334	0	29,334
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		1,694,629	0	1,694,629
73.00	07300	DRUGS CHARGED TO PATIENTS		2,188,319	0	2,188,319
76.00	03020	ACUPUNCTURE		0	0	0
76.01	03610	SLEEP LAB		252,929	0	252,929
76.02	03950	IV THERAPY		0	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC		3,220,758	0	3,220,758
88.01	08801	WYOMING RHC		0	0	0
88.02	08802	GENESEO RHC		2,853,810	0	2,853,810
88.03	08803	ANNANAW RHC		571,620	0	571,620
90.00	09000	CLINIC		666,105	0	666,105
90.01	09001	PAIN CLINIC		104,832	0	104,832
90.02	09002	SPECIALTY CLINIC		0	0	0
90.03	09003	SURGICAL CLINIC		1,196,794	0	1,196,794
90.04	09004	GENESEO CLINIC		0	0	0
91.00	09100	EMERGENCY		3,729,684	0	3,729,684
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		1,450,043	0	1,450,043
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF		0		0
101.00	10100	HOME HEALTH AGENCY		1,103,248		1,103,248
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
200.00		Subtotal (see instructions)	0	48,285,440	0	48,285,440
201.00		Less Observation Beds		1,450,043		1,450,043
202.00		Total (see instructions)	0	46,835,397	0	46,835,397

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet C
Part I
Date/Time Prepared:
10/22/2021 7:54 am

			Title XVIII		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,106,959		3,106,959		30.00
43.00	04300	NURSERY	0		0		43.00
44.00	04400	SKILLED NURSING FACILITY	2,760,402		2,760,402		44.00
46.00	04600	OTHER LONG TERM CARE	0		0		46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,836,260	20,969,242	26,805,502	0.231924	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	755,811	24,040,885	24,796,696	0.165453	54.00
60.00	06000	LABORATORY	1,674,316	28,878,593	30,552,909	0.222522	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	114,330	123,473	237,803	0.579236	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	541,180	6,571,912	7,113,092	0.369705	66.00
67.00	06700	OCCUPATIONAL THERAPY	394,021	1,747,948	2,141,969	0.333557	67.00
68.00	06800	SPEECH PATHOLOGY	34,689	249,830	284,519	0.646488	68.00
69.00	06900	ELECTROCARDIOLOGY	505,522	3,817,971	4,323,493	0.150484	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	317,680	91,610	409,290	0.071670	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	848,999	3,003,229	3,852,228	0.439909	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,954,917	4,373,632	6,328,549	0.345785	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	900,723	900,723	0.280807	76.01
76.02	03950	IV THERAPY	0	0	0	0.000000	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	KEWANEE RHC	0	5,460,567	5,460,567		88.00
88.01	08801	WYOMING RHC	0	0	0		88.01
88.02	08802	GENESE0 RHC	0	3,341,144	3,341,144		88.02
88.03	08803	ANNAWAN RHC	0	618,361	618,361		88.03
90.00	09000	CLINIC	0	641,526	641,526	1.038313	90.00
90.01	09001	PAIN CLINIC	0	19,097	19,097	5.489449	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0.000000	90.02
90.03	09003	SURGICAL CLINIC	66,591	54,904	121,495	9.850562	90.03
90.04	09004	GENESE0 CLINIC	0	0	0	0.000000	90.04
91.00	09100	EMERGENCY	75,246	4,497,448	4,572,694	0.815643	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	128,908	1,234,009	1,362,917	1.063926	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	1,043,260	1,043,260		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	19,115,831	111,679,364	130,795,195		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	19,115,831	111,679,364	130,795,195		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet C
Part I
Date/Time Prepared:
10/22/2021 7:54 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
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	0.231924		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	0.165453		54.00
60.00	06000	LABORATORY	0.222522		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.579236		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600	PHYSICAL THERAPY	0.369705		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.333557		67.00
68.00	06800	SPEECH PATHOLOGY	0.646488		68.00
69.00	06900	ELECTROCARDIOLOGY	0.150484		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.071670		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.439909		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.345785		73.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.280807		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	GENESEO RHC			88.02
88.03	08803	ANNAWAN RHC			88.03
90.00	09000	CLINIC	1.038313		90.00
90.01	09001	PAIN CLINIC	5.489449		90.01
90.02	09002	SPECIALTY CLINIC	0.000000		90.02
90.03	09003	SURGICAL CLINIC	9.850562		90.03
90.04	09004	GENESEO CLINIC	0.000000		90.04
91.00	09100	EMERGENCY	0.815643		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.063926		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 06/01/2020
To 05/31/2021Worksheet C
Part I
Date/Time Prepared:
10/22/2021 7:54 am

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE	Total Costs	
						Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,576,404		4,576,404	0	4,576,404	30.00
43.00	04300	NURSERY	0		0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	3,212,181		3,212,181	0	3,212,181	44.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,216,845		6,216,845	0	6,216,845	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	4,102,683		4,102,683	0	4,102,683	54.00
60.00	06000	LABORATORY	6,798,706		6,798,706	0	6,798,706	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	137,744		137,744	0	137,744	62.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	2,629,748	0	2,629,748	0	2,629,748	66.00
67.00	06700	OCCUPATIONAL THERAPY	714,469	0	714,469	0	714,469	67.00
68.00	06800	SPEECH PATHOLOGY	183,938	0	183,938	0	183,938	68.00
69.00	06900	ELECTROCARDIOLOGY	650,617		650,617	0	650,617	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	29,334		29,334	0	29,334	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,694,629		1,694,629	0	1,694,629	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,188,319		2,188,319	0	2,188,319	73.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	252,929		252,929	0	252,929	76.01
76.02	03950	IV THERAPY	0		0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	KEWANEE RHC	3,220,758		3,220,758	0	3,220,758	88.00
88.01	08801	WYOMING RHC	0		0	0	0	88.01
88.02	08802	GENESE0 RHC	2,853,810		2,853,810	0	2,853,810	88.02
88.03	08803	ANNAWAN RHC	571,620		571,620	0	571,620	88.03
90.00	09000	CLINIC	666,105		666,105	0	666,105	90.00
90.01	09001	PAIN CLINIC	104,832		104,832	0	104,832	90.01
90.02	09002	SPECIALTY CLINIC	0		0	0	0	90.02
90.03	09003	SURGICAL CLINIC	1,196,794		1,196,794	0	1,196,794	90.03
90.04	09004	GENESE0 CLINIC	0		0	0	0	90.04
91.00	09100	EMERGENCY	3,729,684		3,729,684	0	3,729,684	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1,450,043		1,450,043	0	1,450,043	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	1,103,248		1,103,248		1,103,248	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	48,285,440	0	48,285,440	0	48,285,440	200.00
201.00		Less Observation Beds	1,450,043		1,450,043		1,450,043	201.00
202.00		Total (see instructions)	46,835,397	0	46,835,397	0	46,835,397	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet C
Part I
Date/Time Prepared:
10/22/2021 7:54 am

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,106,959		3,106,959		30.00
43.00	04300	NURSERY	0		0		43.00
44.00	04400	SKILLED NURSING FACILITY	2,760,402		2,760,402		44.00
46.00	04600	OTHER LONG TERM CARE	0		0		46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,836,260	20,969,242	26,805,502	0.231924	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	755,811	24,040,885	24,796,696	0.165453	54.00
60.00	06000	LABORATORY	1,674,316	28,878,593	30,552,909	0.222522	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	114,330	123,473	237,803	0.579236	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	541,180	6,571,912	7,113,092	0.369705	66.00
67.00	06700	OCCUPATIONAL THERAPY	394,021	1,747,948	2,141,969	0.333557	67.00
68.00	06800	SPEECH PATHOLOGY	34,689	249,830	284,519	0.646488	68.00
69.00	06900	ELECTROCARDIOLOGY	505,522	3,817,971	4,323,493	0.150484	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	317,680	91,610	409,290	0.071670	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	848,999	3,003,229	3,852,228	0.439909	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,954,917	4,373,632	6,328,549	0.345785	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	900,723	900,723	0.280807	76.01
76.02	03950	IV THERAPY	0	0	0	0.000000	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	KEWANEE RHC	0	5,460,567	5,460,567	0.589821	88.00
88.01	08801	WYOMING RHC	0	0	0	0.000000	88.01
88.02	08802	GENESE0 RHC	0	3,341,144	3,341,144	0.854142	88.02
88.03	08803	ANNAWAN RHC	0	618,361	618,361	0.924411	88.03
90.00	09000	CLINIC	0	641,526	641,526	1.038313	90.00
90.01	09001	PAIN CLINIC	0	19,097	19,097	5.489449	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0.000000	90.02
90.03	09003	SURGICAL CLINIC	66,591	54,904	121,495	9.850562	90.03
90.04	09004	GENESE0 CLINIC	0	0	0	0.000000	90.04
91.00	09100	EMERGENCY	75,246	4,497,448	4,572,694	0.815643	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	128,908	1,234,009	1,362,917	1.063926	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	1,043,260	1,043,260		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	19,115,831	111,679,364	130,795,195		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	19,115,831	111,679,364	130,795,195		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet C
Part I
Date/Time Prepared:
10/22/2021 7:54 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
46.00	04600	OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000	LABORATORY	0.000000			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.000000			62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03020	ACUPUNCTURE	0.000000			76.00
76.01	03610	SLEEP LAB	0.000000			76.01
76.02	03950	IV THERAPY	0.000000			76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0.000000			88.00
88.01	08801	WYOMING RHC	0.000000			88.01
88.02	08802	GENESEO RHC	0.000000			88.02
88.03	08803	ANNAWAN RHC	0.000000			88.03
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	GENESEO 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 06/01/2020 To 05/31/2021	Worksheet D Part II Date/Time Prepared: 10/22/2021 7:54 am
Title XVIII				Hospital		Cost
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	768,536	26,805,502	0.028671	2,300,477	65,957	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	540,945	24,796,696	0.021815	339,990	7,417	54.00
60.00 06000 LABORATORY	233,170	30,552,909	0.007632	746,690	5,699	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD	2,764	237,803	0.011623	48,885	568	62.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
66.00 06600 PHYSICAL THERAPY	363,558	7,113,092	0.051111	105,014	5,367	66.00
67.00 06700 OCCUPATIONAL THERAPY	26,371	2,141,969	0.012312	78,140	962	67.00
68.00 06800 SPEECH PATHOLOGY	5,541	284,519	0.019475	5,881	115	68.00
69.00 06900 ELECTROCARDIOLOGY	47,831	4,323,493	0.011063	252,689	2,795	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	1,231	409,290	0.003008	160,580	483	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	26,677	3,852,228	0.006925	523,334	3,624	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	67,174	6,328,549	0.010614	786,529	8,348	73.00
76.00 03020 ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01 03610 SLEEP LAB	20,841	900,723	0.023138	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	141,947	5,460,567	0.025995	0	0	88.00
88.01 08801 WYOMING RHC	0	0	0.000000	0	0	88.01
88.02 08802 GENESEO RHC	160,616	3,341,144	0.048072	0	0	88.02
88.03 08803 ANNAWAN RHC	33,481	618,361	0.054145	0	0	88.03
90.00 09000 CLINIC	19,926	641,526	0.031060	0	0	90.00
90.01 09001 PAIN CLINIC	3,181	19,097	0.166571	0	0	90.01
90.02 09002 SPECIALTY CLINIC	0	0	0.000000	0	0	90.02
90.03 09003 SURGICAL CLINIC	13,012	121,495	0.107099	170	18	90.03
90.04 09004 GENESEO CLINIC	0	0	0.000000	0	0	90.04
91.00 09100 EMERGENCY	311,394	4,572,694	0.068099	11,902	811	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	150,361	1,362,917	0.110323	2,950	325	92.00
200.00 Total (lines 50 through 199)	2,938,557	123,884,574		5,363,231	102,489	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet D
Part IV
Date/Time Prepared:
10/22/2021 7:54 am

Cost Center Description			Title XVIII		Hospital		Cost
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health
			1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0 62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0 76.00
76.01	03610	SLEEP LAB	0	0	0	0	0 76.01
76.02	03950	IV THERAPY	0	0	0	0	0 76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	KEWANEE RHC	0	0	0	0	0 88.00
88.01	08801	WYOMING RHC	0	0	0	0	0 88.01
88.02	08802	GENESEO RHC	0	0	0	0	0 88.02
88.03	08803	ANNAWAN RHC	0	0	0	0	0 88.03
90.00	09000	CLINIC	0	0	0	0	0 90.00
90.01	09001	PAIN CLINIC	0	0	0	0	0 90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0 90.02
90.03	09003	SURGICAL CLINIC	0	0	0	0	0 90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0 90.04
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0 92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1319		Period: From 06/01/2020 To 05/31/2021		Worksheet D Part IV Date/Time Prepared: 10/22/2021 7:54 am	
				Title XVIII		Hospital		Cost	
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	26,805,502	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	24,796,696	0.000000	54.00
60.00	06000	LABORATORY		0	0	0	30,552,909	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD		0	0	0	237,803	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	7,113,092	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	2,141,969	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	284,519	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	4,323,493	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT		0	0	0	409,290	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	3,852,228	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	6,328,549	0.000000	73.00
76.00	03020	ACUPUNCTURE		0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB		0	0	0	900,723	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	5,460,567	0.000000	88.00
88.01	08801	WYOMING RHC		0	0	0	0	0.000000	88.01
88.02	08802	GENESEO RHC		0	0	0	3,341,144	0.000000	88.02
88.03	08803	ANNANAW RHC		0	0	0	618,361	0.000000	88.03
90.00	09000	CLINIC		0	0	0	641,526	0.000000	90.00
90.01	09001	PAIN CLINIC		0	0	0	19,097	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	121,495	0.000000	90.03
90.04	09004	GENESEO CLINIC		0	0	0	0	0.000000	90.04
91.00	09100	EMERGENCY		0	0	0	4,572,694	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		0	0	0	1,362,917	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	123,884,574		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet D
Part IV
Date/Time Prepared:
10/22/2021 7:54 am

Cost Center Description			Title XVIII		Hospital		Cost
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	2,300,477	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	339,990	0	0	0
60.00	06000	LABORATORY	0.000000	746,690	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.000000	48,885	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0
66.00	06600	PHYSICAL THERAPY	0.000000	105,014	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	0.000000	78,140	0	0	0
68.00	06800	SPEECH PATHOLOGY	0.000000	5,881	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0.000000	252,689	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	160,580	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	523,334	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	786,529	0	0	0
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0
76.01	03610	SLEEP LAB	0.000000	0	0	0	0
76.02	03950	IV THERAPY	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	KEWANEE RHC	0.000000	0	0	0	0
88.01	08801	WYOMING RHC	0.000000	0	0	0	0
88.02	08802	GENESEO RHC	0.000000	0	0	0	0
88.03	08803	ANNAWAN RHC	0.000000	0	0	0	0
90.00	09000	CLINIC	0.000000	0	0	0	0
90.01	09001	PAIN CLINIC	0.000000	0	0	0	0
90.02	09002	SPECIALTY CLINIC	0.000000	0	0	0	0
90.03	09003	SURGICAL CLINIC	0.000000	170	0	0	0
90.04	09004	GENESEO CLINIC	0.000000	0	0	0	0
91.00	09100	EMERGENCY	0.000000	11,902	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000	2,950	0	0	0
200.00		Total (lines 50 through 199)		5,363,231	0	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet D
Part V
Date/Time Prepared:
10/22/2021 7:54 am

			Title XVIII		Hospital		Cost	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.231924	0	5,904,358	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	0.165453	0	6,854,369	0	0	54.00
60.00	06000	LABORATORY	0.222522	0	6,974,110	1,366	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.579236	0	64,215	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.369705	0	2,298,790	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.333557	0	591,735	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.646488	0	68,957	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.150484	0	1,308,958	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.071670	0	34,932	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.439909	0	1,091,740	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.345785	0	1,721,632	5,753	0	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.280807	0	211,638	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						88.00
88.01	08801	WYOMING RHC						88.01
88.02	08802	GENESEO RHC						88.02
88.03	08803	ANNAWAN RHC						88.03
90.00	09000	CLINIC	1.038313	0	73,020	3,875	0	90.00
90.01	09001	PAIN CLINIC	5.489449	0	19,051	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	9.850562	0	28,919	0	0	90.03
90.04	09004	GENESEO CLINIC	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.815643	0	1,239,694	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.063926	0	513,470	0	0	92.00
200.00		Subtotal (see instructions)		0	28,999,588	10,994	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	28,999,588	10,994	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN:14-1319		Period: From 06/01/2020 To 05/31/2021		Worksheet D Part V Date/Time Prepared: 10/22/2021 7:54 am	
				Title XVIII		Hospital		Cost	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	1,369,362	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	1,134,076	0				54.00	
60.00	06000	LABORATORY	1,551,893	304				60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	37,196	0				62.00	
64.00	06400	INTRAVENOUS THERAPY	0	0				64.00	
66.00	06600	PHYSICAL THERAPY	849,874	0				66.00	
67.00	06700	OCCUPATIONAL THERAPY	197,377	0				67.00	
68.00	06800	SPEECH PATHOLOGY	44,580	0				68.00	
69.00	06900	ELECTROCARDIOLOGY	196,977	0				69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2,504	0				71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	480,266	0				72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	595,315	1,989				73.00	
76.00	03020	ACUPUNCTURE	0	0				76.00	
76.01	03610	SLEEP LAB	59,429	0				76.01	
76.02	03950	IV THERAPY	0	0				76.02	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	KEWANEE RHC						88.00	
88.01	08801	WYOMING RHC						88.01	
88.02	08802	GENESEO RHC						88.02	
88.03	08803	ANNAWAN RHC						88.03	
90.00	09000	CLINIC	75,818	4,023				90.00	
90.01	09001	PAIN CLINIC	104,579	0				90.01	
90.02	09002	SPECIALTY CLINIC	0	0				90.02	
90.03	09003	SURGICAL CLINIC	284,868	0				90.03	
90.04	09004	GENESEO CLINIC	0	0				90.04	
91.00	09100	EMERGENCY	1,011,148	0				91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	546,294	0				92.00	
200.00		Subtotal (see instructions)	8,541,556	6,316				200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0					201.00	
202.00		Net Charges (line 200 - line 201)	8,541,556	6,316				202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1319

Period:

Worksheet D

Component CCN:14-Z319

From 06/01/2020
To 05/31/2021Part V
Date/Time Prepared:
10/22/2021 7:54 am

			Title XVIII	Swing Beds - SNF		Cost	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.231924	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	0.165453	0	0	0	54.00
60.00	06000	LABORATORY	0.222522	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.579236	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.369705	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.333557	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.646488	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.150484	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.071670	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.439909	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.345785	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	76.00
76.01	03610	SLEEP LAB	0.280807	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					88.00
88.01	08801	WYOMING RHC					88.01
88.02	08802	GENESEO RHC					88.02
88.03	08803	ANNAWAN RHC					88.03
90.00	09000	CLINIC	1.038313	0	0	0	90.00
90.01	09001	PAIN CLINIC	5.489449	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.000000	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	9.850562	0	0	0	90.03
90.04	09004	GENESEO CLINIC	0.000000	0	0	0	90.04
91.00	09100	EMERGENCY	0.815643	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.063926	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1319

Period:

Worksheet D

Component CCN:14-Z319

From 06/01/2020
To 05/31/2021Part V
Date/Time Prepared:
10/22/2021 7:54 am

			Title XVIII		Swing Beds - SNF	Cost
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.02	03950	IV THERAPY	0	0		76.02
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	KEWANEE RHC				88.00
88.01	08801	WYOMING RHC				88.01
88.02	08802	GENESEO RHC				88.02
88.03	08803	ANNAWAN RHC				88.03
90.00	09000	CLINIC	0	0		90.00
90.01	09001	PAIN CLINIC	0	0		90.01
90.02	09002	SPECIALTY CLINIC	0	0		90.02
90.03	09003	SURGICAL CLINIC	0	0		90.03
90.04	09004	GENESEO CLINIC	0	0		90.04
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1319 Component CCN: 14-5464		Period: From 06/01/2020 To 05/31/2021		Worksheet D Part IV Date/Time Prepared: 10/22/2021 7:54 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	0	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	KEWANEE RHC	0	0	0	0	0	0	88.00
88.01	08801	WYOMING RHC	0	0	0	0	0	0	88.01
88.02	08802	GENESE0 RHC	0	0	0	0	0	0	88.02
88.03	08803	ANNAWAN RHC	0	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	09001	PAIN CLINIC	0	0	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	0	0	0	0	90.03
90.04	09004	GENESE0 CLINIC	0	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN:14-1319 Component CCN:14-5464		Period: From 06/01/2020 To 05/31/2021		Worksheet D Part IV Date/Time Prepared: 10/22/2021 7:54 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	26,805,502	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	24,796,696	0.000000	54.00
60.00	06000	LABORATORY		0	0	0	30,552,909	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD		0	0	0	237,803	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	7,113,092	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	2,141,969	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	284,519	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	4,323,493	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT		0	0	0	409,290	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	3,852,228	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	6,328,549	0.000000	73.00
76.00	03020	ACUPUNCTURE		0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB		0	0	0	900,723	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	5,460,567	0.000000	88.00
88.01	08801	WYOMING RHC		0	0	0	0	0.000000	88.01
88.02	08802	GENESE0 RHC		0	0	0	3,341,144	0.000000	88.02
88.03	08803	ANNAWAN RHC		0	0	0	618,361	0.000000	88.03
90.00	09000	CLINIC		0	0	0	641,526	0.000000	90.00
90.01	09001	PAIN CLINIC		0	0	0	19,097	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	121,495	0.000000	90.03
90.04	09004	GENESE0 CLINIC		0	0	0	0	0.000000	90.04
91.00	09100	EMERGENCY		0	0	0	4,572,694	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		0	0	0	1,362,917	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	123,884,574		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1319 Component CCN: 14-5464		Period: From 06/01/2020 To 05/31/2021		Worksheet D Part IV Date/Time Prepared: 10/22/2021 7:54 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000		27,846	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		19,065	0	0	0	54.00
60.00	06000	LABORATORY	0.000000		25,256	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.000000		1,110	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.000000		189,020	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		134,482	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		9,807	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		4,415	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000		0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		79,688	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
88.03	08803	ANNANAW RHC	0.000000		0	0	0	0	88.03
90.00	09000	CLINIC	0.000000		0	0	0	0	90.00
90.01	09001	PAIN CLINIC	0.000000		0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.000000		0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0.000000		0	0	0	0	90.03
90.04	09004	GENESEO CLINIC	0.000000		0	0	0	0	90.04
91.00	09100	EMERGENCY	0.000000		0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000		0	0	0	0	92.00
200.00		Total (lines 50 through 199)			490,689	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN:14-1319 Component CCN:14-5464		Period: From 06/01/2020 To 05/31/2021		Worksheet D Part V Date/Time Prepared: 10/22/2021 7:54 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.231924	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	0.165453	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0.222522	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.579236	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.369705	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.333557	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.646488	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.150484	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.071670	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.439909	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.345785	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.280807	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							88.00
88.01	08801	WYOMING RHC							88.01
88.02	08802	GENESEO RHC							88.02
88.03	08803	ANNAWAN RHC							88.03
90.00	09000	CLINIC	1.038313	0	0	0	0	0	90.00
90.01	09001	PAIN CLINIC	5.489449	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	9.850562	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	0.815643	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.063926	0	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN:14-1319 Component CCN:14-5464		Period: From 06/01/2020 To 05/31/2021		Worksheet D Part V Date/Time Prepared: 10/22/2021 7:54 am		
			Title XVIII		Skilled Nursing Facility		PPS		
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0					52.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
60.00	06000	LABORATORY	0	0					60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0					62.00
64.00	06400	INTRAVENOUS THERAPY	0	0					64.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					73.00
76.00	03020	ACUPUNCTURE	0	0					76.00
76.01	03610	SLEEP LAB	0	0					76.01
76.02	03950	IV THERAPY	0	0					76.02
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	KEWANEE RHC							88.00
88.01	08801	WYOMING RHC							88.01
88.02	08802	GENESE0 RHC							88.02
88.03	08803	ANNAWAN RHC							88.03
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 06/01/2020 To 05/31/2021	Worksheet D-1 Date/Time Prepared: 10/22/2021 7:54 am
		Title XVIII	Hospital	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,724	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,350	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)		2,174	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)		-9	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)		-7	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,065	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)		-4	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)		4,576,404	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)		-934	25.00
26.00	Total swing-bed cost (see instructions)		445,760	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,130,644	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)		4,130,644	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)		1,233.03	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,313,177	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)		1,313,177	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021

Worksheet D-1

Date/Time Prepared:
10/22/2021 7:54 am

Cost Center Description		Title XVIII		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	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)					1,419,195	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,732,372	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					363,744	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					-4,932	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					358,812	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,176	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,233.03	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,450,043	89.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:14-1319		Period: From 06/01/2020 To 05/31/2021		Worksheet D-1 Date/Time Prepared: 10/22/2021 7:54 am	
				Title XVIII		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)			
		1.00	2.00	3.00	4.00	5.00			
COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
90.00	Capital-related cost	474,546	4,576,404	0.103694	1,450,043	150,361	90.00		
91.00	Nursing School cost	0	4,576,404	0.000000	1,450,043	0	91.00		
92.00	Allied health cost	0	4,576,404	0.000000	1,450,043	0	92.00		
93.00	All other Medical Education	0	4,576,404	0.000000	1,450,043	0	93.00		

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1319 Component CCN: 14-5464	Period: From 06/01/2020 To 05/31/2021	Worksheet D-1 Date/Time Prepared: 10/22/2021 7:54 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		12,699	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		12,699	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)		12,699	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)		623	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)		3,212,181	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)		3,212,181	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)		3,212,181	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-1319 Component CCN: 14-5464	Period: From 06/01/2020 To 05/31/2021	Worksheet D-1 Date/Time Prepared: 10/22/2021 7:54 am
				Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT						43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges						54.00
55.00 Target amount per discharge						55.00
56.00 Target amount (line 54 x line 55)						56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00 Bonus payment (see instructions)						58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00 Relief payment (see instructions)						62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					3,212,181	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					252.95	71.00
72.00 Program routine service cost (line 9 x line 71)					157,588	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)					157,588	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)					157,588	83.00
84.00 Program inpatient ancillary services (see instructions)					165,173	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)					322,761	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 06/01/2020 To 05/31/2021		Worksheet D-1 Date/Time Prepared: 10/22/2021 7:54 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
				1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
90.00	Capital-related cost			0	0	0.000000	0	0	90.00
91.00	Nursing School cost			0	0	0.000000	0	0	91.00
92.00	Allied health cost			0	0	0.000000	0	0	92.00
93.00	All other Medical Education			0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1319	Period: From 06/01/2020 To 05/31/2021	Worksheet D-3 Date/Time Prepared: 10/22/2021 7:54 am
			Title XVIII	Hospital	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,413,266	30.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.231924	2,300,477	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.165453	339,990	54.00
60.00	06000	LABORATORY	0.222522	746,690	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.579236	48,885	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
66.00	06600	PHYSICAL THERAPY	0.369705	105,014	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.333557	78,140	67.00
68.00	06800	SPEECH PATHOLOGY	0.646488	5,881	68.00
69.00	06900	ELECTROCARDIOLOGY	0.150484	252,689	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.071670	160,580	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.439909	523,334	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.345785	786,529	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	76.00
76.01	03610	SLEEP LAB	0.280807	0	76.01
76.02	03950	IV THERAPY	0.000000	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	KEWANEE RHC	0.000000		88.00
88.01	08801	WYOMING RHC	0.000000		88.01
88.02	08802	GENESEO RHC	0.000000		88.02
88.03	08803	ANNAWAN RHC	0.000000		88.03
90.00	09000	CLINIC	1.038313	0	90.00
90.01	09001	PAIN CLINIC	5.489449	0	90.01
90.02	09002	SPECIALTY CLINIC	0.000000	0	90.02
90.03	09003	SURGICAL CLINIC	9.850562	170	90.03
90.04	09004	GENESEO CLINIC	0.000000	0	90.04
91.00	09100	EMERGENCY	0.815643	11,902	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.063926	2,950	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,363,231	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)		5,363,231	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1319	Period: From 06/01/2020 To 05/31/2021	Worksheet D-3
			Component CCN: 14-Z319		Date/Time Prepared: 10/22/2021 7:54 am
			Title XVIII	Swing Beds - SNF	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.231924	48,204	11,180
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0
53.00	05300	ANESTHESIOLOGY	0.000000	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.165453	18,570	3,072
60.00	06000	LABORATORY	0.222522	39,149	8,712
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.579236	1,850	1,072
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0
66.00	06600	PHYSICAL THERAPY	0.369705	79,825	29,512
67.00	06700	OCCUPATIONAL THERAPY	0.333557	58,718	19,586
68.00	06800	SPEECH PATHOLOGY	0.646488	1,217	787
69.00	06900	ELECTROCARDIOLOGY	0.150484	25,303	3,808
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.071670	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.439909	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.345785	85,729	29,644
76.00	03020	ACUPUNCTURE	0.000000	0	0
76.01	03610	SLEEP LAB	0.280807	0	0
76.02	03950	IV THERAPY	0.000000	0	0
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	KEWANEE RHC	0.000000		0
88.01	08801	WYOMING RHC	0.000000		0
88.02	08802	GENESEO RHC	0.000000		0
88.03	08803	ANNAWAN RHC	0.000000		0
90.00	09000	CLINIC	1.038313	0	0
90.01	09001	PAIN CLINIC	5.489449	0	0
90.02	09002	SPECIALTY CLINIC	0.000000	0	0
90.03	09003	SURGICAL CLINIC	9.850562	0	0
90.04	09004	GENESEO CLINIC	0.000000	0	0
91.00	09100	EMERGENCY	0.815643	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.063926	0	0
200.00		Total (sum of lines 50 through 94 and 96 through 98)		358,565	107,373
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0
202.00		Net charges (line 200 minus line 201)		358,565	107,373

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1319 Component CCN: 14-5464	Period: From 06/01/2020 To 05/31/2021	Worksheet D-3 Date/Time Prepared: 10/22/2021 7:54 am	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.231924	27,846	6,458	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	0.165453	19,065	3,154	54.00
60.00	06000 LABORATORY	0.222522	25,256	5,620	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD	0.579236	1,110	643	62.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
66.00	06600 PHYSICAL THERAPY	0.369705	189,020	69,882	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.333557	134,482	44,857	67.00
68.00	06800 SPEECH PATHOLOGY	0.646488	9,807	6,340	68.00
69.00	06900 ELECTROCARDIOLOGY	0.150484	4,415	664	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.071670	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.439909	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.345785	79,688	27,555	73.00
76.00	03020 ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610 SLEEP LAB	0.280807	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
88.03	08803 ANNAWAN RHC	0.000000		0	88.03
90.00	09000 CLINIC	1.038313	0	0	90.00
90.01	09001 PAIN CLINIC	5.489449	0	0	90.01
90.02	09002 SPECIALTY CLINIC	0.000000	0	0	90.02
90.03	09003 SURGICAL CLINIC	9.850562	0	0	90.03
90.04	09004 GENESEO CLINIC	0.000000	0	0	90.04
91.00	09100 EMERGENCY	0.815643	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	1.063926	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		490,689	165,173	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)		490,689		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-1319	Period: From 06/01/2020 To 05/31/2021	Worksheet E Part B Date/Time Prepared: 10/22/2021 7:54 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			8,547,872 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)			8,547,872 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)			8,633,351 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)			68,625 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			4,355,030 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)			4,209,696 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)			4,209,696 30.00
31.00	Primary payer payments			367 31.00
32.00	Subtotal (line 30 minus line 31)			4,209,329 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)			48,040 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			31,226 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 36.00
37.00	Subtotal (see instructions)			4,240,555 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)			4,240,555 40.00
40.01	Sequestration adjustment (see instructions)			0 40.01
40.02	Demonstration payment adjustment amount after sequestration			0 40.02
40.03	Sequestration adjustment-PARHM pass-throughs			0 40.03
41.00	Interim payments			3,408,230 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)			832,325 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 Component CCN: 14-5464	Period: From 06/01/2020 To 05/31/2021	Worksheet E Part B Date/Time Prepared: 10/22/2021 7:54 am
		Title XVIII	Skilled Nursing Facility	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
4.01	Outlier reconciliation amount (see instructions)			4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		0	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		0	37.00
38.00	MSP-LCC reconciliation amount from PS&R			38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		0	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		0	41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		0	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021Worksheet E-1
Part I
Date/Time Prepared:
10/22/2021 7:54 am

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,479,386		3,034,837	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	01/11/2021	37,587	01/11/2021	277,605	3.01
3.02		05/20/2021	15,551	05/20/2021	95,788	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)		53,138		373,393	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)		2,532,524		3,408,230	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		832,325	6.01
6.02	SETTLEMENT TO PROGRAM		106,104		0	6.02
7.00	Total Medicare program liability (see instructions)		2,426,420		4,240,555	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 06/01/2020

Part I

To 05/31/2021

Date/Time Prepared:

10/22/2021 7:54 am

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		397,894		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	01/11/2021	14,583		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)		14,583		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)		412,477		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		55,126		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		467,603		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 06/01/2020 To 05/31/2021	Worksheet E-1 Part I Date/Time Prepared: 10/22/2021 7:54 am	
		Title XVIII	Skilled Nursing Facility	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider		269,967		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)		269,967		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		2		0 6.02
7.00	Total Medicare program liability (see instructions)		269,965		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 06/01/2020 To 05/31/2021	Worksheet E-1 Part II Date/Time Prepared: 10/22/2021 7:54 am
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1319	Period: From 06/01/2020 To 05/31/2021	Worksheet E-2	
		Component CCN: 14-Z319		Date/Time Prepared: 10/22/2021 7:54 am	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		362,400	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)		108,447	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		291	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)		470,847	0	8.00
9.00	Primary payer payments (see instructions)			0	9.00
10.00	Subtotal (line 8 minus line 9)		470,847	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)		470,847	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		3,244	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		467,603	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)		467,603	0	19.00
19.01	Sequestration adjustment (see instructions)		0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
19.25	Sequestration for non-claims based amounts (see instructions)		0	0	19.25
20.00	Interim payments		412,477	0	20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)		55,126	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 06/01/2020 To 05/31/2021	Worksheet E-3 Part V Date/Time Prepared: 10/22/2021 7:54 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		2,732,372	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)		2,732,372	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,759,696	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)		2,759,696	19.00
20.00	Deductibles (exclude professional component)		335,781	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		2,423,915	22.00
23.00	Coinsurance		742	23.00
24.00	Subtotal (line 22 minus line 23)		2,423,173	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		4,995	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		3,247	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)		2,426,420	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)		2,426,420	30.00
30.01	Sequestration adjustment (see instructions)		0	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM		0	30.03
31.00	Interim payments		2,532,524	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)		-106,104	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 06/01/2020 To 05/31/2021	Worksheet E-3 Part VI Date/Time Prepared: 10/22/2021 7:54 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		325,047	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)		325,047	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		55,081	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)		269,966	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)		269,966	15.00
15.01	Sequestration adjustment (see instructions)		1	15.01
15.02	Demonstration payment adjustment amount after sequestration		0	15.02
15.75	Sequestration for non-claims based amounts (see instructions)		0	15.75
16.00	Interim payments		269,967	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)		-2	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 06/01/2020
To 05/31/2021

Worksheet G

Date/Time Prepared:
10/22/2021 7:54 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	13,932,630	0	0	0	1.00
2.00	Temporary investments	40,368,679	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	32,833,447	0	0	0	4.00
5.00	Other receivable	1,056,635	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-28,991,972	0	0	0	6.00
7.00	Inventory	857,020	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	1,518,937	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)	61,575,376	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	-1,202,261	0	0	0	14.00
15.00	Buildings	44,855,703	0	0	0	15.00
16.00	Accumulated depreciation	-27,602,699	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	15,944,380	0	0	0	19.00
20.00	Accumulated depreciation	-11,807,162	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	-1,090,547	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	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	23,936,231	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	10,737,149	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	10,737,149	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	96,248,756	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	0	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,092,242	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	3,560,390	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,330,053	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,982,685	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	11,734,301	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	23,798,986	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	35,533,287	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	44,515,972	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	51,732,784	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)	51,732,784	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	96,248,756	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021

Worksheet G-1

Date/Time Prepared:
10/22/2021 7:54 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		45,712,467		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,999,884				2.00
3.00	Total (sum of line 1 and line 2)		51,712,351		0		3.00
4.00	NET INCOME FROM FOUNDATION	20,433		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)		20,433		0		10.00
11.00	Subtotal (line 3 plus line 10)		51,732,784		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)		51,732,784		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 06/01/2020
To 05/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
10/22/2021 7:54 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,106,959		3,106,959	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	2,760,402		2,760,402	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,867,361		5,867,361	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,867,361		5,867,361	17.00
18.00	Ancillary services	13,248,470	100,500,605	113,749,075	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	KEWANEE RHC	0	5,460,567	5,460,567	20.00
20.01	WYOMING RHC	0	0	0	20.01
20.02	GENESEO RHC	0	3,341,144	3,341,144	20.02
20.03	ANNAWAN RHC	0	618,361	618,361	20.03
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,043,260	1,043,260	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	641,526	641,526	27.00
27.01	PAIN CLINIC	0	18,997	18,997	27.01
27.02	SURGICAL CLINIC	0	166,478	166,478	27.02
27.03	PROFESSIONAL FEES	1,376,272	10,970,846	12,347,118	27.03
27.04	CAMBRIDGE CLINIC	0	778,171	778,171	27.04
27.05	ANNAWAN CLINIC	0	114,624	114,624	27.05
27.06	PORT BYRON CLINIC	0	625,485	625,485	27.06
27.07	MUSCATINE CLINIC	0	831,837	831,837	27.07
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	20,492,103	125,111,901	145,604,004	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		53,077,781		29.00
30.00	PROVISION FOR BAD DEBT	2,268,411			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)		2,268,411		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)		55,346,192		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1319

Period:
From 06/01/2020
To 05/31/2021

Worksheet G-3

Date/Time Prepared:
10/22/2021 7:54 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	145,604,004	1.00
2.00	Less contractual allowances and discounts on patients' accounts	88,188,102	2.00
3.00	Net patient revenues (line 1 minus line 2)	57,415,902	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	55,346,192	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,069,710	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	114,535	6.00
7.00	Income from investments	536,806	7.00
8.00	Revenues from telephone and other miscellaneous communication services	173	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	176,978	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	185,080	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	445	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	2,454,049	24.00
24.01	RENTAL INCOME	255,103	24.01
24.02	PROPERTY INCOME	849,689	24.02
24.03	340B PHARMACY REVENUE	1,621,614	24.03
24.04	CARES ACT FUNDING	-1,745,075	24.04
24.05	OTHER OPERATING REVENUE	242,253	24.05
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	4,691,650	25.00
26.00	Total (line 5 plus line 25)	6,761,360	26.00
27.00	340B PHARMACY EXPENSES	760,807	27.00
27.02	LOSS ON SALE OF FIXED ASSETS	669	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	761,476	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,999,884	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-1319
HHA CCN: 14-7450
Period: From 06/01/2020 To 05/31/2021
Worksheet H
Date/Time Prepared: 10/22/2021 7:54 am

					Home Health Agency I	PPS
	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)
	1.00	2.00	3.00	4.00	5.00	6.00
GENERAL SERVICE COST CENTERS						
1.00 Capital Related - Bldg. & Fixtures			0		0	0
2.00 Capital Related - Movable Equipment			0		0	0
3.00 Plant Operation & Maintenance	0	0	0	0	0	0
4.00 Transportation	0	0	0	0	0	0
5.00 Administrative and General	136,110	0	83	14,024	10,851	161,068
HHA REIMBURSABLE SERVICES						
6.00 Skilled Nursing Care	461,584	0	56,593	0	2,600	520,777
7.00 Physical Therapy	0	0	0	0	0	0
8.00 Occupational Therapy	0	0	0	0	0	0
9.00 Speech Pathology	0	0	0	0	0	0
10.00 Medical Social Services	0	0	0	0	0	0
11.00 Home Health Aide	32,354	0	20	0	0	32,354
12.00 Supplies (see instructions)	0	0	0	0	74,082	74,082
13.00 Drugs	0	0	0	0	0	0
14.00 DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES						
15.00 Home Dialysis Aide Services	0	0	0	0	0	0
16.00 Respiratory Therapy	0	0	0	0	0	0
17.00 Private Duty Nursing	0	0	0	0	0	0
18.00 Clinic	0	0	0	0	0	0
19.00 Health Promotion Activities	0	0	0	0	0	0
20.00 Day Care Program	0	0	0	0	0	0
21.00 Home Delivered Meals Program	0	0	0	0	0	0
22.00 Homemaker Service	0	0	0	0	0	0
23.00 All Others (specify)	0	0	0	0	0	0
23.50 Telemedicine	0	0	0	0	0	0
24.00 Total (sum of lines 1-23)	630,028	0	56,696	14,024	87,533	788,281
	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	161,068	-14,120	146,948		5.00
HHA REIMBURSABLE SERVICES						
6.00 Skilled Nursing Care	0	520,777	0	520,777		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	32,354	0	32,354		11.00
12.00 Supplies (see instructions)	0	74,082	0	74,082		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	788,281	-14,120	774,161		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 06/01/2020
To 05/31/2021Part I
Date/Time Prepared:
10/22/2021 7:54 amHome 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	146,948	0	0	0	0	146,948	5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	520,777	0	0	0	0	520,777	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	32,354	0	0	0	0	32,354	11.00	
12.00	Supplies (see instructions)	74,082	0	0	0	0	74,082	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)	774,161	0	0	0	0	774,161	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	146,948							5.00
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	122,012	642,789						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	7,580	39,934						11.00
12.00	Supplies (see instructions)	17,356	91,438						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)		774,161						24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-1319

Period:

Worksheet H-1

HHA CCN: 14-7450

From 06/01/2020
To 05/31/2021Part II
Date/Time Prepared:
10/22/2021 7:54 amHome 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	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-146,948	627,213	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	520,777	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	32,354	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	74,082	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	-146,948	627,213	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		146,948	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.234287	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1319

Period:

Worksheet H-2

HHA CCN: 14-7450

From 06/01/2020

Part I

To 05/31/2021

Date/Time Prepared:

10/22/2021 7:54 am

Home 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	23,740	1,873	164,927	38,917	1,616	1.00
2.00	Skilled Nursing Care	642,789	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	39,934	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	91,438	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)	774,161	23,740	1,873	164,927	38,917	1,616	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	8,014	239,087	16,551	17,919	0	1.00
2.00	Skilled Nursing Care	0	0	642,789	44,498	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	39,934	2,764	0	0	7.00
8.00	Supplies (see instructions)	0	0	91,438	6,330	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	8,014	1,013,248	70,143	17,919	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 06/01/2020
To 05/31/2021Part I
Date/Time Prepared:
10/22/2021 7:54 amHome 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	1,938	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)	1,938	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	275,495	0	275,495	1.00
2.00	Skilled Nursing Care	0	0	0	687,287	0	687,287	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	42,698	0	42,698	7.00
8.00	Supplies (see instructions)	0	0	0	97,768	0	97,768	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	1,103,248	0	1,103,248	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 06/01/2020
To 05/31/2021Part I
Date/Time Prepared:
10/22/2021 7:54 amHome Health
Agency I

PPS

Cost Center Description		Allocated HHA A&G (see Part II)	Total HHA Costs		
		27.00	28.00		
1.00	Administrative and General				1.00
2.00	Skilled Nursing Care	228,745	916,032		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	14,211	56,909		7.00
8.00	Supplies (see instructions)	32,539	130,307		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)	275,495	1,103,248		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.	0.332823			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 06/01/2020

Worksheet H-2

HHA CCN: 14-7450

To 05/31/2021

Part II

Date/Time Prepared: 10/22/2021 7:54 am

Home Health Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (TIME SPENT)	PURCHASING RECEIVING AND STORES (SUPPLY COST)	ADMITTING (GROSS CHARGES)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
		1.00	2.00	4.00	5.01	5.02	5.03	
1.00	Administrative and General	1,127	1,838	630,028	1,850	79,835	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	1,838	630,028	1,850	79,835	0	20.00
21.00	Total cost to be allocated	23,740	1,873	164,927	38,917	1,616	0	21.00
22.00	Unit cost multiplier	21.064774	1.019042	0.261777	21.036216	0.020242	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	1,043,260	0	239,087	1,127	0	450	1.00
2.00	Skilled Nursing Care	0	0	642,789	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	39,934	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	91,438	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)	1,043,260		1,013,248	1,127	0	450	20.00
21.00	Total cost to be allocated	8,014		70,143	17,919	0	1,938	21.00
22.00	Unit cost multiplier	0.007682		0.069226	15.899734	0.000000	4.306667	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 06/01/2020
To 05/31/2021Part II
Date/Time Prepared:
10/22/2021 7:54 am

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 06/01/2020
To 05/31/2021Part I
Date/Time Prepared:
10/22/2021 7:54 am

Title XVIII				Home Health Agency I		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	916,032		916,032	5,712	160.37
2.00	Physical Therapy	3.00	0	112,802	112,802	2,111	53.44
3.00	Occupational Therapy	4.00	0	51,297	51,297	1,222	41.98
4.00	Speech Pathology	5.00	0	24,444	24,444	119	205.41
5.00	Medical Social Services	6.00	0	0	9	0.00	5.00
6.00	Home Health Aide	7.00	56,909	56,909	780	72.96	6.00
7.00	Total (sum of lines 1-6)		972,941	188,543	1,161,484	9,953	7.00
Program Visits							
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Part B		
					Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
		0	1.00	2.00	3.00	4.00	5.00
Limitation Cost Computation							
8.00	Skilled Nursing Care		19340	0	2,365		8.00
8.01	Skilled Nursing Care		99914	0	472		8.01
9.00	Physical Therapy		19340	0	605		9.00
9.01	Physical Therapy		99914	0	308		9.01
10.00	Occupational Therapy		19340	0	288		10.00
10.01	Occupational Therapy		99914	0	280		10.01
11.00	Speech Pathology		19340	0	15		11.00
11.01	Speech Pathology		99914	0	27		11.01
12.00	Medical Social Services		19340	0	2		12.00
12.01	Medical Social Services		99914	0	1		12.01
13.00	Home Health Aide		19340	0	267		13.00
13.01	Home Health Aide		99914	0	109		13.01
14.00	Total (sum of lines 8-13)			0	4,739		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	130,307	0	130,307	0	0.000000
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000
Program Visits							
Cost Center Description		Part A	Part B		Cost of Services	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
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	2,837		0	454,970	1.00
2.00	Physical Therapy	0	913		0	48,791	2.00
3.00	Occupational Therapy	0	568		0	23,845	3.00
4.00	Speech Pathology	0	42		0	8,627	4.00
5.00	Medical Social Services	0	3		0	0	5.00
6.00	Home Health Aide	0	376		0	27,433	6.00
7.00	Total (sum of lines 1-6)	0	4,739		0	563,666	7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1319

Period:

Worksheet H-3

HHA CCN: 14-7450

From 06/01/2020
To 05/31/2021Part I
Date/Time Prepared:
10/22/2021 7:54 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description						Agency 1			
		6.00	7.00	8.00	9.00	10.00	11.00		
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	454,970							1.00
2.00	Physical Therapy	48,791							2.00
3.00	Occupational Therapy	23,845							3.00
4.00	Speech Pathology	8,627							4.00
5.00	Medical Social Services	0							5.00
6.00	Home Health Aide	27,433							6.00
7.00	Total (sum of lines 1-6)	563,666							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 06/01/2020
To 05/31/2021Part II
Date/Time Prepared:
10/22/2021 7:54 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.369705	305,114	112,802	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.333557	153,788	51,297	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.646488	37,810	24,444	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.071670	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.345785	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1319 HHA CCN: 14-7450	Period: From 06/01/2020 To 05/31/2021	Worksheet H-4 Part I-II Date/Time Prepared: 10/22/2021 7:54 am	
		Title XVIII	Home Health Agency I	PPS	
		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES					
Reasonable Cost of Part A & Part B Services					
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
Customary Charges					
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00
			Part A Services	Part B Services	
			1.00	2.00	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
10.00	Total reasonable cost (see instructions)		0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	610,353	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	96,931	12.00
13.00	Total PPS Reimbursement - LUPA Episodes		0	9,174	13.00
14.00	Total PPS Reimbursement - PEP Episodes		0	1,215	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	29,050	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0	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	746,723	22.00
23.00	Excess reasonable cost (from line 8)		0	0	23.00
24.00	Subtotal (line 22 minus line 23)		0	746,723	24.00
25.00	Coinsurance billed to program patients (from your records)			0	25.00
26.00	Net cost (line 24 minus line 25)		0	746,723	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	746,723	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	746,723	31.00
31.01	Sequestration adjustment (see instructions)		0	3,768	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	0	31.02
32.00	Interim payments (see instructions)		0	742,956	32.00
33.00	Tentative settlement (for contractor use only)		0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	-1	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED
TO PROGRAM BENEFICIARIESProvider CCN: 14-1319
HHA CCN: 14-7450Period:
From 06/01/2020
To 05/31/2021Worksheet H-5
Date/Time Prepared:
10/22/2021 7:54 am

				Home Health Agency I		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		742,956	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) Program to Provider					3.00
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		742,956	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) Program to Provider					5.00
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1	6.02
7.00	Total Medicare program liability (see instructions)		0		742,955	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.		06101		8.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1319

Period:

Worksheet M-1

Component CCN: 14-8576

From 06/01/2020
To 05/31/2021Date/Time Prepared:
10/22/2021 7:54 am

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	568,045	0	568,045	251,856	819,901
2.00	Physician Assistant	2,038	0	2,038	0	2,038
3.00	Nurse Practitioner	493,668	0	493,668	0	493,668
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	212,021	0	212,021	0	212,021
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	192,291	0	192,291	-61,139	131,152
10.00	Subtotal (sum of lines 1 through 9)	1,468,063	0	1,468,063	190,717	1,658,780
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	231,038	231,038	0	231,038
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	231,038	231,038	0	231,038
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,468,063	231,038	1,699,101	190,717	1,889,818
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	81,978	81,978	0	81,978
30.00	Administrative Costs	234,292	306,860	541,152	26,907	568,059
31.00	Total Facility Overhead (sum of lines 29 and 30)	234,292	388,838	623,130	26,907	650,037
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,702,355	619,876	2,322,231	217,624	2,539,855

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1319

Period:

Worksheet M-1

Component CCN: 14-8576

From 06/01/2020
To 05/31/2021Date/Time Prepared:
10/22/2021 7:54 am

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	819,901	1.00
2.00	Physician Assistant	0	2,038	2.00
3.00	Nurse Practitioner	0	493,668	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	212,021	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	131,152	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,658,780	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	231,038	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	231,038	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,889,818	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	81,978	29.00
30.00	Administrative Costs	0	568,059	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	650,037	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,539,855	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1319

Period:

Worksheet M-1

Component CCN: 14-8587

From 06/01/2020
To 05/31/2021Date/Time Prepared:
10/22/2021 7:54 am

		RHC III		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	636,284	0	636,284	223,745	860,029
2.00	Physician Assistant	804	0	804	0	804
3.00	Nurse Practitioner	325,009	0	325,009	0	325,009
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	295,413	0	295,413	0	295,413
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	96,255	0	96,255	-2,318	93,937
10.00	Subtotal (sum of lines 1 through 9)	1,353,765	0	1,353,765	221,427	1,575,192
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	169,099	169,099	0	169,099
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	169,099	169,099	0	169,099
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,353,765	169,099	1,522,864	221,427	1,744,291
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	15	15	0	15
30.00	Administrative Costs	174,927	55,881	230,808	16,463	247,271
31.00	Total Facility Overhead (sum of lines 29 and 30)	174,927	55,896	230,823	16,463	247,286
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,528,692	224,995	1,753,687	237,890	1,991,577

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1319

Period:

Worksheet M-1

Component CCN: 14-8587

From 06/01/2020
To 05/31/2021Date/Time Prepared:
10/22/2021 7:54 am

		RHC III		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	860,029	1.00
2.00	Physician Assistant	0	804	2.00
3.00	Nurse Practitioner	0	325,009	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	295,413	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	93,937	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,575,192	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	169,099	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	169,099	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,744,291	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	15	29.00
30.00	Administrative Costs	0	247,271	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	247,286	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,991,577	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1319

Period:

Worksheet M-1

Component CCN: 14-8615

From 06/01/2020
To 05/31/2021Date/Time Prepared:
10/22/2021 7:54 am

				RHC IV		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	0	30,378	30,378	0	30,378	1.00
2.00	Physician Assistant	89,099	0	89,099	21,151	110,250	2.00
3.00	Nurse Practitioner	93,512	0	93,512	21,151	114,663	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	177	0	177	0	177	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	108,806	0	108,806	-56,389	52,417	9.00
10.00	Subtotal (sum of lines 1 through 9)	291,594	30,378	321,972	-14,087	307,885	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	24,682	24,682	0	24,682	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	24,682	24,682	0	24,682	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	291,594	55,060	346,654	-14,087	332,567	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	54,618	54,618	0	54,618	29.00
30.00	Administrative Costs	2,721	37,037	39,758	3,047	42,805	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	2,721	91,655	94,376	3,047	97,423	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	294,315	146,715	441,030	-11,040	429,990	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1319

Period:

Worksheet M-1

Component CCN: 14-8615

From 06/01/2020
To 05/31/2021Date/Time Prepared:
10/22/2021 7:54 am

		RHC IV		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	30,378	1.00
2.00	Physician Assistant	0	110,250	2.00
3.00	Nurse Practitioner	0	114,663	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	177	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	52,417	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	307,885	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	24,682	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	24,682	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	332,567	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	54,618	29.00
30.00	Administrative Costs	0	42,805	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	97,423	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	429,990	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1319

Period:

Worksheet M-2

Component CCN: 14-8576

From 06/01/2020
To 05/31/2021Date/Time Prepared:
10/22/2021 7:54 am

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	1.67	4,633	4,200	7,014		1.00
2.00	Physician Assistant	0.02	10	2,100	42		2.00
3.00	Nurse Practitioner	3.00	11,559	2,100	6,300		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.69	16,202		13,356	16,202	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)	4.69	16,202			16,202	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)					1,889,818	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)					1,889,818	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)					650,037	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					680,903	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,330,940	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,330,940	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,330,940	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,220,758	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1319

Period:

Worksheet M-2

Component CCN: 14-8577

From 06/01/2020
To 05/31/2021Date/Time Prepared:
10/22/2021 7:54 am

		RHC II		Cost	
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
	1.00	2.00	3.00	4.00	5.00
VISITS AND PRODUCTIVITY					
Positions					
1.00	Physician	0.00	0	4,200	0
2.00	Physician Assistant	0.00	0	2,100	0
3.00	Nurse Practitioner	0.00	0	2,100	0
4.00	Subtotal (sum of lines 1 through 3)	0.00	0	0	0
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)	0.00	0		0
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)				0
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)				0
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.000000
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				0
15.00	Parent provider overhead allocated to facility (see instructions)				0
16.00	Total overhead (sum of lines 14 and 15)				0
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				0
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				0
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				0

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1319

Period:

Worksheet M-2

Component CCN: 14-8587

From 06/01/2020
To 05/31/2021Date/Time Prepared:
10/22/2021 7:54 am

				RHC III		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	1.86	6,601	4,200	7,812		1.00
2.00	Physician Assistant	0.01	10	2,100	21		2.00
3.00	Nurse Practitioner	1.81	6,543	2,100	3,801		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.68	13,154		11,634	13,154	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)	3.68	13,154			13,154	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)					1,744,291	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)					1,744,291	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)					247,286	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					862,233	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,109,519	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,109,519	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,109,519	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,853,810	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1319

Period:

Worksheet M-2

Component CCN: 14-8615

From 06/01/2020
To 05/31/2021Date/Time Prepared:
10/22/2021 7:54 am

		RHC IV		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	0.00	0	4,200	0
2.00	Physician Assistant	0.54	1,462	2,100	1,134
3.00	Nurse Practitioner	0.57	1,462	2,100	1,197
4.00	Subtotal (sum of lines 1 through 3)	1.11	2,924	2,331	2,924
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)	1.11	2,924		2,924
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)				332,567
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)				332,567
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)				97,423
15.00	Parent provider overhead allocated to facility (see instructions)				141,630
16.00	Total overhead (sum of lines 14 and 15)				239,053
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				239,053
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				239,053
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				571,620

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1319 Component CCN: 14-8576	Period: From 06/01/2020 To 05/31/2021	Worksheet M-3 Date/Time Prepared: 10/22/2021 7:54 am	
		Title XVIII	RHC I	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			3,220,758	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			57,686	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			3,163,072	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			16,202	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)			16,202	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			195.23	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	83.45	83.45	206.51	8.00
9.00	Rate for Program covered visits (see instructions)	195.23	195.23	195.23	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	0	2,891	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	0	564,410	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	564,410		16.00
16.01	Total program charges (see instructions)(from contractor's records)		710,790		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		123,278		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		97,890		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.)		338,747		16.04
16.05	Total program cost (see instructions)	0	436,637		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		43,086		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		108,885		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		436,637		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		13,282		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		449,919		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)		449,919		26.00
26.01	Sequestration adjustment (see instructions)		0		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		463,604		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)		-13,685		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 06/01/2020 To 05/31/2021	Worksheet M-3 Date/Time Prepared: 10/22/2021 7:54 am	
		Title XVIII	RHC II	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			0	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			0	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			0	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			0	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)			0	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			0.00	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	0.00	0.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	0	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	0	0	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	0	0	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		0		16.04
16.05	Total program cost (see instructions)	0	0		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		0		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		0		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)		0		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)		0		26.00
26.01	Sequestration adjustment (see instructions)		0		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		0		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)		0		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 06/01/2020 To 05/31/2021	Worksheet M-3 Date/Time Prepared: 10/22/2021 7:54 am		
		Title XVIII	RHC III	Cost		
					1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)				2,853,810	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)				35,039	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)				2,818,771	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)				13,154	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)				13,154	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)				214.29	7.00
		Calculation of Limit (1)				
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)		
		1.00	2.00	3.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	83.45	83.45	245.87	8.00	
9.00	Rate for Program covered visits (see instructions)	214.29	214.29	214.29	9.00	
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)	0	0	2,676	10.00	
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	0	573,440	11.00	
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00	
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00	
14.00	Limit adjustment for mental health services (see instructions)	0	0	0	14.00	
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00	
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	573,440		16.00	
16.01	Total program charges (see instructions)(from contractor's records)		568,128		16.01	
16.02	Total program preventive charges (see instructions)(from provider's records)		82,064		16.02	
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		82,831		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.)		348,522		16.04	
16.05	Total program cost (see instructions)	0	431,353		16.05	
17.00	Primary payer amounts		0		17.00	
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		54,956		18.00	
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		86,222		19.00	
20.00	Net Medicare cost excluding vaccines (see instructions)		431,353		20.00	
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		8,118		21.00	
22.00	Total reimbursable Program cost (line 20 plus line 21)		439,471		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)		439,471		26.00	
26.01	Sequestration adjustment (see instructions)		0		26.01	
26.02	Demonstration payment adjustment amount after sequestration		0		26.02	
27.00	Interim payments		479,504		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)		-40,033		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: 14-8615	Period: From 06/01/2020 To 05/31/2021	Worksheet M-3 Date/Time Prepared: 10/22/2021 7:54 am	
		Title XVIII	RHC IV	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)			571,620	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			2,083	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			569,537	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,924	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			2,924	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			194.78	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	83.45	83.45	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	194.78	194.78	0.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	123	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	23,958	0	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	23,958		16.00
16.01	Total program charges (see instructions)(from contractor's records)		23,745		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		10,395		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		10,488		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		9,538		16.04
16.05	Total program cost (see instructions)	0	20,026		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		1,547		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		2,361		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		20,026		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		312		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		20,338		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)		20,338		26.00
26.01	Sequestration adjustment (see instructions)		0		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		21,278		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)		-940		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1319

Period:

Worksheet M-4

Component CCN: 14-8576

From 06/01/2020

Date/Time Prepared:

To 05/31/2021

10/22/2021 7:54 am

		Title XVIII		RHC I	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,658,780	1,658,780	1,658,780	1,658,780	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000812	0.000543	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,347	901	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	23,446	8,154	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	24,793	9,055	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,889,818	1,889,818	1,889,818	1,889,818	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,330,940	1,330,940	1,330,940	1,330,940	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.013119	0.004791	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	17,461	6,377	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	42,254	15,432	0	0	10.00
11.00	Total number of injections/infusions (from your records)	438	293	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	96.47	52.67	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	94	80	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees	0	0	0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	9,068	4,214	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		57,686			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		13,282			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1319

Period:

Worksheet M-4

Component CCN: 14-8577

From 06/01/2020
To 05/31/2021Date/Time Prepared:
10/22/2021 7:54 am

		Title XVIII		RHC II	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	0	0	0	0	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.000000	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	0	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	0	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	0	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	0	0	0	0	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	0	0	0	0	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.000000	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	0	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	0	0	0	10.00
11.00	Total number of injections/infusions (from your records)	0	0	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	0.00	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	0	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees	0	0	0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	0	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		0			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		0			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1319

Period:

Worksheet M-4

Component CCN: 14-8587

From 06/01/2020
To 05/31/2021Date/Time Prepared:
10/22/2021 7:54 am

		Title XVIII		RHC III	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,575,192	1,575,192	1,575,192	1,575,192	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000406	0.000770	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	640	1,213	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	9,850	9,713	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	10,490	10,926	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,744,291	1,744,291	1,744,291	1,744,291	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,109,519	1,109,519	1,109,519	1,109,519	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.006014	0.006264	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	6,673	6,950	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	17,163	17,876	0	0	10.00
11.00	Total number of injections/infusions (from your records)	184	349	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	93.28	51.22	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	42	82	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees	0	0	0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	3,918	4,200	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		35,039			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		8,118			16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1319

Period:

Worksheet M-4

Component CCN: 14-8615

From 06/01/2020

Date/Time Prepared:

To 05/31/2021

10/22/2021 7:54 am

		Title XVIII		RHC IV	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	307,885	307,885	307,885	307,885	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.000322	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	99	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	1,113	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	1,212	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	332,567	332,567	332,567	332,567	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	239,053	239,053	239,053	239,053	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.003644	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	871	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	2,083	0	0	10.00
11.00	Total number of injections/infusions (from your records)	0	40	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	52.08	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	6	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees	0	0	0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	312	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		2,083			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		312			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 06/01/2020 To 05/31/2021	Worksheet M-5 Date/Time Prepared: 10/22/2021 7:54 am	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		495,978	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		01/11/2021	32,374	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)		-32,374	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		463,604	4.00	
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00	
Program to Provider					
5.01			0	5.01	
5.02			0	5.02	
5.03			0	5.03	
Provider to Program					
5.50			0	5.50	
5.51			0	5.51	
5.52			0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00	
6.01	SETTLEMENT TO PROVIDER		0	6.01	
6.02	SETTLEMENT TO PROGRAM		13,685	6.02	
7.00	Total Medicare program liability (see instructions)		449,919	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 06/01/2020 To 05/31/2021	Worksheet M-5 Date/Time Prepared: 10/22/2021 7:54 am	
			RHC II	Cost	
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		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	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01			0		3.01
3.02			0		3.02
3.03			0		3.03
3.04			0		3.04
3.05			0		3.05
Provider to Program					
3.50			0		3.50
3.51			0		3.51
3.52			0		3.52
3.53			0		3.53
3.54			0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		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			0		5.01
5.02			0		5.02
5.03			0		5.03
Provider to Program					
5.50			0		5.50
5.51			0		5.51
5.52			0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		0		7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN:14-1319 Component CCN:14-8587	Period: From 06/01/2020 To 05/31/2021	Worksheet M-5 Date/Time Prepared: 10/22/2021 7:54 am	
			RHC III	Cost	
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC			436,830	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		01/11/2021		42,674	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)			42,674	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			479,504	4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01				0	5.01
5.02				0	5.02
5.03				0	5.03
Provider to Program					
5.50				0	5.50
5.51				0	5.51
5.52				0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER			0	6.01
6.02	SETTLEMENT TO PROGRAM			40,033	6.02
7.00	Total Medicare program liability (see instructions)			439,471	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: 14-8615	Period: From 06/01/2020 To 05/31/2021	Worksheet M-5 Date/Time Prepared: 10/22/2021 7:54 am	
		RHC IV	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		21,278	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01			0		3.01
3.02			0		3.02
3.03			0		3.03
3.04			0		3.04
3.05			0		3.05
Provider to Program					
3.50			0		3.50
3.51			0		3.51
3.52			0		3.52
3.53			0		3.53
3.54			0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		21,278		4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01			0		5.01
5.02			0		5.02
5.03			0		5.03
Provider to Program					
5.50			0		5.50
5.51			0		5.51
5.52			0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER		0		6.01
6.02	SETTLEMENT TO PROGRAM		940		6.02
7.00	Total Medicare program liability (see instructions)		20,338		7.00
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00