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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1319	Period: From 06/01/2016 To 05/31/2017	Worksheet S Parts I-III Date/Time Prepared: 10/14/2017 11:13 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 10/14/2017 Time: 11:13 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received: 10/31/2016
7. Contractor No. 06101
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] 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 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 06/01/2016 and ending 05/31/2017 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.

(Signed)_____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	459,824	-75,330	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	37,597	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	-31		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	-727		0	9.00
10.00	KEWANEE RHC I	0		0		0	10.00
10.01	WYOMING RHC II	0		0		0	10.01
200.00	Total	0	497,421	-76,088	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1319	Period: From 06/01/2016 To 05/31/2017	Worksheet S-2 Part I Date/Time Prepared: 10/14/2017 11:12 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	99914	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	14Z319	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		08/07/2017	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	HAMMOND-HENRY HOSPITAL RHP-WYOMING	148577	99914		08/07/2017	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	06/01/2016	05/31/2017	20.00
21.00	Type of Control (see instructions)	11		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 10/14/2017 11:12 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	

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		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	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 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00

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		1.00	2.00	3.00	
76.00	If line 75 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 a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.	N	87.00

		V	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
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	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	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	323,956	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 state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	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
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N	N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 10/14/2017 11:12 am

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	Y	Y	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
161.10	CORF		N	N	N	161.10
					1.00	
	Multicampus					
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
							1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	06/01/2016	05/31/2017	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	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 10/14/2017 11:12 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		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

Attachment A - Audited Financial Statements to be available later.

		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

Exhibit 5

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	08/11/2017	Y	08/11/2017	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

Attachments B - E

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 10/14/2017 11:12 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.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	Y	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	Y	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	35.00

Attachment F

Attachment G

		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.	ANDREW	MCCABE	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.	715-858-6660	AMCCABE@WIPFLI.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1319	Period: From 06/01/2016 To 05/31/2017	Worksheet S-2 Part II Date/Time Prepared: 10/14/2017 11:12 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

HFS Supplemental Information | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet S-2 Part IX | Date/Time Prepared: 10/14/2017 11:12 am

		Title V	Title XIX	
		1.00	2.00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE			
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?	N	N	3.01
		Inpatient	Outpatient	
		1.00	2.00	
	CRITICAL ACCESS HOSPITALS			
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
	RCE DISALLOWANCE			
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
	PASS THROUGH COST			
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "O") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00
	RHC			
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00
	FQHC			
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	9.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 10/14/2017 11:12 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	72,072.00	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	72,072.00	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	72,072.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	37	13,505		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	46.00	0	0			21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	99.10				0	25.10
26.00	KEWANEE RHC	88.00				0	26.00
26.01	WYOMING RHC	88.01				0	26.01
26.25	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 10/14/2017 11:12 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)	1,313	156	3,003			1.00
2.00	HMO and other (see instructions)	346	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	216	0	269			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	12			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,529	156	3,284			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		194	348			13.00
14.00	Total (see instructions)	1,529	350	3,632	0.00	229.38	14.00
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	935	0	12,356	0.00	23.84	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE			0	0.00	0.00	21.00
22.00	HOME HEALTH AGENCY	4,882	0	8,603	0.00	8.12	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00	KEWANEE RHC	0	0	1,526	0.00	1.61	26.00
26.01	WYOMING RHC	0	0	244	0.00	0.24	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	263.19	27.00
28.00	Observation Bed Days		0	787			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)			89			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 10/14/2017 11:12 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		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	424	52	1,076	1.00
2.00	HMO and other (see instructions)			109	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	424	52	1,076	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	0.00				0	21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					25.10
26.00	KEWANEE RHC	0.00					26.00
26.01	WYOMING RHC	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 14-1319 | Component CCN: 14-7450 | Period: From 06/01/2016 To 05/31/2017 | Worksheet S-4 | Date/Time Prepared: 10/14/2017 11:12 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	13,556	0	0	13,556	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	268.00	0.00	0.00	268.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.84	0.00	0.84	5.00
6.00	Direct Nursing Service			0.00	0.00	0.00	6.00
7.00	Nursing Supervisor			1.00	0.00	1.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			6.52	0.00	6.52	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					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	2,114	159	70	50	2,393	21.00
22.00	Skilled Nursing Visit Charges	342,837	25,769	11,377	8,138	388,121	22.00
23.00	Physical Therapy Visits	969	43	3	31	1,046	23.00
24.00	Physical Therapy Visit Charges	193,808	8,626	602	6,219	209,255	24.00
25.00	Occupational Therapy Visits	596	53	2	4	655	25.00
26.00	Occupational Therapy Visit Charges	119,004	10,632	401	802	130,839	26.00
27.00	Speech Pathology Visits	97	0	0	4	101	27.00
28.00	Speech Pathology Visit Charges	19,439	0	0	802	20,241	28.00
29.00	Medical Social Service Visits	13	0	0	0	13	29.00
30.00	Medical Social Service Visit Charges	3,233	0	0	0	3,233	30.00
31.00	Home Health Aide Visits	549	121	0	4	674	31.00
32.00	Home Health Aide Visit Charges	46,885	10,557	0	351	57,793	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,338	376	75	93	4,882	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)	725,206	55,584	12,380	16,312	809,482	35.00
36.00	Total Number of Episodes (standard/non outlier)	255		25	9	289	36.00
37.00	Total Number of Outlier Episodes		10		0	10	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet S-7 | Date/Time Prepared: 10/14/2017 11:12 am

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	05/21/2003	2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	13	0	13	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	45	0	45	12.00
13.00		RUB	13	0	13	13.00
14.00		RUA	11	0	11	14.00
15.00		RVC	0	0	0	15.00
16.00		RVB	32	0	32	16.00
17.00		RVA	370	0	370	17.00
18.00		RHC	30	0	30	18.00
19.00		RHB	70	0	70	19.00
20.00		RHA	194	0	194	20.00
21.00		RMC	27	0	27	21.00
22.00		RMB	68	0	68	22.00
23.00		RMA	40	0	40	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	8	0	8	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	9	0	9	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	5	0	5	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	0	0	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	0	0	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	0	0	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet S-7 | Date/Time Prepared: 10/14/2017 11:12 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		935	0	935	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	99914	99914	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	817,616	33.47	Y	202.00
203.00	Recruitment	0	0.00	N	203.00
204.00	Retention of employees	0	0.00	N	204.00
205.00	Training	392	0.02	N	205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	2,442,987			207.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1319 | Component CCN: 14-8576 | Period: From 06/01/2016 To 05/31/2017 | Worksheet S-8 | Date/Time Prepared: 10/14/2017 11:12 am

RHC I | Cost

					1.00		
	Clinic Address and Identification						
1.00	Street				1258 WEST SOUTH STREET #2		1.00
		City			State	ZIP Code	
		1.00			2.00	3.00	
2.00	City, State, ZIP Code, County	KEWANEE			IL	61443	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0	3.00
				Grant Award		Date	
				1.00		2.00	
	Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS Act)						4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)						5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)						6.00
7.00	Appalachian Regional Commission						7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECIFY)						9.00
					1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N	0	10.00
		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			07:30	18:00	07:30	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC name, CCN number						14.00
		Y/N	V	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	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 06/01/2016
To 05/31/2017

Worksheet S-8

Date/Time Prepared:
10/14/2017 11:12 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: 14-8577 | Period: From 06/01/2016 To 05/31/2017 | Worksheet S-8 | Date/Time Prepared: 10/14/2017 11:12 am

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			101 SOUTH GALENA AVENUE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	WYOMING		IL	61491	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:30	17:00	08:30	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
			Provider name		CCN number	
			1.00		2.00	
14.00	RHC/FQHC name, CCN number					14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
			County				
			4.00				
2.00	City, State, ZIP Code, County		STARK				2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	17:00	08:30	12:00			11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 14-1319 Component CCN: 14-8577	Period: From 06/01/2016 To 05/31/2017	Worksheet S-8 Date/Time Prepared: 10/14/2017 11:12 am
		RHC II	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:30	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1319	Period: From 06/01/2016 To 05/31/2017	Worksheet S-10 Date/Time Prepared: 10/14/2017 11:12 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)	0.398784	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	639,750	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH or supplemental payments from Medicaid	693,641	5.00
6.00	Medicaid charges	2,163,090	6.00
7.00	Medicaid cost (line 1 times line 6)	862,606	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)	82,913	269,883	352,796	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	33,064	269,883	302,947	21.00
22.00	Payments received from patients for amounts previously written off as charity care	749	46,473	47,222	22.00
23.00	Cost of charity care (line 21 minus line 22)	32,315	223,410	255,725	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, 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)	1,091,764	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	27,828	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	42,812	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	1,048,952	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	433,289	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	689,014	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	689,014	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet A | Date/Time Prepared: 10/14/2017 11:12 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,103,283	2,103,283	861,881	2,965,164	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,005,957	1,005,957	18,674	1,024,631	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	116,474	3,834,294	3,950,768	-239,048	3,711,720	4.00
5.01	00550	DATA PROCESSING	329,038	674,741	1,003,779	0	1,003,779	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	114,487	5,275	119,762	0	119,762	5.02
5.03	00570	ADMITTING	155,446	51,306	206,752	0	206,752	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	295,777	299,072	594,849	0	594,849	5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	666,183	1,807,274	2,473,457	-82,658	2,390,799	5.05
7.00	00700	OPERATION OF PLANT	209,462	958,573	1,168,035	0	1,168,035	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	30,393	100,260	130,653	0	130,653	8.00
9.00	00900	HOUSEKEEPING	378,838	101,167	480,005	0	480,005	9.00
10.00	01000	DIETARY	455,181	402,362	857,543	0	857,543	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	151,119	6,933	158,052	0	158,052	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	28,275	28,275	0	28,275	14.00
15.00	01500	PHARMACY	212,855	195,648	408,503	0	408,503	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	344,963	64,822	409,785	0	409,785	16.00
17.00	01700	SOCIAL SERVICE	98,334	958	99,292	0	99,292	17.00
18.00	01080	INSERVICE EDUCATION	96,378	45,913	142,291	0	142,291	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,135,985	202,679	2,338,664	-23,501	2,315,163	30.00
43.00	04300	NURSERY	0	14,316	14,316	8,314	22,630	43.00
44.00	04400	SKILLED NURSING FACILITY	859,067	158,896	1,017,963	0	1,017,963	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	1,216,370	2,714,498	3,930,868	-1,188,620	2,742,248	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	15,187	15,187	52.00
53.00	05300	ANESTHESIOLOGY	731,443	0	731,443	148,687	880,130	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	801,284	1,161,977	1,963,261	0	1,963,261	54.00
60.00	06000	LABORATORY	642,393	905,075	1,547,468	0	1,547,468	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	103,241	103,241	0	103,241	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,171,246	61,548	1,232,794	0	1,232,794	66.00
67.00	06700	OCCUPATIONAL THERAPY	346,687	22,915	369,602	0	369,602	67.00
68.00	06800	SPEECH PATHOLOGY	96,750	7,816	104,566	0	104,566	68.00
69.00	06900	ELECTROCARDIOLOGY	210,479	197,945	408,424	0	408,424	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	1,188,620	1,188,620	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,134,957	1,134,957	0	1,134,957	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	68,696	64,225	132,921	0	132,921	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	149,082	40,101	189,183	0	189,183	88.00
88.01	08801	WYOMING RHC	12,216	7,573	19,789	0	19,789	88.01
90.00	09000	CLINIC	633,968	228,224	862,192	120,108	982,300	90.00
90.01	09001	OB 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	47,819	1,628,893	1,676,712	0	1,676,712	90.03
91.00	09100	EMERGENCY	667,480	1,560,372	2,227,852	10,609	2,238,461	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	464,256	98,484	562,740	0	562,740	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		838,253	838,253	-838,253	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,910,149	22,838,101	36,748,250	0	36,748,250	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	2,984	2,984	0	2,984	192.01
192.02	19201	CARDIOLOGY CLINIC	44	0	44	0	44	192.02
192.03	19202	LEASED SPACE	66,981	71,993	138,974	0	138,974	192.03
194.00	07955	FOUNDATION	0	0	0	0	0	194.00
194.01	07950	SPORTS MEDICINE	118,558	25,491	144,049	0	144,049	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	6,251	6,251	0	6,251	194.07

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet A | Date/Time Prepared: 10/14/2017 11:12 am

	Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
200.00	TOTAL (SUM OF LINES 118-199)	14,095,732	22,944,820	37,040,552	0	37,040,552	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet A | Date/Time Prepared: 10/14/2017 11:12 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	42,469	3,007,633		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-24,121	1,000,510		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,711,720		4.00
5.01	00550	DATA PROCESSING	0	1,003,779		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-37,654	82,108		5.02
5.03	00570	ADMITTING	0	206,752		5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	-84,725	510,124		5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	-91,631	2,299,168		5.05
7.00	00700	OPERATION OF PLANT	0	1,168,035		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	130,653		8.00
9.00	00900	HOUSEKEEPING	0	480,005		9.00
10.00	01000	DIETARY	-182,458	675,085		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	158,052		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	28,275		14.00
15.00	01500	PHARMACY	0	408,503		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-914	408,871		16.00
17.00	01700	SOCIAL SERVICE	0	99,292		17.00
18.00	01080	INSERVICE EDUCATION	0	142,291		18.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-4,844	2,310,319		30.00
43.00	04300	NURSERY	0	22,630		43.00
44.00	04400	SKILLED NURSING FACILITY	-7,945	1,010,018		44.00
46.00	04600	OTHER LONG TERM CARE	0	0		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-129,188	2,613,060		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	15,187		52.00
53.00	05300	ANESTHESIOLOGY	-880,130	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,963,261		54.00
60.00	06000	LABORATORY	0	1,547,468		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	103,241		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	-581	1,232,213		66.00
67.00	06700	OCCUPATIONAL THERAPY	-194	369,408		67.00
68.00	06800	SPEECH PATHOLOGY	0	104,566		68.00
69.00	06900	ELECTROCARDIOLOGY	-24,791	383,633		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,188,620		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,134,957		73.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	-388	132,533		76.01
76.02	03950	IV THERAPY	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	KEWANEE RHC	0	189,183		88.00
88.01	08801	WYOMING RHC	0	19,789		88.01
90.00	09000	CLINIC	-392,327	589,973		90.00
90.01	09001	OB CLINIC	0	0		90.01
90.02	09002	SPECIALTY CLINIC	0	0		90.02
90.03	09003	SURGICAL CLINIC	-1,175,565	501,147		90.03
91.00	09100	EMERGENCY	-798,368	1,440,093		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				92.00
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	562,740		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,793,355	32,954,895		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	2,984		192.01
192.02	19201	CARDIOLOGY CLINIC	0	44		192.02
192.03	19202	LEASED SPACE	0	138,974		192.03
194.00	07955	FOUNDATION	0	0		194.00
194.01	07950	SPORTS MEDICINE	0	144,049		194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0		194.02
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	6,251		194.07
200.00		TOTAL (SUM OF LINES 118-199)	-3,793,355	33,247,197		200.00

COST CENTERS USED IN COST REPORT | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet Non-CMS W | Date/Time Prepared: 10/14/2017 11:12 am

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.01	DATA PROCESSING	00550	DATA PROCESSING	5.01
5.02	PURCHASING RECEIVING AND STORES	00560	PURCHASING RECEIVING AND STORES	5.02
5.03	ADMITTING	00570	ADMITTING	5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.04
5.05	ALL OTHER ADMINISTRATIVE AND GE	00590		5.05
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
18.00	INSERVICE EDUCATION	01080	INSERVICE EDUCATION	18.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
43.00	NURSERY	04300		43.00
44.00	SKILLED NURSING FACILITY	04400		44.00
46.00	OTHER LONG TERM CARE	04600		46.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	05000		50.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD	06200		62.00
64.00	INTRAVENOUS THERAPY	06400		64.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PAT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.00	ACUPUNCTURE	03020	ACUPUNCTURE	76.00
76.01	SLEEP LAB	03610	SLEEP LAB	76.01
76.02	IV THERAPY	03950		76.02
	OUTPATIENT SERVICE COST CENTERS			
88.00	KEWANEE RHC	08800		88.00
88.01	WYOMING RHC	08801		88.01
90.00	CLINIC	09000		90.00
90.01	OB CLINIC	09001		90.01
90.02	SPECIALTY CLINIC	09002		90.02
90.03	SURGICAL CLINIC	09003		90.03
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT	09200		92.00
	OTHER REIMBURSABLE COST CENTERS			
99.10	CORF	09910		99.10
101.00	HOME HEALTH AGENCY	10100		101.00
	SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT FLOWER COFFEE SHOP & CAN	19000		190.00
192.00	PHYSICIANS PRIVATE OFFICES	19200		192.00
192.01	MUSCATINE CLINIC	19203		192.01
192.02	CARDIOLOGY CLINIC	19201		192.02
192.03	LEASED SPACE	19202		192.03
194.00	FOUNDATION	07955		194.00
194.01	SPORTS MEDICINE	07950		194.01
194.02	KELLY MEDICAL RENTAL AREA	07951		194.02
194.03	ANESTHESIA BILLNG	07952		194.03
194.04	SPECIALTY CLINIC	07953		194.04
194.05	COLONA CLINIC	07954		194.05

COST CENTERS USED IN COST REPORT | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet Non-CMS W | Date/Time Prepared: 10/14/2017 11:12 am

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
194.06	TRINITY/DIALYSIS LEASED SPACE	07956		194.06
194.07	COMMUNITY HEALTH	07957		194.07
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet A-6 | Date/Time Prepared: 10/14/2017 11:12 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	38,958		1.00
	TOTALS		0	38,958		
	C - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	838,253		1.00
	TOTALS		0	838,253		
	E - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	62,586		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	18,674		2.00
3.00	CLINIC	90.00	0	1,398		3.00
	TOTALS		0	82,658		
	F - DELIVERY AND LABOR RECLASS					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	15,187	0		1.00
2.00	NURSERY	43.00	8,314	0		2.00
	TOTALS		23,501	0		
	H - IMPLANT EXP RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,188,620		1.00
	TOTALS		0	1,188,620		
	I - PHYSICIAN AND MID-LEVEL BENEFITS					
1.00	ANESTHESIOLOGY	53.00	0	148,687		1.00
2.00	CLINIC	90.00	0	79,752		2.00
3.00	EMERGENCY	91.00	0	10,609		3.00
	TOTALS		0	239,048		
500.00	Grand Total: Increases		23,501	2,387,537		500.00

RECLASSIFICATIONS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet A-6 | Date/Time Prepared: 10/14/2017 11:12 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - COLONA CLINIC BUILDING DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	38,958	9		1.00
	TOTALS		0	38,958			
	C - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	838,253	11		1.00
	TOTALS		0	838,253			
	E - OTHER CAPITAL COSTS						
1.00	ALL OTHER ADMINISTRATIVE AND GE	5.05	0	82,658	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	82,658			
	F - DELIVERY AND LABOR RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	23,501	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		23,501	0			
	H - IMPLANT EXP RECLASS						
1.00	OPERATING ROOM	50.00	0	1,188,620	0		1.00
	TOTALS		0	1,188,620			
	I - PHYSICIAN AND MID-LEVEL BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	239,048	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	239,048			
500.00	Grand Total: Decreases		23,501	2,387,537			500.00

RECLASSIFICATIONS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 10/14/2017 11:12 am

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	A - COLONA CLINIC BUILDING DEPRECIATION								
1.00	CLINIC	90.00	0	38,958	CAP REL COSTS-BLDG & FIXT	1.00	0	38,958	1.00
	TOTALS		0	38,958	TOTALS		0	38,958	
	C - INTEREST EXPENSE								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	838,253	INTEREST EXPENSE	113.00	0	838,253	1.00
	TOTALS		0	838,253	TOTALS		0	838,253	
	E - OTHER CAPITAL COSTS								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	62,586	ALL OTHER ADMINISTRATIVE AND GE	5.05	0	82,658	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	18,674		0.00	0	0	2.00
3.00	CLINIC	90.00	0	1,398		0.00	0	0	3.00
	TOTALS		0	82,658	TOTALS		0	82,658	
	F - DELIVERY AND LABOR RECLASS								
1.00	DELIVERY ROOM & LABOR ROOM	52.00	15,187	0	ADULTS & PEDIATRICS	30.00	23,501	0	1.00
2.00	NURSERY	43.00	8,314	0		0.00	0	0	2.00
	TOTALS		23,501	0	TOTALS		23,501	0	
	H - IMPLANT EXP RECLASS								
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,188,620	OPERATING ROOM	50.00	0	1,188,620	1.00
	TOTALS		0	1,188,620	TOTALS		0	1,188,620	
	I - PHYSICIAN AND MID-LEVEL BENEFITS								
1.00	ANESTHESIOLOGY	53.00	0	148,687	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	239,048	1.00
2.00	CLINIC	90.00	0	79,752		0.00	0	0	2.00
3.00	EMERGENCY	91.00	0	10,609		0.00	0	0	3.00
	TOTALS		0	239,048	TOTALS		0	239,048	
500.00	Grand Total: Increases		23,501	2,387,537	Grand Total: Decreases		23,501	2,387,537	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 10/14/2017 11:12 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,316,669	0	0	0	0	1.00
2.00	Land Improvements	1,601,201	28,735	0	28,735	0	2.00
3.00	Buildings and Fixtures	44,854,741	82,733	0	82,733	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	12,468,069	1,866,869	0	1,866,869	898,245	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	60,240,680	1,978,337	0	1,978,337	898,245	8.00
9.00	Reconciling Items	-125,271	-17,251	0	-17,251	-70,831	9.00
10.00	Total (line 8 minus line 9)	60,365,951	1,995,588	0	1,995,588	969,076	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,316,669	0	1.00
2.00	Land Improvements	1,629,936	0	2.00
3.00	Buildings and Fixtures	44,937,474	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	13,436,693	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	61,320,772	0	8.00
9.00	Reconciling Items	-71,691	0	9.00
10.00	Total (line 8 minus line 9)	61,392,463	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet A-7 Part II | Date/Time Prepared: 10/14/2017 11:12 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	2,103,283	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,005,957	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,109,240	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	2,103,283		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,005,957		2.00
3.00	Total (sum of lines 1-2)	0	3,109,240		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet A-7 Part III | Date/Time Prepared: 10/14/2017 11:12 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	46,039,548	0	46,039,548	0.774083	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	13,436,693	0	13,436,693	0.225917	0	2.00
3.00	Total (sum of lines 1-2)	59,476,241	0	59,476,241	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,064,325	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	981,836	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,046,161	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	880,722	62,586	0	0	3,007,633	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	18,674	0	0	1,000,510	2.00
3.00	Total (sum of lines 1-2)	880,722	81,260	0	0	4,008,143	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet A-8 | Date/Time Prepared: 10/14/2017 11:12 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
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)	A	-642	PURCHASING RECEIVING AND STORES	5.02	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	A	-37,012	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	-3,377	ALL OTHER ADMINISTRATIVE AND GE	5.05	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,516,557			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	-182,458	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	-914	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** 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
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet A-8 | Date/Time Prepared: 10/14/2017 11:12 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-24,121	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	ADVERTISING EXPENSE	A	-71,304	ALL OTHER ADMINISTRATIVE AND GE	5.05	0	33.00
33.01	PART B BILLING	A	-84,725	CASHIERING/ACCOUNTS RECEIVABLE	5.04	0	33.01
33.02	PHYSICIAN RECRUITING	A	-7,671	ALL OTHER ADMINISTRATIVE AND GE	5.05	0	33.02
33.03	UNAMMORTIZED BOND ISSUE COST	B	42,469	CAP REL COSTS-BLDG & FIXT	1.00	11	33.03
33.04	TV SERVICE - MED SURG	A	-4,844	ADULTS & PEDIATRICS	30.00	0	33.04
33.05	TV SERVICE - CARDIAC	A	-388	ELECTROCARDIOLOGY	69.00	0	33.05
33.06	TV SERVICE - LTC	A	-7,945	SKILLED NURSING FACILITY	44.00	0	33.06
33.07	TV SERVICE - OR	A	-3,100	OPERATING ROOM	50.00	0	33.07
33.08	TV SERVICE - ER	A	-194	EMERGENCY	91.00	0	33.08
33.09	TV SERVICE - PT	A	-581	PHYSICAL THERAPY	66.00	0	33.09
33.10	TV SERVICE - OT	A	-194	OCCUPATIONAL THERAPY	67.00	0	33.10
33.11	TV SERVICE - SLEEP	A	-388	SLEEP LAB	76.01	0	33.11
33.12	CRNA EXPENSES	A	-880,130	ANESTHESIOLOGY	53.00	0	33.12
33.13			0		0.00	0	33.13
33.14	LOBBYING	A	-9,279	ALL OTHER ADMINISTRATIVE AND GE	5.05	0	33.14
33.15			0		0.00	0	33.15
33.16			0		0.00	0	33.16
33.17			0		0.00	0	33.17
33.18			0		0.00	0	33.18
33.19			0		0.00	0	33.19
33.21			0		0.00	0	33.21
33.23			0		0.00	0	33.23
33.24			0		0.00	0	33.24
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,793,355				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 06/01/2016 To 05/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 10/14/2017 11:12 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	35,983	0	35,983	0	0	1.00
2.00	91.00	EMERGENCY	1,451,226	798,174	653,052	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	24,403	24,403	0	0	0	3.00
4.00	90.00	CLINIC	392,327	392,327	0	0	0	4.00
5.00	90.03	SURGICAL CLINIC	1,175,565	1,175,565	0	0	0	5.00
6.00	50.00	OPERATING ROOM	126,088	126,088	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,205,592	2,516,557	689,035		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	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	0		1.00
2.00	91.00	EMERGENCY	0	0	0	798,174		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	24,403		3.00
4.00	90.00	CLINIC	0	0	0	392,327		4.00
5.00	90.03	SURGICAL CLINIC	0	0	0	1,175,565		5.00
6.00	50.00	OPERATING ROOM	0	0	0	126,088		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,516,557		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet B Part I Date/Time Prepared: 10/14/2017 11:12 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,007,633	3,007,633				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,000,510		1,000,510			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,711,720	14,336	3,113	3,729,169		4.00
5.01	00550	DATA PROCESSING	1,003,779	59,640	72,744	96,114	1,232,277	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	82,108	64,335	0	33,442	11,512	5.02
5.03	00570	ADMITTING	206,752	25,699	0	45,407	37,858	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	510,124	24,825	1,241	75,653	0	5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	2,299,168	76,598	12,665	144,263	199,742	5.05
7.00	00700	OPERATION OF PLANT	1,168,035	177,522	16,859	61,185	27,453	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	130,653	19,131	1,482	8,878	0	8.00
9.00	00900	HOUSEKEEPING	480,005	33,342	0	110,661	3,764	9.00
10.00	01000	DIETARY	675,085	75,849	11,727	132,961	14,922	10.00
11.00	01100	CAFETERIA	0	49,400	0	0	2,967	11.00
13.00	01300	NURSING ADMINISTRATION	158,052	11,888	438	94,476	31,261	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	28,275	2,647	0	0	0	14.00
15.00	01500	PHARMACY	408,503	30,719	2,178	62,176	22,582	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	408,871	35,290	6,980	100,766	84,351	16.00
17.00	01700	SOCIAL SERVICE	99,292	8,417	0	28,724	8,856	17.00
18.00	01080	INSERVICE EDUCATION	142,291	23,127	0	28,153	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,310,319	285,938	95,953	617,061	190,983	30.00
43.00	04300	NURSERY	22,630	4,820	6,453	2,429	611	43.00
44.00	04400	SKILLED NURSING FACILITY	1,010,018	366,382	34,266	250,939	49,902	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	2,613,060	304,545	316,755	355,309	77,621	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,187	2,073	0	4,436	1,727	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,963,261	185,889	221,820	234,060	63,761	54.00
60.00	06000	LABORATORY	1,547,468	58,491	60,493	187,647	48,042	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	103,241	1,923	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,232,213	191,283	25,718	342,128	61,326	66.00
67.00	06700	OCCUPATIONAL THERAPY	369,408	75,175	402	101,269	6,952	67.00
68.00	06800	SPEECH PATHOLOGY	104,566	12,413	0	28,261	4,516	68.00
69.00	06900	ELECTROCARDIOLOGY	383,633	25,824	12,038	61,482	14,789	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	1,188,620	5,245	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,134,957	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	132,533	15,809	0	20,067	0	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	189,183	0	0	43,548	16,808	88.00
88.01	08801	WYOMING RHC	19,789	0	0	3,568	2,807	88.01
90.00	09000	CLINIC	589,973	0	32,675	70,585	59,174	90.00
90.01	09001	OB 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	501,147	41,059	28,572	13,968	13,089	90.03
91.00	09100	EMERGENCY	1,440,093	149,475	29,562	179,730	133,279	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	562,740	24,301	270	135,612	41,622	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	32,954,895	2,483,410	994,404	3,674,958	1,232,277	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	13,661	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	2,984	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	44	0	0	13	0	192.02
192.03	19202	LEASED SPACE	138,974	90,185	5,872	19,566	0	192.03
194.00	07955	FOUNDATION	0	8,392	0	0	0	194.00
194.01	07950	SPORTS MEDICINE	144,049	0	234	34,632	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	12,138	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

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet B Part I Date/Time Prepared: 10/14/2017 11:12 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	399,847	0	0	0	194.06
194.07	07957	COMMUNITY HEALTH	6,251	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	33,247,197	3,007,633	1,000,510	3,729,169	1,232,277	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet B Part I Date/Time Prepared: 10/14/2017 11:12 am

		Cost Center Description	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS 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	191,397					5.02
5.03	00570	ADMITTING	182	315,898				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	297	0	612,140			5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	520	0	0	2,732,956	2,732,956	5.05
7.00	00700	OPERATION OF PLANT	2,785	0	0	1,453,839	131,939	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	160,144	14,533	8.00
9.00	00900	HOUSEKEEPING	2,676	0	0	630,448	57,214	9.00
10.00	01000	DIETARY	1,948	0	0	912,492	82,810	10.00
11.00	01100	CAFETERIA	0	0	0	52,367	4,752	11.00
13.00	01300	NURSING ADMINISTRATION	99	0	0	296,214	26,882	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,870	0	0	32,792	2,976	14.00
15.00	01500	PHARMACY	90	0	0	526,248	47,758	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	160	0	0	636,418	57,756	16.00
17.00	01700	SOCIAL SERVICE	20	0	0	145,309	13,187	17.00
18.00	01080	INSERVICE EDUCATION	1,115	0	0	194,686	17,668	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,462	15,819	29,836	3,553,371	322,476	30.00
43.00	04300	NURSERY	784	1,452	2,740	41,919	3,804	43.00
44.00	04400	SKILLED NURSING FACILITY	2,328	0	18,532	1,732,367	157,216	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	53,190	78,372	147,743	3,946,595	358,177	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,834	3,459	28,716	2,606	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,768	64,804	122,229	2,867,592	260,240	54.00
60.00	06000	LABORATORY	23,605	40,236	75,890	2,041,872	185,304	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	945	1,783	107,892	9,791	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,074	21,242	40,065	1,915,049	173,795	66.00
67.00	06700	OCCUPATIONAL THERAPY	291	6,994	13,192	573,683	52,063	67.00
68.00	06800	SPEECH PATHOLOGY	70	1,117	2,107	153,050	13,890	68.00
69.00	06900	ELECTROCARDIOLOGY	884	14,865	27,397	540,912	49,089	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,647	3,107	4,754	431	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	65,115	12,049	22,727	1,293,756	117,411	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,955	39,524	1,195,436	108,488	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	210	3,956	7,461	180,036	16,339	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	929	0	2,529	252,997	22,960	88.00
88.01	08801	WYOMING RHC	344	0	422	26,930	2,444	88.01
90.00	09000	CLINIC	2,096	0	8,903	763,406	69,281	90.00
90.01	09001	OB 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	1,473	1,044	1,969	602,321	54,662	90.03
91.00	09100	EMERGENCY	5,592	28,567	33,883	2,000,181	181,520	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	1,755	0	6,642	772,942	70,146	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	190,732	315,898	612,140	32,369,690	2,689,608	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	13,661	1,240	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	163	0	0	3,147	286	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	57	5	192.02
192.03	19202	LEASED SPACE	58	0	0	254,655	23,110	192.03
194.00	07955	FOUNDATION	141	0	0	8,533	774	194.00
194.01	07950	SPORTS MEDICINE	303	0	0	179,218	16,264	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	12,138	1,102	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	399,847	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	6,251	567	194.07
200.00		Cross Foot Adjustments				0		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet B Part I Date/Time Prepared: 10/14/2017 11:12 am

	Cost Center Description	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	ALL OTHER ADMINISTRATIVE AND GE	
		5.02	5.03	5.04	5A.04	5.05	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	191,397	315,898	612,140	33,247,197	2,732,956	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet B Part I | Date/Time Prepared: 10/14/2017 11:12 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	1,585,778					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	14,014	188,691				8.00
9.00	00900	HOUSEKEEPING	24,423	18,795	730,880			9.00
10.00	01000	DIETARY	55,561	507	39,159	1,090,529		10.00
11.00	01100	CAFETERIA	36,187	0	6,803	705,061	805,170	11.00
13.00	01300	NURSING ADMINISTRATION	8,708	0	0	0	19,311	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,939	0	0	0	0	14.00
15.00	01500	PHARMACY	22,502	0	2,891	0	13,759	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25,850	0	6,165	0	50,808	16.00
17.00	01700	SOCIAL SERVICE	6,165	0	1,828	0	9,041	17.00
18.00	01080	INSERVICE EDUCATION	16,941	0	0	0	7,322	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	209,455	38,997	197,857	92,723	161,514	30.00
43.00	04300	NURSERY	3,531	1,952	3,401	0	541	43.00
44.00	04400	SKILLED NURSING FACILITY	268,383	51,952	181,721	292,745	117,144	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	223,085	24,103	113,140	0	89,873	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,518	488	1,423	0	934	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	136,167	16,234	29,040	0	66,041	54.00
60.00	06000	LABORATORY	42,846	0	16,369	0	71,250	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	1,409	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	140,119	13,217	24,193	0	88,890	66.00
67.00	06700	OCCUPATIONAL THERAPY	55,067	0	4,719	0	24,864	67.00
68.00	06800	SPEECH PATHOLOGY	9,092	0	0	0	6,683	68.00
69.00	06900	ELECTROCARDIOLOGY	18,917	0	8,333	0	17,493	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	3,842	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	11,580	1,596	0	0	6,240	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
90.00	09000	CLINIC	0	833	0	0	0	90.00
90.01	09001	OB 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	30,076	0	8,589	0	0	90.03
91.00	09100	EMERGENCY	109,493	18,376	38,096	0	44,863	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	17,801	0	3,104	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,494,671	187,050	686,831	1,090,529	796,571	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	10,007	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	66,062	110	34,312	0	8,599	192.03
194.00	07955	FOUNDATION	6,147	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	8,891	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	1,531	9,737	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

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet B Part I Date/Time Prepared: 10/14/2017 11:12 am

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
202.00	TOTAL (sum lines 118-201)	1,585,778	188,691	730,880	1,090,529	805,170	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet B Part I | Date/Time Prepared: 10/14/2017 11:12 am

		Cost Center Description	NURSING ADMINISTRATION	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	351,115					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	37,707				14.00
15.00	01500	PHARMACY	12,104	0	625,262			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	776,997		16.00
17.00	01700	SOCIAL SERVICE	7,954	0	0	0	183,484	17.00
18.00	01080	INSERVICE EDUCATION	6,441	0	0	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	142,098	0	0	39,272	71,068	30.00
43.00	04300	NURSERY	476	0	0	3,606	630	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	4,387	94,227	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	79,068	0	0	194,491	151	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	821	0	0	4,553	160	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	160,883	0	54.00
60.00	06000	LABORATORY	62,684	0	0	99,889	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	2,346	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	52,735	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	17,364	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,773	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	36,061	452	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	37,707	0	4,089	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	29,914	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	625,262	52,023	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	9,820	0	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0	0	0	3,328	0	88.00
88.01	08801	WYOMING RHC	0	0	0	556	0	88.01
90.00	09000	CLINIC	0	0	0	11,718	0	90.00
90.01	09001	OB 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	2,591	0	90.03
91.00	09100	EMERGENCY	39,469	0	0	44,598	14,612	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	2,184	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	351,115	37,707	625,262	776,997	183,484	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	0	0	0	0	192.03
194.00	07955	FOUNDATION	0	0	0	0	0	194.00
194.01	07950	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet B Part I Date/Time Prepared: 10/14/2017 11:12 am

	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	351,115	37,707	625,262	776,997	183,484	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet B Part I | Date/Time Prepared: 10/14/2017 11:12 am

		Cost Center Description	OTHER GENERAL SERVICE INSERVICE EDUCATION	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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	243,058					18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,976	4,840,807	0	4,840,807		30.00
43.00	04300	NURSERY	1,100	60,960	0	60,960		43.00
44.00	04400	SKILLED NURSING FACILITY	7,439	2,907,581	0	2,907,581		44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0		46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	59,317	5,088,000	0	5,088,000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,389	42,608	0	42,608		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	49,062	3,585,259	0	3,585,259		54.00
60.00	06000	LABORATORY	30,462	2,550,676	0	2,550,676		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	716	122,154	0	122,154		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	16,082	2,424,080	0	2,424,080		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,295	733,055	0	733,055		67.00
68.00	06800	SPEECH PATHOLOGY	846	186,334	0	186,334		68.00
69.00	06900	ELECTROCARDIOLOGY	10,997	682,254	0	682,254		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,247	48,228	0	48,228		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,122	1,454,045	0	1,454,045		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,865	1,997,074	0	1,997,074		73.00
76.00	03020	ACUPUNCTURE	0	0	0	0		76.00
76.01	03610	SLEEP LAB	2,995	228,606	0	228,606		76.01
76.02	03950	IV THERAPY	0	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	1,015	280,300	0	280,300		88.00
88.01	08801	WYOMING RHC	169	30,099	0	30,099		88.01
90.00	09000	CLINIC	3,574	848,812	0	848,812		90.00
90.01	09001	OB CLINIC	0	0	0	0		90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0		90.02
90.03	09003	SURGICAL CLINIC	790	699,029	0	699,029		90.03
91.00	09100	EMERGENCY	13,600	2,504,808	0	2,504,808		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	866,177	0	866,177		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	243,058	32,180,946	0	32,180,946		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	24,908	0	24,908		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0		192.00
192.01	19203	MUSCATINE CLINIC	0	3,433	0	3,433		192.01
192.02	19201	CARDIOLOGY CLINIC	0	62	0	62		192.02
192.03	19202	LEASED SPACE	0	386,848	0	386,848		192.03
194.00	07955	FOUNDATION	0	15,454	0	15,454		194.00
194.01	07950	SPORTS MEDICINE	0	195,482	0	195,482		194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	22,131	0	22,131		194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0		194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0		194.04

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet B Part I Date/Time Prepared: 10/14/2017 11:12 am

		Cost Center Description	OTHER GENERAL SERVICE INSERVICE EDUCATION	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			18.00	24.00	25.00	26.00		
194.05	07954	COLONA CLINIC	0	0	0	0		194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	411,115	0	411,115		194.06
194.07	07957	COMMUNITY HEALTH	0	6,818	0	6,818		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 118-201)	243,058	33,247,197	0	33,247,197		202.00

COST ALLOCATION STATISTICS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet Non-CMS W | Date/Time Prepared: 10/14/2017 11:12 am

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

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet B Part II | Date/Time Prepared: 10/14/2017 11:12 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			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	14,336	3,113	17,449	17,449	4.00
5.01	00550	DATA PROCESSING	0	59,640	72,744	132,384	450	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	64,335	0	64,335	157	5.02
5.03	00570	ADMITTING	0	25,699	0	25,699	212	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	24,825	1,241	26,066	354	5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	0	76,598	12,665	89,263	675	5.05
7.00	00700	OPERATION OF PLANT	0	177,522	16,859	194,381	286	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	19,131	1,482	20,613	42	8.00
9.00	00900	HOUSEKEEPING	0	33,342	0	33,342	518	9.00
10.00	01000	DIETARY	0	75,849	11,727	87,576	622	10.00
11.00	01100	CAFETERIA	0	49,400	0	49,400	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	11,888	438	12,326	442	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,647	0	2,647	0	14.00
15.00	01500	PHARMACY	0	30,719	2,178	32,897	291	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	35,290	6,980	42,270	472	16.00
17.00	01700	SOCIAL SERVICE	0	8,417	0	8,417	134	17.00
18.00	01080	INSERVICE EDUCATION	0	23,127	0	23,127	132	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	285,938	95,953	381,891	2,885	30.00
43.00	04300	NURSERY	0	4,820	6,453	11,273	11	43.00
44.00	04400	SKILLED NURSING FACILITY	0	366,382	34,266	400,648	1,174	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	304,545	316,755	621,300	1,663	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,073	0	2,073	21	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	185,889	221,820	407,709	1,095	54.00
60.00	06000	LABORATORY	0	58,491	60,493	118,984	878	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	1,923	0	1,923	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	191,283	25,718	217,001	1,601	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	75,175	402	75,577	474	67.00
68.00	06800	SPEECH PATHOLOGY	0	12,413	0	12,413	132	68.00
69.00	06900	ELECTROCARDIOLOGY	0	25,824	12,038	37,862	288	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	5,245	0	5,245	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	15,809	0	15,809	94	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	204	88.00
88.01	08801	WYOMING RHC	0	0	0	0	17	88.01
90.00	09000	CLINIC	0	0	32,675	32,675	330	90.00
90.01	09001	OB 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	41,059	28,572	69,631	65	90.03
91.00	09100	EMERGENCY	0	149,475	29,562	179,037	841	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	0	24,301	270	24,571	635	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,483,410	994,404	3,477,814	17,195	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	13,661	0	13,661	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	90,185	5,872	96,057	92	192.03
194.00	07955	FOUNDATION	0	8,392	0	8,392	0	194.00
194.01	07950	SPORTS MEDICINE	0	0	234	234	162	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	12,138	0	12,138	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet B Part II Date/Time Prepared: 10/14/2017 11:12 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	399,847	0	399,847	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	3,007,633	1,000,510	4,008,143	17,449	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet B Part II Date/Time Prepared: 10/14/2017 11:12 am

		Cost Center Description	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS 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	132,834					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	1,241	65,733				5.02
5.03	00570	ADMITTING	4,081	63	30,055			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	102	0	26,522		5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	21,529	178	0	0	111,645	5.05
7.00	00700	OPERATION OF PLANT	2,959	956	0	0	5,389	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	594	8.00
9.00	00900	HOUSEKEEPING	406	919	0	0	2,337	9.00
10.00	01000	DIETARY	1,609	669	0	0	3,383	10.00
11.00	01100	CAFETERIA	320	0	0	0	194	11.00
13.00	01300	NURSING ADMINISTRATION	3,370	34	0	0	1,098	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	642	0	0	122	14.00
15.00	01500	PHARMACY	2,434	31	0	0	1,951	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,093	55	0	0	2,359	16.00
17.00	01700	SOCIAL SERVICE	955	7	0	0	539	17.00
18.00	01080	INSERVICE EDUCATION	0	383	0	0	722	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,587	2,563	1,506	1,294	13,172	30.00
43.00	04300	NURSERY	66	269	138	119	155	43.00
44.00	04400	SKILLED NURSING FACILITY	5,379	800	0	804	6,422	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	8,367	18,267	7,437	6,382	14,641	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	186	0	175	150	106	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,873	4,041	6,171	5,301	10,630	54.00
60.00	06000	LABORATORY	5,179	8,107	3,832	3,291	7,569	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	90	77	400	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	6,611	369	2,023	1,738	7,099	66.00
67.00	06700	OCCUPATIONAL THERAPY	749	100	666	572	2,127	67.00
68.00	06800	SPEECH PATHOLOGY	487	24	106	91	567	68.00
69.00	06900	ELECTROCARDIOLOGY	1,594	303	1,416	1,188	2,005	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	157	135	18	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,364	1,147	986	4,796	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,995	1,714	4,431	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	72	377	324	667	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	1,812	319	0	110	938	88.00
88.01	08801	WYOMING RHC	303	118	0	18	100	88.01
90.00	09000	CLINIC	6,379	720	0	386	2,830	90.00
90.01	09001	OB 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	1,411	506	99	85	2,233	90.03
91.00	09100	EMERGENCY	14,367	1,921	2,720	1,469	7,415	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	4,487	603	0	288	2,865	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	132,834	65,505	30,055	26,522	109,874	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	51	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	56	0	0	12	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	20	0	0	944	192.03
194.00	07955	FOUNDATION	0	48	0	0	32	194.00
194.01	07950	SPORTS MEDICINE	0	104	0	0	664	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	45	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	0	23	194.07
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet B Part II Date/Time Prepared: 10/14/2017 11:12 am

	Cost Center Description	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	ALL OTHER ADMINISTRATIVE AND GE	
		5.01	5.02	5.03	5.04	5.05	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	132,834	65,733	30,055	26,522	111,645	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet B Part II Date/Time Prepared: 10/14/2017 11:12 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	203,971					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,803	23,052				8.00
9.00	00900	HOUSEKEEPING	3,141	2,296	42,959			9.00
10.00	01000	DIETARY	7,147	62	2,302	103,370		10.00
11.00	01100	CAFETERIA	4,655	0	400	66,832	121,801	11.00
13.00	01300	NURSING ADMINISTRATION	1,120	0	0	0	2,921	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	249	0	0	0	0	14.00
15.00	01500	PHARMACY	2,894	0	170	0	2,081	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,325	0	362	0	7,686	16.00
17.00	01700	SOCIAL SERVICE	793	0	107	0	1,368	17.00
18.00	01080	INSERVICE EDUCATION	2,179	0	0	0	1,108	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,941	4,764	11,630	8,789	24,433	30.00
43.00	04300	NURSERY	454	238	200	0	82	43.00
44.00	04400	SKILLED NURSING FACILITY	34,520	6,347	10,681	27,749	17,721	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	28,694	2,945	6,650	0	13,595	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	195	60	84	0	141	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,514	1,983	1,707	0	9,990	54.00
60.00	06000	LABORATORY	5,511	0	962	0	10,778	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	181	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	18,023	1,615	1,422	0	13,447	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,083	0	277	0	3,761	67.00
68.00	06800	SPEECH PATHOLOGY	1,170	0	0	0	1,011	68.00
69.00	06900	ELECTROCARDIOLOGY	2,433	0	490	0	2,646	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	494	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	1,490	195	0	0	944	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
90.00	09000	CLINIC	0	102	0	0	0	90.00
90.01	09001	OB 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	3,869	0	505	0	0	90.03
91.00	09100	EMERGENCY	14,084	2,245	2,239	0	6,787	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	2,290	0	182	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	192,252	22,852	40,370	103,370	120,500	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	1,287	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	8,497	13	2,017	0	1,301	192.03
194.00	07955	FOUNDATION	791	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	1,144	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	187	572	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

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet B Part II Date/Time Prepared: 10/14/2017 11:12 am

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
202.00	TOTAL (sum lines 118-201)	203,971	23,052	42,959	103,370	121,801	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet B Part II Date/Time Prepared: 10/14/2017 11:12 am

		Cost Center Description	NURSING ADMINISTRATION	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	21,311					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,660				14.00
15.00	01500	PHARMACY	735	0	43,484			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	65,622		16.00
17.00	01700	SOCIAL SERVICE	483	0	0	0	12,803	17.00
18.00	01080	INSERVICE EDUCATION	391	0	0	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,623	0	0	3,316	4,959	30.00
43.00	04300	NURSERY	29	0	0	304	44	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	370	6,574	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	4,799	0	0	16,445	11	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	50	0	0	384	11	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,583	0	54.00
60.00	06000	LABORATORY	3,805	0	0	8,433	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	198	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,452	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,466	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	234	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,044	32	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	3,660	0	345	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,526	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	43,484	4,392	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	829	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	281	0	88.00
88.01	08801	WYOMING RHC	0	0	0	47	0	88.01
90.00	09000	CLINIC	0	0	0	989	0	90.00
90.01	09001	OB 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	219	0	90.03
91.00	09100	EMERGENCY	2,396	0	0	3,765	1,020	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	152	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,311	3,660	43,484	65,622	12,803	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	0	0	0	0	192.03
194.00	07955	FOUNDATION	0	0	0	0	0	194.00
194.01	07950	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet B Part II Date/Time Prepared: 10/14/2017 11:12 am

	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	21,311	3,660	43,484	65,622	12,803	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet B Part II | Date/Time Prepared: 10/14/2017 11:12 am

		Cost Center Description	OTHER GENERAL SERVICE INSERVICE EDUCATION	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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	28,042					18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,381	518,734	0	518,734		30.00
43.00	04300	NURSERY	127	13,509	0	13,509		43.00
44.00	04400	SKILLED NURSING FACILITY	857	520,046	0	520,046		44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0		46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,862	758,058	0	758,058		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	160	3,796	0	3,796		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,655	492,252	0	492,252		54.00
60.00	06000	LABORATORY	3,511	180,840	0	180,840		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	82	2,951	0	2,951		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	1,854	277,255	0	277,255		66.00
67.00	06700	OCCUPATIONAL THERAPY	610	93,462	0	93,462		67.00
68.00	06800	SPEECH PATHOLOGY	97	16,332	0	16,332		68.00
69.00	06900	ELECTROCARDIOLOGY	1,268	54,569	0	54,569		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	144	4,459	0	4,459		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,052	38,610	0	38,610		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,829	57,845	0	57,845		73.00
76.00	03020	ACUPUNCTURE	0	0	0	0		76.00
76.01	03610	SLEEP LAB	345	21,146	0	21,146		76.01
76.02	03950	IV THERAPY	0	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	117	3,781	0	3,781		88.00
88.01	08801	WYOMING RHC	20	623	0	623		88.01
90.00	09000	CLINIC	412	44,823	0	44,823		90.00
90.01	09001	OB CLINIC	0	0	0	0		90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0		90.02
90.03	09003	SURGICAL CLINIC	91	78,714	0	78,714		90.03
91.00	09100	EMERGENCY	1,568	241,874	0	241,874		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	36,073	0	36,073		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	28,042	3,459,752	0	3,459,752		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	14,999	0	14,999		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0		192.00
192.01	19203	MUSCATINE CLINIC	0	68	0	68		192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0		192.02
192.03	19202	LEASED SPACE	0	108,941	0	108,941		192.03
194.00	07955	FOUNDATION	0	9,263	0	9,263		194.00
194.01	07950	SPORTS MEDICINE	0	1,164	0	1,164		194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	13,327	0	13,327		194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0		194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0		194.04

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet B Part II Date/Time Prepared: 10/14/2017 11:12 am

		Cost Center Description	OTHER GENERAL SERVICE INSERVICE EDUCATION	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			18.00	24.00	25.00	26.00		
194.05	07954	COLONA CLINIC	0	0	0	0		194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	400,606	0	400,606		194.06
194.07	07957	COMMUNITY HEALTH	0	23	0	23		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 118-201)	28,042	4,008,143	0	4,008,143		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet B-1 | Date/Time Prepared: 10/14/2017 11:12 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (TIME SPENT)	PURCHASING RECEIVING AND STORES (SUPPLY COST)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	120,426					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		916,055				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	574	2,850	12,766,513			4.00
5.01	00550	DATA PROCESSING	2,388	66,604	329,038	139,150		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	2,576	0	114,487	1,300	3,493,784	5.02
5.03	00570	ADMITTING	1,029	0	155,446	4,275	3,327	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	994	1,136	258,992	0	5,424	5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	3,067	11,596	493,872	22,555	9,487	5.05
7.00	00700	OPERATION OF PLANT	7,108	15,436	209,462	3,100	50,833	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	766	1,357	30,393	0	0	8.00
9.00	00900	HOUSEKEEPING	1,335	0	378,838	425	48,846	9.00
10.00	01000	DIETARY	3,037	10,737	455,181	1,685	35,559	10.00
11.00	01100	CAFETERIA	1,978	0	0	335	0	11.00
13.00	01300	NURSING ADMINISTRATION	476	401	323,431	3,530	1,805	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	106	0	0	0	34,134	14.00
15.00	01500	PHARMACY	1,230	1,994	212,855	2,550	1,645	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,413	6,391	344,963	9,525	2,920	16.00
17.00	01700	SOCIAL SERVICE	337	0	98,334	1,000	359	17.00
18.00	01080	INSERVICE EDUCATION	926	0	96,378	0	20,360	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,449	87,853	2,112,484	21,566	136,209	30.00
43.00	04300	NURSERY	193	5,908	8,314	69	14,316	43.00
44.00	04400	SKILLED NURSING FACILITY	14,670	31,374	859,067	5,635	42,500	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	12,194	290,017	1,216,370	8,765	970,943	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	83	0	15,187	195	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,443	203,096	801,284	7,200	214,807	54.00
60.00	06000	LABORATORY	2,342	55,387	642,393	5,425	430,892	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	77	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	7,659	23,547	1,171,246	6,925	19,613	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,010	368	346,687	785	5,309	67.00
68.00	06800	SPEECH PATHOLOGY	497	0	96,750	510	1,273	68.00
69.00	06900	ELECTROCARDIOLOGY	1,034	11,022	210,479	1,670	16,128	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	210	0	0	0	1,188,620	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	633	0	68,696	0	3,827	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	149,082	1,898	16,953	88.00
88.01	08801	WYOMING RHC	0	0	12,216	317	6,272	88.01
90.00	09000	CLINIC	0	29,917	241,641	6,682	38,268	90.00
90.01	09001	OB 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	1,644	26,160	47,819	1,478	26,882	90.03
91.00	09100	EMERGENCY	5,985	27,067	615,289	15,050	102,081	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	973	247	464,256	4,700	32,043	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	99,436	910,465	12,580,930	139,150	3,481,635	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	547	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	2,984	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	44	0	0	192.02
192.03	19202	LEASED SPACE	3,611	5,376	66,981	0	1,062	192.03
194.00	07955	FOUNDATION	336	0	0	0	2,571	194.00
194.01	07950	SPORTS MEDICINE	0	214	118,558	0	5,532	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	486	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

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet B-1 | Date/Time Prepared: 10/14/2017 11:12 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (TIME SPENT)	PURCHASING RECEIVING AND STORES (SUPPLY COST)	
			1.00	2.00	4.00	5.01	5.02	
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	16,010	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)	3,007,633	1,000,510	3,729,169	1,232,277	191,397	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.974947	1.092194	0.292106	8.855746	0.054782	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			17,449	132,834	65,733	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001367	0.954610	0.018814	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet B-1 | Date/Time Prepared: 10/14/2017 11:12 am

		Cost Center Description	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS 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	78,537,267					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	80,697,739				5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	0	0	-2,732,956	30,114,394		5.05
7.00	00700	OPERATION OF PLANT	0	0	0	1,453,839	86,680	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	160,144	766	8.00
9.00	00900	HOUSEKEEPING	0	0	0	630,448	1,335	9.00
10.00	01000	DIETARY	0	0	0	912,492	3,037	10.00
11.00	01100	CAFETERIA	0	0	0	52,367	1,978	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	296,214	476	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	32,792	106	14.00
15.00	01500	PHARMACY	0	0	0	526,248	1,230	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	636,418	1,413	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	145,309	337	17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	194,686	926	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,933,088	3,933,088	0	3,553,371	11,449	30.00
43.00	04300	NURSERY	361,133	361,133	0	41,919	193	43.00
44.00	04400	SKILLED NURSING FACILITY	0	2,442,987	0	1,732,367	14,670	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	19,480,319	19,480,319	0	3,946,595	12,194	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	456,023	456,023	0	28,716	83	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,112,424	16,112,424	0	2,867,592	7,443	54.00
60.00	06000	LABORATORY	10,003,947	10,003,947	0	2,041,872	2,342	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	235,001	235,001	0	107,892	77	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	5,281,408	5,281,408	0	1,915,049	7,659	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,738,964	1,738,964	0	573,683	3,010	67.00
68.00	06800	SPEECH PATHOLOGY	277,743	277,743	0	153,050	497	68.00
69.00	06900	ELECTROCARDIOLOGY	3,695,887	3,611,478	0	540,912	1,034	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	409,542	409,542	0	4,754	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,995,887	2,995,887	0	1,293,756	210	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,210,139	5,210,139	0	1,195,436	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	983,483	983,483	0	180,036	633	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0	333,316	0	252,997	0	88.00
88.01	08801	WYOMING RHC	0	55,662	0	26,930	0	88.01
90.00	09000	CLINIC	0	1,173,590	0	763,406	0	90.00
90.01	09001	OB 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	259,514	259,514	0	602,321	1,644	90.03
91.00	09100	EMERGENCY	7,102,765	4,466,492	0	2,000,181	5,985	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	875,599	0	772,942	973	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	78,537,267	80,697,739	-2,732,956	29,636,734	81,700	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	13,661	547	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	3,147	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	57	0	192.02
192.03	19202	LEASED SPACE	0	0	0	254,655	3,611	192.03
194.00	07955	FOUNDATION	0	0	0	8,533	336	194.00
194.01	07950	SPORTS MEDICINE	0	0	0	179,218	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	12,138	486	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	-399,847	0	0	194.06

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet B-1 | Date/Time Prepared: 10/14/2017 11:12 am

		Cost Center Description	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS 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	
194.07	07957	COMMUNITY HEALTH	0	0	0	6,251	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)	315,898	612,140		2,732,956	1,585,778	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.004022	0.007586		0.090752	18.294624	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	30,055	26,522		111,645	203,971	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000383	0.000329		0.003707	2.353150	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet B-1 | Date/Time Prepared: 10/14/2017 11:12 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (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	266,275					8.00
9.00	00900	HOUSEKEEPING	26,523	429,750				9.00
10.00	01000	DIETARY	715	23,025	134,889			10.00
11.00	01100	CAFETERIA	0	4,000	87,210	16,386		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	393	8,122	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	1,700	0	280	280	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,625	0	1,034	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,075	0	184	184	17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	149	149	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	55,031	116,338	11,469	3,287	3,287	30.00
43.00	04300	NURSERY	2,754	2,000	0	11	11	43.00
44.00	04400	SKILLED NURSING FACILITY	73,314	106,850	36,210	2,384	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	34,014	66,525	0	1,829	1,829	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	688	837	0	19	19	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,909	17,075	0	1,344	0	54.00
60.00	06000	LABORATORY	0	9,625	0	1,450	1,450	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	18,652	14,225	0	1,809	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,775	0	506	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	136	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,900	0	356	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	2,252	0	0	127	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
90.00	09000	CLINIC	1,176	0	0	0	0	90.00
90.01	09001	OB 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	5,050	0	0	0	90.03
91.00	09100	EMERGENCY	25,932	22,400	0	913	913	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	1,825	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	263,960	403,850	134,889	16,211	8,122	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	155	20,175	0	175	0	192.03
194.00	07955	FOUNDATION	0	0	0	0	0	194.00
194.01	07950	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	2,160	5,725	0	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	0	0	194.07

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet B-1 | Date/Time Prepared: 10/14/2017 11:12 am

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES)	
		8.00	9.00	10.00	11.00	13.00	
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)	188,691	730,880	1,090,529	805,170	351,115	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.708632	1.700710	8.084640	49.137679	43.230116	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	23,052	42,959	103,370	121,801	21,311	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.086572	0.099963	0.766334	7.433236	2.623861	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet B-1 | Date/Time Prepared: 10/14/2017 11:12 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	77,818,550			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	60,900		17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	0	79,822,140	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	3,933,088	23,588	3,933,088	30.00
43.00	04300	NURSERY	0	0	361,133	209	361,133	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	439,397	31,275	2,442,987	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	19,480,319	50	19,480,319	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	456,023	53	456,023	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	16,112,424	0	16,112,424	54.00
60.00	06000	LABORATORY	0	0	10,003,947	0	10,003,947	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	235,001	0	235,001	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	5,281,408	0	5,281,408	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,738,964	0	1,738,964	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	277,743	0	277,743	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	3,611,478	150	3,611,478	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	100	0	409,542	0	409,542	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,995,887	0	2,995,887	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	5,210,139	0	5,210,139	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	983,483	0	983,483	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	333,316	0	333,316	88.00
88.01	08801	WYOMING RHC	0	0	55,662	0	55,662	88.01
90.00	09000	CLINIC	0	0	1,173,590	0	1,173,590	90.00
90.01	09001	OB 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	259,514	0	259,514	90.03
91.00	09100	EMERGENCY	0	0	4,466,492	4,850	4,466,492	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	725	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	100	77,818,550	60,900	79,822,140	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	0	0	0	0	192.03
194.00	07955	FOUNDATION	0	0	0	0	0	194.00
194.01	07950	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet B-1 | Date/Time Prepared: 10/14/2017 11:12 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQ UIS)	PHARMACY (COSTED REQ UIS)	MEDICAL RECORDS & LIBRARY (GROSS PT. CHARGES)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE INSERVICE EDUCATION (GROSS CHAR GES)	
			14.00	15.00	16.00	17.00	18.00	
194.05	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)	37,707	625,262	776,997	183,484	243,058	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	377.070000	6,252.620000	0.009985	3.012874	0.003045	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	3,660	43,484	65,622	12,803	28,042	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	36.600000	434.840000	0.000843	0.210230	0.000351	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet C Part I Date/Time Prepared: 10/14/2017 11:12 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,840,807		4,840,807	0	4,840,807	30.00
43.00	04300	NURSERY	60,960		60,960	0	60,960	43.00
44.00	04400	SKILLED NURSING FACILITY	2,907,581		2,907,581	0	2,907,581	44.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,088,000		5,088,000	0	5,088,000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	42,608		42,608	0	42,608	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,585,259		3,585,259	0	3,585,259	54.00
60.00	06000	LABORATORY	2,550,676		2,550,676	0	2,550,676	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	122,154		122,154	0	122,154	62.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	2,424,080	0	2,424,080	0	2,424,080	66.00
67.00	06700	OCCUPATIONAL THERAPY	733,055	0	733,055	0	733,055	67.00
68.00	06800	SPEECH PATHOLOGY	186,334	0	186,334	0	186,334	68.00
69.00	06900	ELECTROCARDIOLOGY	682,254		682,254	0	682,254	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	48,228		48,228	0	48,228	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,454,045		1,454,045	0	1,454,045	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,997,074		1,997,074	0	1,997,074	73.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	228,606		228,606	0	228,606	76.01
76.02	03950	IV THERAPY	0		0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	280,300		280,300	0	280,300	88.00
88.01	08801	WYOMING RHC	30,099		30,099	0	30,099	88.01
90.00	09000	CLINIC	848,812		848,812	0	848,812	90.00
90.01	09001	OB CLINIC	0		0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0		0	0	0	90.02
90.03	09003	SURGICAL CLINIC	699,029		699,029	0	699,029	90.03
91.00	09100	EMERGENCY	2,504,808		2,504,808	0	2,504,808	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	938,277		938,277		938,277	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	866,177		866,177		866,177	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	33,119,223	0	33,119,223	0	33,119,223	200.00
201.00		Less Observation Beds	938,277		938,277		938,277	201.00
202.00		Total (see instructions)	32,180,946	0	32,180,946	0	32,180,946	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet C Part I Date/Time Prepared: 10/14/2017 11:12 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,147,964		3,147,964			30.00
43.00	04300	NURSERY	361,133		361,133			43.00
44.00	04400	SKILLED NURSING FACILITY	2,442,987		2,442,987			44.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,361,346	12,118,974	19,480,320	0.261187	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	378,737	77,286	456,023	0.093434	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	792,605	15,319,819	16,112,424	0.222515	0.000000	54.00
60.00	06000	LABORATORY	1,126,821	8,877,126	10,003,947	0.254967	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	152,957	82,044	235,001	0.519802	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	669,247	4,612,161	5,281,408	0.458984	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	384,945	1,354,019	1,738,964	0.421547	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	72,006	205,737	277,743	0.670886	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	225,468	3,386,010	3,611,478	0.188913	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	316,273	93,269	409,542	0.117761	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,511,004	484,883	2,995,887	0.485347	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,402,079	2,808,060	5,210,139	0.383305	0.000000	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	983,483	983,483	0.232445	0.000000	76.01
76.02	03950	IV THERAPY	0	0	0	0.000000	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0	333,316	333,316			88.00
88.01	08801	WYOMING RHC	0	55,662	55,662			88.01
90.00	09000	CLINIC	0	1,173,590	1,173,590	0.723261	0.000000	90.00
90.01	09001	OB CLINIC	0	0	0	0.000000	0.000000	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0.000000	0.000000	90.02
90.03	09003	SURGICAL CLINIC	0	259,514	259,514	2.693608	0.000000	90.03
91.00	09100	EMERGENCY	144,024	4,322,468	4,466,492	0.560800	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	33,480	751,644	785,124	1.195069	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	875,599	875,599			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	22,523,076	58,174,664	80,697,740			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	22,523,076	58,174,664	80,697,740			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet C Part I Date/Time Prepared: 10/14/2017 11:12 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
46.00	04600	OTHER LONG TERM CARE		46.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	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		88.00
88.01	08801	WYOMING RHC		88.01
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	OB CLINIC	0.000000	90.01
90.02	09002	SPECIALTY CLINIC	0.000000	90.02
90.03	09003	SURGICAL CLINIC	0.000000	90.03
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 06/01/2016 To 05/31/2017 | Worksheet D Part II Date/Time Prepared: 10/14/2017 11:12 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	758,058	19,480,320	0.038914	2,933,143	114,140	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,796	456,023	0.008324	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	492,252	16,112,424	0.030551	292,663	8,941	54.00
60.00	06000	LABORATORY	180,840	10,003,947	0.018077	326,947	5,910	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	2,951	235,001	0.012557	58,069	729	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
66.00	06600	PHYSICAL THERAPY	277,255	5,281,408	0.052496	150,339	7,892	66.00
67.00	06700	OCCUPATIONAL THERAPY	93,462	1,738,964	0.053746	85,826	4,613	67.00
68.00	06800	SPEECH PATHOLOGY	16,332	277,743	0.058803	8,621	507	68.00
69.00	06900	ELECTROCARDIOLOGY	54,569	3,611,478	0.015110	111,102	1,679	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	4,459	409,542	0.010888	169,878	1,850	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,610	2,995,887	0.012888	1,345,691	17,343	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	57,845	5,210,139	0.011102	824,170	9,150	73.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	21,146	983,483	0.021501	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	3,781	333,316	0.011344	0	0	88.00
88.01	08801	WYOMING RHC	623	55,662	0.011193	0	0	88.01
90.00	09000	CLINIC	44,823	1,173,590	0.038193	0	0	90.00
90.01	09001	OB CLINIC	0	0	0.000000	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0.000000	0	0	90.02
90.03	09003	SURGICAL CLINIC	78,714	259,514	0.303313	0	0	90.03
91.00	09100	EMERGENCY	241,874	4,466,492	0.054153	4,264	231	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	100,545	785,124	0.128063	4,826	618	92.00
200.00		Total (lines 50-199)	2,471,935	73,870,057		6,315,539	173,603	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet D Part IV Date/Time Prepared: 10/14/2017 11:12 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OB 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
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 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet D Part IV Date/Time Prepared: 10/14/2017 11:12 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	19,480,320	0.000000	0.000000	2,933,143	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	456,023	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,112,424	0.000000	0.000000	292,663	54.00
60.00	06000	LABORATORY	0	10,003,947	0.000000	0.000000	326,947	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	235,001	0.000000	0.000000	58,069	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
66.00	06600	PHYSICAL THERAPY	0	5,281,408	0.000000	0.000000	150,339	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,738,964	0.000000	0.000000	85,826	67.00
68.00	06800	SPEECH PATHOLOGY	0	277,743	0.000000	0.000000	8,621	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,611,478	0.000000	0.000000	111,102	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	409,542	0.000000	0.000000	169,878	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,995,887	0.000000	0.000000	1,345,691	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,210,139	0.000000	0.000000	824,170	73.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	983,483	0.000000	0.000000	0	76.01
76.02	03950	IV THERAPY	0	0	0.000000	0.000000	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0	333,316	0.000000	0.000000	0	88.00
88.01	08801	WYOMING RHC	0	55,662	0.000000	0.000000	0	88.01
90.00	09000	CLINIC	0	1,173,590	0.000000	0.000000	0	90.00
90.01	09001	OB CLINIC	0	0	0.000000	0.000000	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0.000000	0.000000	0	90.02
90.03	09003	SURGICAL CLINIC	0	259,514	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	4,466,492	0.000000	0.000000	4,264	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	785,124	0.000000	0.000000	4,826	92.00
200.00		Total (lines 50-199)	0	73,870,057			6,315,539	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet D Part IV | Date/Time Prepared: 10/14/2017 11:12 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		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
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OB 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
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 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet D Part IV | Date/Time Prepared: 10/14/2017 11:12 am

Title XVIII | Hospital | Cost

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			23.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.02	03950	IV THERAPY	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	KEWANEE RHC	0	0		88.00
88.01	08801	WYOMING RHC	0	0		88.01
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OB CLINIC	0	0		90.01
90.02	09002	SPECIALTY CLINIC	0	0		90.02
90.03	09003	SURGICAL CLINIC	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0		92.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet D Part V Date/Time Prepared: 10/14/2017 11:12 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.261187	0	3,236,780	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.093434	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222515	0	4,417,658	0	0	54.00
60.00	06000	LABORATORY	0.254967	0	2,853,227	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.519802	0	44,418	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.458984	0	1,286,324	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.421547	0	395,380	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.670886	0	34,975	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.188913	0	1,432,017	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.117761	0	34,981	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.485347	0	91,919	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.383305	0	1,199,886	4,950	0	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.232445	0	307,697	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0.000000				0	88.00
88.01	08801	WYOMING RHC	0.000000				0	88.01
90.00	09000	CLINIC	0.723261	0	91,875	1,713	0	90.00
90.01	09001	OB 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	2.693608	0	43,588	0	0	90.03
91.00	09100	EMERGENCY	0.560800	0	1,256,030	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.195069	0	307,144	0	0	92.00
200.00		Subtotal (see instructions)		0	17,033,899	6,663	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	17,033,899	6,663	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet D Part V Date/Time Prepared: 10/14/2017 11:12 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	845,405	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	982,995	0		54.00
60.00	06000	LABORATORY	727,479	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	23,089	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	590,402	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	166,671	0		67.00
68.00	06800	SPEECH PATHOLOGY	23,464	0		68.00
69.00	06900	ELECTROCARDIOLOGY	270,527	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	4,119	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	44,613	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	459,922	1,897		73.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	71,523	0		76.01
76.02	03950	IV THERAPY	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	KEWANEE RHC	0	0		88.00
88.01	08801	WYOMING RHC	0	0		88.01
90.00	09000	CLINIC	66,450	1,239		90.00
90.01	09001	OB CLINIC	0	0		90.01
90.02	09002	SPECIALTY CLINIC	0	0		90.02
90.03	09003	SURGICAL CLINIC	117,409	0		90.03
91.00	09100	EMERGENCY	704,382	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	367,058	0		92.00
200.00		Subtotal (see instructions)	5,465,508	3,136		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,465,508	3,136		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1319 | Component CCN: 14-Z319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet D Part V | Date/Time Prepared: 10/14/2017 11:12 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.261187	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.093434	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222515	0	0	0	0	54.00
60.00	06000	LABORATORY	0.254967	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.519802	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.458984	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.421547	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.670886	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.188913	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.117761	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.485347	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.383305	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.232445	0	0	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0.000000				0	88.00
88.01	08801	WYOMING RHC	0.000000				0	88.01
90.00	09000	CLINIC	0.723261	0	0	0	0	90.00
90.01	09001	OB 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	2.693608	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.560800	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.195069	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1319 | Component CCN: 14-Z319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet D Part V | Date/Time Prepared: 10/14/2017 11:12 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.02	03950	IV THERAPY	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	KEWANEE RHC	0	0		88.00
88.01	08801	WYOMING RHC	0	0		88.01
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OB CLINIC	0	0		90.01
90.02	09002	SPECIALTY CLINIC	0	0		90.02
90.03	09003	SURGICAL CLINIC	0	0		90.03
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 06/01/2016 To 05/31/2017
Worksheet D Part IV
Date/Time Prepared: 10/14/2017 11:12 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OB 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
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 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1319 | Component CCN: 14-5464 | Period: From 06/01/2016 To 05/31/2017 | Worksheet D Part IV | Date/Time Prepared: 10/14/2017 11:12 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	19,480,320	0.000000	0.000000	17,417	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	456,023	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,112,424	0.000000	0.000000	5,035	54.00
60.00	06000	LABORATORY	0	10,003,947	0.000000	0.000000	10,067	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	235,001	0.000000	0.000000	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
66.00	06600	PHYSICAL THERAPY	0	5,281,408	0.000000	0.000000	230,894	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,738,964	0.000000	0.000000	143,137	67.00
68.00	06800	SPEECH PATHOLOGY	0	277,743	0.000000	0.000000	45,191	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,611,478	0.000000	0.000000	1,029	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	409,542	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,995,887	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,210,139	0.000000	0.000000	110,292	73.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	983,483	0.000000	0.000000	0	76.01
76.02	03950	IV THERAPY	0	0	0.000000	0.000000	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0	333,316	0.000000	0.000000	0	88.00
88.01	08801	WYOMING RHC	0	55,662	0.000000	0.000000	0	88.01
90.00	09000	CLINIC	0	1,173,590	0.000000	0.000000	0	90.00
90.01	09001	OB CLINIC	0	0	0.000000	0.000000	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0.000000	0.000000	0	90.02
90.03	09003	SURGICAL CLINIC	0	259,514	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	4,466,492	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	785,124	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	73,870,057			563,062	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1319 | Component CCN: 14-5464 | Period: From 06/01/2016 To 05/31/2017 | Worksheet D Part IV Date/Time Prepared: 10/14/2017 11:12 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		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
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OB 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
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 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1319 | Component CCN: 14-5464 | Period: From 06/01/2016 To 05/31/2017 | Worksheet D Part IV Date/Time Prepared: 10/14/2017 11:12 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			23.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.02	03950	IV THERAPY	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	KEWANEE RHC	0	0		88.00
88.01	08801	WYOMING RHC	0	0		88.01
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OB CLINIC	0	0		90.01
90.02	09002	SPECIALTY CLINIC	0	0		90.02
90.03	09003	SURGICAL CLINIC	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0		92.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1319 | Component CCN: 14-5464 | Period: From 06/01/2016 To 05/31/2017 | Worksheet D Part V Date/Time Prepared: 10/14/2017 11:12 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.261187	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.093434	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222515	0	0	0	0	54.00
60.00	06000	LABORATORY	0.254967	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.519802	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.458984	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.421547	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.670886	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.188913	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.117761	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.485347	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.383305	0	0	75	0	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.232445	0	0	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0.000000				0	88.00
88.01	08801	WYOMING RHC	0.000000				0	88.01
90.00	09000	CLINIC	0.723261	0	0	0	0	90.00
90.01	09001	OB 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	2.693608	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.560800	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.195069	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	75	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	75	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1319 | Component CCN: 14-5464 | Period: From 06/01/2016 To 05/31/2017 | Worksheet D Part V | Date/Time Prepared: 10/14/2017 11:12 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: 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	29		73.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.02	03950	IV THERAPY	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	KEWANEE RHC	0	0		88.00
88.01	08801	WYOMING RHC	0	0		88.01
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OB CLINIC	0	0		90.01
90.02	09002	SPECIALTY CLINIC	0	0		90.02
90.03	09003	SURGICAL CLINIC	0	0		90.03
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	29		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	29		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet D-1 | Date/Time Prepared: 10/14/2017 11:12 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)	4,071	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,790	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)	3,003	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	157	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)	112	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	7	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)	5	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,313	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	126	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	90	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)	4,840,807	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)	934	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)	667	25.00
26.00	Total swing-bed cost (see instructions)	322,308	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,518,499	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)	4,518,499	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)	1,192.22	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,565,385	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)	1,565,385	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet D-1 | Date/Time Prepared: 10/14/2017 11:12 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	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)	2,073,920	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,639,305	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)	150,220	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	107,300	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	257,520	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)	787	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,192.22	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	938,277	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet D-1 | Date/Time Prepared: 10/14/2017 11:12 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	518,734	4,840,807	0.107159	938,277	100,545	90.00
91.00	Nursing School cost	0	4,840,807	0.000000	938,277	0	91.00
92.00	Allied health cost	0	4,840,807	0.000000	938,277	0	92.00
93.00	All other Medical Education	0	4,840,807	0.000000	938,277	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1319 Component CCN: 14-5464	Period: From 06/01/2016 To 05/31/2017	Worksheet D-1 Date/Time Prepared: 10/14/2017 11:12 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)	12,356	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,356	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)	12,356	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)	935	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,907,581	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,907,581	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,907,581	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 06/01/2016 To 05/31/2017 | Worksheet D-1 | Date/Time Prepared: 10/14/2017 11:12 am

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	2,907,581	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	235.32	71.00
72.00	Program routine service cost (line 9 x line 71)	220,024	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)	220,024	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)	220,024	83.00
84.00	Program inpatient ancillary services (see instructions)	247,339	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)	467,363	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 06/01/2016 To 05/31/2017	Worksheet D-1 Date/Time Prepared: 10/14/2017 11:12 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 06/01/2016 To 05/31/2017 | Worksheet D-3 | Date/Time Prepared: 10/14/2017 11:12 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		1,317,546		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.261187	2,933,143	766,099	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.093434	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222515	292,663	65,122	54.00
60.00	06000	LABORATORY	0.254967	326,947	83,361	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.519802	58,069	30,184	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.458984	150,339	69,003	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.421547	85,826	36,180	67.00
68.00	06800	SPEECH PATHOLOGY	0.670886	8,621	5,784	68.00
69.00	06900	ELECTROCARDIOLOGY	0.188913	111,102	20,989	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.117761	169,878	20,005	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.485347	1,345,691	653,127	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.383305	824,170	315,908	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.232445	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
90.00	09000	CLINIC	0.723261	0	0	90.00
90.01	09001	OB CLINIC	0.000000	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.000000	0	0	90.02
90.03	09003	SURGICAL CLINIC	2.693608	0	0	90.03
91.00	09100	EMERGENCY	0.560800	4,264	2,391	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.195069	4,826	5,767	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		6,315,539	2,073,920	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)		6,315,539		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1319 | Component CCN: 14-Z319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet D-3 | Date/Time Prepared: 10/14/2017 11:12 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		0		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.261187	32,639	8,525	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.093434	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222515	1,996	444	54.00
60.00	06000	LABORATORY	0.254967	13,519	3,447	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.519802	2,192	1,139	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.458984	63,603	29,193	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.421547	32,634	13,757	67.00
68.00	06800	SPEECH PATHOLOGY	0.670886	7,368	4,943	68.00
69.00	06900	ELECTROCARDIOLOGY	0.188913	101	19	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.117761	437	51	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.485347	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.383305	60,469	23,178	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.232445	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
90.00	09000	CLINIC	0.723261	0	0	90.00
90.01	09001	OB CLINIC	0.000000	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.000000	0	0	90.02
90.03	09003	SURGICAL CLINIC	2.693608	0	0	90.03
91.00	09100	EMERGENCY	0.560800	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.195069	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		214,958	84,696	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)		214,958		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1319 | Component CCN: 14-5464 | Period: From 06/01/2016 To 05/31/2017 | Worksheet D-3 | Date/Time Prepared: 10/14/2017 11:12 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.261187	17,417	4,549	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.093434	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222515	5,035	1,120	54.00
60.00	06000	LABORATORY	0.254967	10,067	2,567	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.519802	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.458984	230,894	105,977	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.421547	143,137	60,339	67.00
68.00	06800	SPEECH PATHOLOGY	0.670886	45,191	30,318	68.00
69.00	06900	ELECTROCARDIOLOGY	0.188913	1,029	194	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.117761	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.485347	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.383305	110,292	42,275	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.232445	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
90.00	09000	CLINIC	0.723261	0	0	90.00
90.01	09001	OB CLINIC	0.000000	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.000000	0	0	90.02
90.03	09003	SURGICAL CLINIC	2.693608	0	0	90.03
91.00	09100	EMERGENCY	0.560800	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.195069	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		563,062	247,339	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)		563,062		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1319	Period: From 06/01/2016 To 05/31/2017	Worksheet E Part B Date/Time Prepared: 10/14/2017 11:12 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,468,644	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,468,644	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 (line 11 minus line 20) (for CAH see instructions)	5,523,330	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	76,164	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,793,176	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,653,990	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,653,990	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	2,653,990	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)	32,201	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	20,931	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	2,674,921	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,674,921	40.00
40.01	Sequestration adjustment (see instructions)	53,498	40.01
41.00	Interim payments	2,696,753	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-75,330	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

		Overrides 1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1319 Component CCN: 14-5464	Period: From 06/01/2016 To 05/31/2017	Worksheet E Part B Date/Time Prepared: 10/14/2017 11:12 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	29	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	29	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	75	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)	75	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)	75	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	46	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	29	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	29	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)	29	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	29	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)	29	37.00
38.00	MSP-LCC reconciliation amount from PS&R		38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	29	40.00
40.01	Sequestration adjustment (see instructions)	1	40.01
41.00	Interim payments	59	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-31	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00
		Overrides 1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet E-1 Part I Date/Time Prepared: 10/14/2017 11:12 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		2,766,875		2,786,256	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	12/15/2016	83,149		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	05/25/2017	130,960	12/15/2016	65,047	3.50
3.51			0	05/25/2017	24,456	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)		-47,811		-89,503	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)		2,719,064		2,696,753	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		459,824		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		75,330	6.02
7.00	Total Medicare program liability (see instructions)		3,178,888		2,621,423	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-Z319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 10/14/2017 11:12 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		290,979		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	05/25/2017	9,665		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)		9,665		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)		300,644		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		37,597		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		338,241		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 06/01/2016 To 05/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 10/14/2017 11:12 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		329,413		59	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)		329,413		59	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		31	6.02
7.00	Total Medicare program liability (see instructions)		329,413		28	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 06/01/2016 To 05/31/2017	Worksheet E-1 Part II Date/Time Prepared: 10/14/2017 11:12 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	1,076	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,313	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	346	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	3,003	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	80,697,740	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	352,796	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00
		Overrides	
		1.00	
	CONTRACTOR OVERRIDES		
108.00	Override of HIT payment	0	108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 14-1319 Component CCN: 14-Z319	Period: From 06/01/2016 To 05/31/2017	Worksheet E-2 Date/Time Prepared: 10/14/2017 11:12 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)	260,095	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	85,543	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	216	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)	345,638	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	345,638	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)	345,638	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	494	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	345,144	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	345,144	0	19.00
19.01	Sequestration adjustment (see instructions)	6,903	0	19.01
20.00	Interim payments	300,644	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	37,597	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1319	Period: From 06/01/2016 To 05/31/2017	Worksheet E-3 Part V Date/Time Prepared: 10/14/2017 11:12 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,639,305	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	3,639,305	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,675,698	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	3,675,698	19.00
20.00	Deductibles (exclude professional component)	438,832	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,236,866	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	3,236,866	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	10,611	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	6,897	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)	3,243,763	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	3,243,763	30.00
30.01	Sequestration adjustment (see instructions)	64,875	30.01
31.00	Interim payments	2,719,064	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	459,824	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1319 Component CCN: 14-5464	Period: From 06/01/2016 To 05/31/2017	Worksheet E-3 Part VI Date/Time Prepared: 10/14/2017 11:12 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	383,939	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)	383,939	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	47,803	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)	336,136	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (see instructions	336,136	15.00
15.01	Sequestration adjustment (see instructions)	6,723	15.01
16.00	Interim payments	329,413	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet G | Date/Time Prepared: 10/14/2017 11:12 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	6,375,520	0	0	0	1.00
2.00	Temporary investments	15,691,448	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	24,534,041	0	0	0	4.00
5.00	Other receivable	868,240	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-20,726,932	0	0	0	6.00
7.00	Inventory	920,366	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	6,636,805	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)	34,299,488	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,316,669	0	0	0	12.00
13.00	Land improvements	1,629,936	0	0	0	13.00
14.00	Accumulated depreciation	-823,663	0	0	0	14.00
15.00	Buildings	44,937,473	0	0	0	15.00
16.00	Accumulated depreciation	-21,151,223	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	11,658,418	0	0	0	19.00
20.00	Accumulated depreciation	-8,091,950	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	1,778,275	0	0	0	23.00
24.00	Accumulated depreciation	-1,313,593	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	71,692	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	30,012,034	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	824,525	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	806,593	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,631,118	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	65,942,640	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	0	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,675,651	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	462,103	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	6,687,618	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,825,372	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,936,261	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	23,653,979	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	25,590,240	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	35,415,612	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	30,527,028				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	30,527,028	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	65,942,640	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1319 | Period: From 06/01/2016 To 05/31/2017 | Worksheet G-1 | Date/Time Prepared: 10/14/2017 11:12 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		32,416,455		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-2,455,534				2.00
3.00	Total (sum of line 1 and line 2)		29,960,921		0		3.00
4.00	ACQUISITION OF RHP CLINICS	566,107		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)		566,107		0		10.00
11.00	Subtotal (line 3 plus line 10)		30,527,028		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)		30,527,028		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	ACQUISITION OF RHP CLINICS		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 06/01/2016 To 05/31/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 10/14/2017 11:12 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,147,964		3,147,964	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	2,442,987		2,442,987	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)	5,590,951		5,590,951	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)	5,590,951		5,590,951	17.00
18.00	Ancillary services	16,634,923	55,672,565	72,307,488	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	KEWANEE RHC	0	333,316	333,316	20.00
20.01	WYOMING RHC	0	55,662	55,662	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		875,599	875,599	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	NURSERY	361,133	0	361,133	27.00
27.01	SURGICAL CLINIC	0	1,063,643	1,063,643	27.01
27.02	PROFESSIONAL FEES	1,891,877	9,679,825	11,571,702	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	24,478,884	67,680,610	92,159,494	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		37,040,552		29.00
30.00	PROVISION FOR BAD DEBT	1,307,852			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)		1,307,852		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)		38,348,404		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-1319	Period: From 06/01/2016 To 05/31/2017	Worksheet G-3 Date/Time Prepared: 10/14/2017 11:12 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	92,159,494	1.00
2.00	Less contractual allowances and discounts on patients' accounts	54,452,233	2.00
3.00	Net patient revenues (line 1 minus line 2)	37,707,261	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	38,348,404	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-641,143	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	80,997	6.00
7.00	Income from investments	231,033	7.00
8.00	Revenues from telephone and other miscellaneous communication services	212	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	642	10.00
11.00	Rebates and refunds of expenses	37,012	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	182,905	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	914	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		0	24.00
24.01	RENTAL INCOME	365,026	24.01
24.02	PROPERTY INCOME	695,793	24.02
24.03		0	24.03
24.04		0	24.04
25.00	Total other income (sum of lines 6-24)	1,594,534	25.00
26.00	Total (line 5 plus line 25)	953,391	26.00
27.00	CHANGE IN IMRF PENSION	3,408,925	27.00
27.02		0	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	3,408,925	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-2,455,534	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-1319 | HHA CCN: 14-7450 | Period: From 06/01/2016 To 05/31/2017 | Worksheet H | Date/Time Prepared: 10/14/2017 11:12 am

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	105,234	0	91	12,853	8,473	126,651	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	319,307	0	44,136	0	2,600	366,043	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	5,545	0	1,132	0	0	6,677	10.00
11.00	Home Health Aide	34,169	0	121	0	0	34,290	11.00
12.00	Supplies (see instructions)	0	0	0	0	29,079	29,079	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)	464,255	0	45,480	12,853	40,152	562,740	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	126,651	0	126,651			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	366,043	0	366,043			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	6,677	0	6,677			10.00
11.00	Home Health Aide	0	34,290	0	34,290			11.00
12.00	Supplies (see instructions)	0	29,079	0	29,079			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	562,740	0	562,740			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 | HHA CCN: 14-7450 | Period: From 06/01/2016 To 05/31/2017 | Worksheet H-1 Part I | Date/Time Prepared: 10/14/2017 11:12 am

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	126,651	0	0	0	0	126,651	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	366,043	0	0	0	0	366,043	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	6,677	0	0	0	0	6,677	10.00
11.00	Home Health Aide	34,290	0	0	0	0	34,290	11.00
12.00	Supplies (see instructions)	29,079	0	0	0	0	29,079	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)	562,740	0	0	0	0	562,740	24.00

		Administrative & 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	126,651		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	106,308	472,351	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	1,939	8,616	10.00
11.00	Home Health Aide	9,959	44,249	11.00
12.00	Supplies (see instructions)	8,445	37,524	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)		562,740	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 14-1319 | HHA CCN: 14-7450 | Period: From 06/01/2016 To 05/31/2017 | Worksheet H-1 Part II | Date/Time Prepared: 10/14/2017 11:12 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		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	-126,651	436,089	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	366,043	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	6,677	10.00
11.00	Home Health Aide	0	0	0	0	0	34,290	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	29,079	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	-126,651	436,089	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		126,651	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.290425	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1319 | HHA CCN: 14-7450 | Period: From 06/01/2016 To 05/31/2017 | Worksheet H-2 Part I | Date/Time Prepared: 10/14/2017 11:12 am

Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	PURCHASING RECEIVING AND STORES	
		0	1.00	2.00	4.00	5.01	5.02	
1.00	Administrative and General	0	24,301	270	135,612	41,622	1,755	1.00
2.00	Skilled Nursing Care	472,351	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	8,616	0	0	0	0	0	6.00
7.00	Home Health Aide	44,249	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	37,524	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)	562,740	24,301	270	135,612	41,622	1,755	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/ACCOUNTS RECEIVABLE	Subtotal	ALL OTHER ADMINISTRATIVE AND GE	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5.03	5.04	5A.04	5.05	7.00	8.00	
1.00	Administrative and General	0	6,642	210,202	19,076	17,801	0	1.00
2.00	Skilled Nursing Care	0	0	472,351	42,867	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	8,616	782	0	0	6.00
7.00	Home Health Aide	0	0	44,249	4,016	0	0	7.00
8.00	Supplies (see instructions)	0	0	37,524	3,405	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	6,642	772,942	70,146	17,801	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 | HHA CCN: 14-7450 | Period: From 06/01/2016 To 05/31/2017 | Worksheet H-2 Part I | Date/Time Prepared: 10/14/2017 11:12 am

Home Health Agency I | PPS

	Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	3,104	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	3,104	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	250,183	0	250,183	1.00
2.00	Skilled Nursing Care	0	0	0	515,218	0	515,218	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	2,184	0	11,582	0	11,582	6.00
7.00	Home Health Aide	0	0	0	48,265	0	48,265	7.00
8.00	Supplies (see instructions)	0	0	0	40,929	0	40,929	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	2,184	0	866,177	0	866,177	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 | HHA CCN: 14-7450 | Period: From 06/01/2016 To 05/31/2017 | Worksheet H-2 Part I | Date/Time Prepared: 10/14/2017 11:12 am

Home 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	209,253	724,471	2.00
3.00	Physical Therapy	0	0	3.00
4.00	Occupational Therapy	0	0	4.00
5.00	Speech Pathology	0	0	5.00
6.00	Medical Social Services	4,704	16,286	6.00
7.00	Home Health Aide	19,603	67,868	7.00
8.00	Supplies (see instructions)	16,623	57,552	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)	250,183	866,177	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.	0.406145		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
HHA CCN: 14-7450

Period: From 06/01/2016 To 05/31/2017

Worksheet H-2 Part II
Date/Time Prepared: 10/14/2017 11:12 am

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (TIME SPENT)	PURCHASING RECEIVING AND STORES (SUPPLY COST)	ADMITTING (GROSS CHARGES)	
		1.00	2.00	4.00	5.01	5.02	5.03	
1.00	Administrative and General	973	247	464,256	4,700	32,043	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)	973	247	464,256	4,700	32,043	0	20.00
21.00	Total cost to be allocated	24,301	270	135,612	41,622	1,755	0	21.00
22.00	Unit cost multiplier	24.975334	1.093117	0.292106	8.855745	0.054770	0.000000	22.00

	Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	ALL OTHER ADMINISTRATIVE AND GE (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	875,599	0	210,202	973	0	1,825	1.00
2.00	Skilled Nursing Care	0	0	472,351	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	8,616	0	0	0	6.00
7.00	Home Health Aide	0	0	44,249	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	37,524	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)	875,599		772,942	973	0	1,825	20.00
21.00	Total cost to be allocated	6,642		70,146	17,801	0	3,104	21.00
22.00	Unit cost multiplier	0.007586		0.090752	18.294964	0.000000	1.700822	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1319
HHA CCN: 14-7450

Period: From 06/01/2016 To 05/31/2017

Worksheet H-2 Part II
Date/Time Prepared: 10/14/2017 11:12 am

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	Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (GROSS PT. CHARGES)	
		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 CHARGES)					
		17.00	18.00					
1.00	Administrative and General	0	0					1.00
2.00	Skilled Nursing Care	0	0					2.00
3.00	Physical Therapy	0	0					3.00
4.00	Occupational Therapy	0	0					4.00
5.00	Speech Pathology	0	0					5.00
6.00	Medical Social Services	725	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)	725	0					20.00
21.00	Total cost to be allocated	2,184	0					21.00
22.00	Unit cost multiplier	3.012414	0.000000					22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-1319 | HHA CCN: 14-7450 | Period: From 06/01/2016 To 05/31/2017 | Worksheet H-3 Part I | Date/Time Prepared: 10/14/2017 11:12 am

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	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	724,471		724,471	4,638	156.20	1.00
2.00	Physical Therapy	3.00	0	140,042	140,042	1,689	82.91	2.00
3.00	Occupational Therapy	4.00	0	64,829	64,829	945	68.60	3.00
4.00	Speech Pathology	5.00	0	25,366	25,366	169	150.09	4.00
5.00	Medical Social Services	6.00	16,286		16,286	8	2,035.75	5.00
6.00	Home Health Aide	7.00	67,868		67,868	1,154	58.81	6.00
7.00	Total (sum of lines 1-6)		808,625	230,237	1,038,862	8,603		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		19340	0	2,304			8.00
8.01	Skilled Nursing Care		99914	0	89			8.01
9.00	Physical Therapy		19340	0	990			9.00
9.01	Physical Therapy		99914	0	56			9.01
10.00	Occupational Therapy		19340	0	632			10.00
10.01	Occupational Therapy		99914	0	23			10.01
11.00	Speech Pathology		19340	0	82			11.00
11.01	Speech Pathology		99914	0	19			11.01
12.00	Medical Social Services		19340	0	12			12.00
12.01	Medical Social Services		99914	0	1			12.01
13.00	Home Health Aide		19340	0	674			13.00
13.01	Home Health Aide		99914	0	0			13.01
14.00	Total (sum of lines 8-13)			0	4,882			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	57,552	0	57,552	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B 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	2,393		0	373,787		1.00
2.00	Physical Therapy	0	1,046		0	86,724		2.00
3.00	Occupational Therapy	0	655		0	44,933		3.00
4.00	Speech Pathology	0	101		0	15,159		4.00
5.00	Medical Social Services	0	13		0	26,465		5.00
6.00	Home Health Aide	0	674		0	39,638		6.00
7.00	Total (sum of lines 1-6)	0	4,882		0	586,706		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1319 | HHA CCN: 14-7450 | Period: From 06/01/2016 To 05/31/2017 | Worksheet H-3 Part I | Date/Time Prepared: 10/14/2017 11:12 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description							
		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	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	373,787						1.00
2.00	Physical Therapy	86,724						2.00
3.00	Occupational Therapy	44,933						3.00
4.00	Speech Pathology	15,159						4.00
5.00	Medical Social Services	26,465						5.00
6.00	Home Health Aide	39,638						6.00
7.00	Total (sum of lines 1-6)	586,706						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 | HHA CCN: 14-7450 | Period: From 06/01/2016 To 05/31/2017 | Worksheet H-3 Part II | Date/Time Prepared: 10/14/2017 11:12 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	0.458984	305,114	140,042	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.421547	153,788	64,829	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.670886	37,810	25,366	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.117761	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.383305	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1319 HHA CCN: 14-7450	Period: From 06/01/2016 To 05/31/2017	Worksheet H-4 Part I-II Date/Time Prepared: 10/14/2017 11:12 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	727,114	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	27,193	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	11,715	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	8,145	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	6,648	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	61	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	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	780,876	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	780,876	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	780,876	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	780,876	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
31.00	Subtotal (see instructions)	0	780,876	31.00
31.01	Sequestration adjustment (see instructions)	0	15,632	31.01
32.00	Interim payments (see instructions)	0	765,971	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	-727	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 14-1319 | HHA CCN: 14-7450 | Period: From 06/01/2016 To 05/31/2017 | Worksheet H-5 | Date/Time Prepared: 10/14/2017 11:12 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		765,971	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		765,971	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		727	6.02
7.00	Total Medicare program liability (see instructions)		0		765,244	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 | Component CCN: 14-8576 | Period: From 06/01/2016 To 05/31/2017 | Worksheet M-1 | Date/Time Prepared: 10/14/2017 11:12 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	81,325	0	81,325	0	81,325	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	18,734	0	18,734	0	18,734	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	12,884	0	12,884	0	12,884	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	13,201	0	13,201	0	13,201	9.00
10.00	Subtotal (sum of lines 1 through 9)	126,144	0	126,144	0	126,144	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	13,602	13,602	0	13,602	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	13,602	13,602	0	13,602	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	126,144	13,602	139,746	0	139,746	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	4,628	4,628	0	4,628	29.00
30.00	Administrative Costs	22,938	21,871	44,809	0	44,809	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	22,938	26,499	49,437	0	49,437	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	149,082	40,101	189,183	0	189,183	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1319 | Component CCN: 14-8576 | Period: From 06/01/2016 To 05/31/2017 | Worksheet M-1 | Date/Time Prepared: 10/14/2017 11:12 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	81,325		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	18,734		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	12,884		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	13,201		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	126,144		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	13,602		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				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	13,602		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	139,746		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				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	4,628		29.00
30.00	Administrative Costs	0	44,809		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	49,437		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	189,183		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1319
Component CCN: 14-8577

Period: From 06/01/2016 To 05/31/2017

Worksheet M-1
Date/Time Prepared: 10/14/2017 11:12 am

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	50	50	0	50	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	5,090	0	5,090	0	5,090	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	3,476	0	3,476	0	3,476	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	104	0	104	0	104	9.00
10.00	Subtotal (sum of lines 1 through 9)	8,670	50	8,720	0	8,720	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	82	82	0	82	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	82	82	0	82	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	8,670	132	8,802	0	8,802	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	781	781	0	781	29.00
30.00	Administrative Costs	3,546	6,660	10,206	0	10,206	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	3,546	7,441	10,987	0	10,987	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	12,216	7,573	19,789	0	19,789	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1319 | Component CCN: 14-8577 | Period: From 06/01/2016 To 05/31/2017 | Worksheet M-1 | Date/Time Prepared: 10/14/2017 11:12 am

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	50		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	5,090		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	3,476		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	104		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	8,720		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	82		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				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	82		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	8,802		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				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	781		29.00
30.00	Administrative Costs	0	10,206		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	10,987		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	19,789		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1319 Component CCN: 14-8576

Period: From 06/01/2016 To 05/31/2017

Worksheet M-2 Date/Time Prepared: 10/14/2017 11:12 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	0.24	961	4,200	1,008		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.12	565	2,100	252		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.36	1,526		1,260	1,526	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.36	1,526			1,526	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)					139,746	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)					139,746	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)					49,437	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					91,117	15.00
16.00	Total overhead (sum of lines 14 and 15)					140,554	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					140,554	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					140,554	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					280,300	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1319 Component CCN: 14-8577

Period: From 06/01/2016 To 05/31/2017

Worksheet M-2 Date/Time Prepared: 10/14/2017 11:12 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	0.01	60	4,200	42		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.03	184	2,100	63		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.04	244		105	244	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.04	244			244	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)					8,802	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)					8,802	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)					10,987	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					10,310	15.00
16.00	Total overhead (sum of lines 14 and 15)					21,297	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					21,297	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					21,297	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					30,099	20.00