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 06/01/2017 To 05/31/2018	Worksheet S Parts I-III Date/Time Prepared: 9/27/2018 2:22 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 9/27/2018 Time: 2:22 pm
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:
7. Contractor No.
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 CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HAMMOND-HENRY HOSPITAL (14-1319) for the cost reporting period beginning 06/01/2017 and ending 05/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Encryption Information

ECR: Date: 9/27/2018 Time: 2:22 pm
mRoob8Cl:y2TxLiP6o2dWkF8TNMKP0
UVMPH0YNpJKr4FElB9ah83FbtBPFy3
4e9y1onxsy0DsG3G

PI: Date: 9/27/2018 Time: 2:22 pm
G2TN:gWltiMupxHfncK9tkL18Or.60
w8bEA0m7pCxM18:UjWWQA39jUuvJEk
zU9G0LIgk20VScq0

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

Title

Date

		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	-161,716	-782,706	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	-63,898	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	-1	-131		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	-727		0	9.00
10.00	KEWANEE RHC I	0		78,546		0	10.00
10.01	WYOMING RHC II	0		8,322		0	10.01
10.02	GENESEO RHC III	0		12,835		0	10.02
200.00	Total	0	-225,615	-683,861	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 06/01/2017 To 05/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 9/27/2018 2:18 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 600 N. COLLEGE AVENUE	PO Box:			1.00
2.00	City: GENESEO	State: IL	Zip Code: 61254-1099	County: HENRY	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		05/01/2017	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	HAMMOND-HENRY HOSPITAL RHP-WYOMING	148577	99914		05/01/2017	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	HAMMOND-HENRY HOSPITAL RHP-GENESEO	148587	99914		05/16/2018	N	O	N	15.02
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: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	06/01/2017	05/31/2018	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 06/01/2017 To 05/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 9/27/2018 2:18 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		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)(i) or (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)(i) or (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(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 9/27/2018 2:18 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 9/27/2018 2:18 pm

		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 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1319	Period: From 06/01/2017 To 05/31/2018	Worksheet S-2 Part I Date/Time Prepared: 9/27/2018 2:18 pm

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		Y	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		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 Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1319	Period: From 06/01/2017 To 05/31/2018	Worksheet S-2 Part I Date/Time Prepared: 9/27/2018 2:18 pm

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
	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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	508,634	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 9/27/2018 2:18 pm

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

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

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

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

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

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	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)	1	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)	06/01/2017	05/31/2018	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 06/01/2017 To 05/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 9/27/2018 2:18 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	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	07/10/2018	Y	07/10/2018	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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 9/27/2018 2:18 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1319	Period: From 06/01/2017 To 05/31/2018	Worksheet S-2 Part II Date/Time Prepared: 9/27/2018 2:18 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CPA		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 9/27/2018 2:18 pm

	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	58,656.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	58,656.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	58,656.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	37	13,505		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	46.00	0	0			21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	99.10				0	25.10
26.00	KEWANEE RHC	88.00				0	26.00
26.01	WYOMING RHC	88.01				0	26.01
26.02	GENESEO RHC	88.02				0	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		62				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 9/27/2018 2:18 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,344	17	2,444			1.00
2.00	HMO and other (see instructions)	97	84				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	297	0	565			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	9			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,641	17	3,018			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	1,641	17	3,018	0.00	237.47	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	853	0	12,823	0.00	25.39	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	5,611	0	9,424	0.00	8.90	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	2,771	0	16,537	0.00	20.04	26.00
26.01	WYOMING RHC	804	0	2,447	0.00	3.06	26.01
26.02	GENESEO RHC	80	0	158	0.00	0.22	26.02
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	295.08	27.00
28.00	Observation Bed Days		0	1,059			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 9/27/2018 2:18 pm

	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	412	6	753	1.00
2.00	HMO and other (see instructions)			38	27		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	412	6	753	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	0.00				0	21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					25.10
26.00	KEWANEE RHC	0.00					26.00
26.01	WYOMING RHC	0.00					26.01
26.02	GENESEO RHC	0.00					26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 14-1319 | Component CCN: 14-7450 | Period: From 06/01/2017 To 05/31/2018 | Worksheet S-4 | Date/Time Prepared: 9/27/2018 2:18 pm

Home Health Agency I | PPS

					1.00		
0.00	County				HENRY		0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	14,586	0	0	14,586	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	337.00	20.00	66.00	423.00	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			0.81	0.00	0.81	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			7.01	0.00	7.01	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 06/01/2017 To 05/31/2018 | Worksheet S-7 | Date/Time Prepared: 9/27/2018 2:18 pm

		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	0	0	0	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	0	0	0	12.00
13.00		RUB	3	0	3	13.00
14.00		RUA	61	0	61	14.00
15.00		RVC	46	0	46	15.00
16.00		RVB	28	0	28	16.00
17.00		RVA	383	0	383	17.00
18.00		RHC	28	0	28	18.00
19.00		RHB	72	0	72	19.00
20.00		RHA	143	0	143	20.00
21.00		RMC	2	0	2	21.00
22.00		RMB	35	0	35	22.00
23.00		RMA	14	0	14	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	0	0	0	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	0	0	0	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	0	0	0	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	3	0	3	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 06/01/2017 To 05/31/2018 | Worksheet S-7 | Date/Time Prepared: 9/27/2018 2:18 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		818	0	818	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	882,044	33.72	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	1,075	0.04	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)	2,616,162			207.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1319 | Component CCN: 14-8576 | Period: From 06/01/2017 To 05/31/2018 | Worksheet S-8 | Date/Time Prepared: 9/27/2018 2:18 pm

RHC I | Cost

					1.00		
	Clinic Address and Identification						
1.00	Street				1258 WEST SOUTH STREET #2		1.00
		City			State	ZIP Code	
		1.00			2.00	3.00	
2.00	City, State, ZIP Code, County	KEWANEE			IL	61443	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0	3.00
				Grant Award		Date	
				1.00		2.00	
	Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS Act)						4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)						5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)						6.00
7.00	Appalachian Regional Commission						7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECIFY)						9.00
					1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N	0	10.00
		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:30	18:00	07:30	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 06/01/2017
To 05/31/2018

Worksheet S-8
Date/Time Prepared:
9/27/2018 2:18 pm

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:30	18:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1319 | Component CCN: 14-8577 | Period: From 06/01/2017 To 05/31/2018 | Worksheet S-8 | Date/Time Prepared: 9/27/2018 2:18 pm

RHC II | Cost

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

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:30	17:00	08:30	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 06/01/2017
To 05/31/2018

Worksheet S-8
Date/Time Prepared:
9/27/2018 2:18 pm

RHC II | Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1319 | Component CCN: 14-8587 | Period: From 06/01/2017 To 05/31/2018 | Worksheet S-8 | Date/Time Prepared: 9/27/2018 2:18 pm

RHC III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			600 N. COLLEGE AVENUE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	GENESEO		IL	61254-1099	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

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

				Provider name	CCN number	
				1.00	2.00	
14.00	RHC/FQHC name, CCN number					14.00

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		HENRY				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08:30	17:00	08:30	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1319
Component CCN: 14-8587

Period:
From 06/01/2017
To 05/31/2018

Worksheet S-8
Date/Time Prepared:
9/27/2018 2:18 pm

RHC III | Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1319	Period: From 06/01/2017 To 05/31/2018	Worksheet S-10 Date/Time Prepared: 9/27/2018 2:18 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.368957	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 and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/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)	798,087	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)	30,591	269,883	300,474	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)	29,842	223,410	253,252	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,091,764	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	32,080	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	49,354	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,042,410	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	401,878	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	655,130	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	655,130	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet A | Date/Time Prepared: 9/27/2018 2:18 pm

		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		2,018,160	2,018,160	538,527	2,556,687	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,059,459	1,059,459	-8,892	1,050,567	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	138,117	4,264,411	4,402,528	-427,953	3,974,575	4.00
5.01	00550	DATA PROCESSING	325,651	963,354	1,289,005	0	1,289,005	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	113,958	3,859	117,817	0	117,817	5.02
5.03	00570	ADMITTING	162,327	59,491	221,818	0	221,818	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	353,800	302,884	656,684	0	656,684	5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	528,108	2,207,040	2,735,148	-88,123	2,647,025	5.05
7.00	00700	OPERATION OF PLANT	219,141	954,052	1,173,193	0	1,173,193	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	26,350	99,271	125,621	0	125,621	8.00
9.00	00900	HOUSEKEEPING	383,599	112,811	496,410	0	496,410	9.00
10.00	01000	DIETARY	457,460	437,755	895,215	0	895,215	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	168,288	1,396	169,684	0	169,684	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	41,190	41,190	0	41,190	14.00
15.00	01500	PHARMACY	211,327	224,083	435,410	0	435,410	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	374,309	66,632	440,941	0	440,941	16.00
17.00	01700	SOCIAL SERVICE	102,009	744	102,753	0	102,753	17.00
18.00	01080	INSERVICE EDUCATION	122,142	25,876	148,018	0	148,018	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,922,395	450,813	2,373,208	0	2,373,208	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	927,877	164,859	1,092,736	323,668	1,416,404	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	1,330,050	3,232,019	4,562,069	-1,264,791	3,297,278	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	839,107	0	839,107	81,609	920,716	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	797,872	1,060,774	1,858,646	0	1,858,646	54.00
60.00	06000	LABORATORY	656,107	981,962	1,638,069	0	1,638,069	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	103,160	103,160	0	103,160	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,262,736	50,974	1,313,710	0	1,313,710	66.00
67.00	06700	OCCUPATIONAL THERAPY	336,221	15,573	351,794	0	351,794	67.00
68.00	06800	SPEECH PATHOLOGY	129,916	7,407	137,323	0	137,323	68.00
69.00	06900	ELECTROCARDIOLOGY	226,540	191,656	418,196	0	418,196	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	1,305,595	1,305,595	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,270,289	1,270,289	0	1,270,289	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	69,195	48,288	117,483	0	117,483	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	1,538,185	516,074	2,054,259	0	2,054,259	88.00
88.01	08801	WYOMING RHC	189,495	77,481	266,976	0	266,976	88.01
88.02	08802	GENESEO RHC	22,945	7,718	30,663	3,025	33,688	88.02
90.00	09000	CLINIC	665,065	237,700	902,765	133,964	1,036,729	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	48,466	1,695,590	1,744,056	0	1,744,056	90.03
90.04	09004	GENESEO CLINIC	344,177	115,768	459,945	45,368	505,313	90.04
91.00	09100	EMERGENCY	1,325,927	1,047,422	2,373,349	146,511	2,519,860	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	514,754	118,043	632,797	0	632,797	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		805,618	805,618	-805,618	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,833,616	25,041,656	41,875,272	-17,110	41,858,162	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	2,667	2,667	0	2,667	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	116,555	75,095	191,650	0	191,650	192.03
192.04	19204	ANNAWAN CLINIC	91,884	75,800	167,684	11,342	179,026	192.04
192.05	19205	CAMBRIDGE CLINIC	68,920	65,999	134,919	5,768	140,687	192.05
194.00	07955	FOUNDATION	0	0	0	0	0	194.00
194.01	07950	SPORTS MEDICINE	119,766	25,860	145,626	0	145,626	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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet A | Date/Time Prepared: 9/27/2018 2:18 pm

		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	
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	8,737	8,737	0	8,737	194.07
200.00		TOTAL (SUM OF LINES 118 through 199)	17,230,741	25,295,814	42,526,555	0	42,526,555	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet A | Date/Time Prepared: 9/27/2018 2:18 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	32,854	2,589,541		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,050,567		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,974,575		4.00
5.01	00550	DATA PROCESSING	0	1,289,005		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-94,490	23,327		5.02
5.03	00570	ADMITTING	0	221,818		5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	-79,113	577,571		5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	-188,870	2,458,155		5.05
7.00	00700	OPERATION OF PLANT	0	1,173,193		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	125,621		8.00
9.00	00900	HOUSEKEEPING	0	496,410		9.00
10.00	01000	DIETARY	-172,764	722,451		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	169,684		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	41,190		14.00
15.00	01500	PHARMACY	0	435,410		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,122	439,819		16.00
17.00	01700	SOCIAL SERVICE	0	102,753		17.00
18.00	01080	INSERVICE EDUCATION	0	148,018		18.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-534,651	1,838,557		30.00
43.00	04300	NURSERY	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	-75	1,416,329		44.00
46.00	04600	OTHER LONG TERM CARE	0	0		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-108,138	3,189,140		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	-920,716	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,858,646		54.00
60.00	06000	LABORATORY	0	1,638,069		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	103,160		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	-463	1,313,247		66.00
67.00	06700	OCCUPATIONAL THERAPY	-154	351,640		67.00
68.00	06800	SPEECH PATHOLOGY	0	137,323		68.00
69.00	06900	ELECTROCARDIOLOGY	-16,944	401,252		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,305,595		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,270,289		73.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	-309	117,174		76.01
76.02	03950	IV THERAPY	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	KEWANEE RHC	0	2,054,259		88.00
88.01	08801	WYOMING RHC	0	266,976		88.01
88.02	08802	GENESEO RHC	0	33,688		88.02
90.00	09000	CLINIC	-559,357	477,372		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	-1,117,717	626,339		90.03
90.04	09004	GENESEO CLINIC	-227,281	278,032		90.04
91.00	09100	EMERGENCY	-698,590	1,821,270		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	632,797		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,687,900	37,170,262		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	2,667		192.01
192.02	19201	CARDIOLOGY CLINIC	0	0		192.02
192.03	19202	LEASED SPACE	0	191,650		192.03
192.04	19204	ANNAWAN CLINIC	0	179,026		192.04
192.05	19205	CAMBRIDGE CLINIC	0	140,687		192.05
194.00	07955	FOUNDATION	0	0		194.00
194.01	07950	SPORTS MEDICINE	0	145,626		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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet A | Date/Time Prepared: 9/27/2018 2:18 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0		194.06
194.07	07957	COMMUNITY HEALTH	0	8,737		194.07
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,687,900	37,838,655		200.00

RECLASSIFICATIONS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet A-6 | Date/Time Prepared: 9/27/2018 2:18 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - COLONA CLINIC BUILDING DEPRECIATION					
1.00	CLINIC	90.00	0	38,958		1.00
	TOTALS		0	38,958		
	C - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	805,618		1.00
	TOTALS		0	805,618		
	E - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	66,355		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	20,288		2.00
3.00	CLINIC	90.00	0	1,480		3.00
	TOTALS		0	88,123		
	H - IMPLANT EXP RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,305,595		1.00
	TOTALS		0	1,305,595		
	I - RECLASS PROVIDER BENEFITS					
1.00	ANESTHESIOLOGY	53.00	0	122,413		1.00
2.00	CLINIC	90.00	0	93,526		2.00
3.00	GENESEO CLINIC	90.04	0	45,368		3.00
4.00	CAMBRIDGE CLINIC	192.05	0	5,768		4.00
5.00	EMERGENCY	91.00	0	146,511		5.00
6.00	GENESEO RHC	88.02	0	3,025		6.00
7.00	ANNAWAN CLINIC	192.04	0	11,342		7.00
	TOTALS		0	427,953		
	J - RECLASS SNF DEPRECIATION AND INTERST					
1.00	SKILLED NURSING FACILITY	44.00	0	178,648		1.00
2.00	SKILLED NURSING FACILITY	44.00	0	115,840		2.00
3.00	SKILLED NURSING FACILITY	44.00	0	29,180		3.00
	TOTALS		0	323,668		
	K - TO CLOSE ANESTHESIA TO OR					
1.00	OPERATING ROOM	50.00	0	40,804		1.00
	TOTALS		0	40,804		
500.00	Grand Total: Increases		0	3,030,719		500.00

RECLASSIFICATIONS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet A-6 | Date/Time Prepared: 9/27/2018 2:18 pm

		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	805,618	11		1.00
	TOTALS		0	805,618			
	E - OTHER CAPITAL COSTS						
1.00	ALL OTHER ADMINISTRATIVE AND GE	5.05	0	88,123	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	88,123			
	H - IMPLANT EXP RECLASS						
1.00	OPERATING ROOM	50.00	0	1,305,595	0		1.00
	TOTALS		0	1,305,595			
	I - RECLASS PROVIDER BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	427,953	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
	TOTALS		0	427,953			
	J - RECLASS SNF DEPRECIATION AND INTERST						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	178,648	9		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	115,840	11		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	29,180	9		3.00
	TOTALS		0	323,668			
	K - TO CLOSE ANESTHESIA TO OR						
1.00	ANESTHESIOLOGY	53.00	0	40,804	0		1.00
	TOTALS		0	40,804			
500.00	Grand Total: Decreases		0	3,030,719			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 9/27/2018 2:18 pm

		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	1,629,936	0	0	0	0	2.00
3.00	Buildings and Fixtures	44,937,474	62,574	0	62,574	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	13,436,693	771,439	0	771,439	419,842	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	61,320,772	834,013	0	834,013	419,842	8.00
9.00	Reconciling Items	-71,691	-203,369	0	-203,369	-123,550	9.00
10.00	Total (line 8 minus line 9)	61,392,463	1,037,382	0	1,037,382	543,392	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	45,000,048	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	13,788,290	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	61,734,943	0	8.00
9.00	Reconciling Items	-151,510	0	9.00
10.00	Total (line 8 minus line 9)	61,886,453	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet A-7 Part II Date/Time Prepared: 9/27/2018 2:18 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,018,160	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,059,459	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,077,619	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	2,018,160		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,059,459		2.00
3.00	Total (sum of lines 1-2)	0	3,077,619		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 9/27/2018 2:18 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	44,785,452	0	44,785,452	0.764599	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	13,788,290	0	13,788,290	0.235401	0	2.00
3.00	Total (sum of lines 1-2)	58,573,742	0	58,573,742	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,800,554	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,030,279	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,830,833	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	722,632	66,355	0	0	2,589,541	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	20,288	0	0	1,050,567	2.00
3.00	Total (sum of lines 1-2)	722,632	86,643	0	0	3,640,108	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet A-8 | Date/Time Prepared: 9/27/2018 2:18 pm

	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	-416	PURCHASING RECEIVING AND STORES	5.02	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	A	-94,074	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	-3,628	ALL OTHER ADMINISTRATIVE AND GE	5.05	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,254,956			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	-172,764	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	-1,122	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet A-8 | Date/Time Prepared: 9/27/2018 2:18 pm

	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	
33.00	ADVERTISING EXPENSE	A	-95,885	ALL OTHER ADMINISTRATIVE AND GE	5.05	0	33.00
33.01	PART B BILLING	A	-79,113	CASHIERING/ACCOUNTS RECEIVABLE	5.04	0	33.01
33.02	PHYSICIAN RECRUITING	A	-77,737	ALL OTHER ADMINISTRATIVE AND GE	5.05	0	33.02
33.03	UNAMMORTIZED BOND ISSUE COST	B	32,854	CAP REL COSTS-BLDG & FIXT	1.00	11	33.03
33.04	TV SERVICE - MED SURG	A	-3,861	ADULTS & PEDIATRICS	30.00	0	33.04
33.05	TV SERVICE - CARDIAC	A	-309	ELECTROCARDIOLOGY	69.00	0	33.05
33.06	TV SERVICE - LTC	A	-6,333	SKILLED NURSING FACILITY	44.00	0	33.06
33.07	TV SERVICE - OR	A	-2,471	OPERATING ROOM	50.00	0	33.07
33.08	TV SERVICE - ER	A	-1,081	EMERGENCY	91.00	0	33.08
33.09	TV SERVICE - PT	A	-463	PHYSICAL THERAPY	66.00	0	33.09
33.10	TV SERVICE - OT	A	-154	OCCUPATIONAL THERAPY	67.00	0	33.10
33.11	TV SERVICE - SLEEP	A	-309	SLEEP LAB	76.01	0	33.11
33.12	CRNA EXPENSES	A	-920,716	ANESTHESIOLOGY	53.00	0	33.12
33.13	UNAMMORTIZED BOND ISSUE COST	A	6,258	SKILLED NURSING FACILITY	44.00	0	33.13
33.14	LOBBYING	A	-11,620	ALL OTHER ADMINISTRATIVE AND GE	5.05	0	33.14
33.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.15
33.16	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.16
33.17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.17
33.18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.18
33.19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.19
33.21	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.21
33.23	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.23
33.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.24
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,687,900				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 06/01/2017 To 05/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 9/27/2018 2:18 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	36,323	0	36,323	0	0	1.00
2.00	91.00	EMERGENCY	1,585,248	697,509	887,739	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	16,635	16,635	0	0	0	3.00
4.00	90.00	CLINIC	559,357	559,357	0	0	0	4.00
5.00	90.03	SURGICAL CLINIC	1,117,717	1,117,717	0	0	0	5.00
6.00	50.00	OPERATING ROOM	105,667	105,667	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	257,652	257,652	0	0	0	7.00
8.00	90.04	GENESEO CLINIC	227,281	227,281	0	0	0	8.00
9.00	30.00	ADULTS & PEDIATRICS	273,138	273,138	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,179,018	3,254,956	924,062		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	90.00	CLINIC	0	0	0	0	0	4.00
5.00	90.03	SURGICAL CLINIC	0	0	0	0	0	5.00
6.00	50.00	OPERATING ROOM	0	0	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	7.00
8.00	90.04	GENESEO CLINIC	0	0	0	0	0	8.00
9.00	30.00	ADULTS & PEDIATRICS	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	697,509		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	16,635		3.00
4.00	90.00	CLINIC	0	0	0	559,357		4.00
5.00	90.03	SURGICAL CLINIC	0	0	0	1,117,717		5.00
6.00	50.00	OPERATING ROOM	0	0	0	105,667		6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	257,652		7.00
8.00	90.04	GENESEO CLINIC	0	0	0	227,281		8.00
9.00	30.00	ADULTS & PEDIATRICS	0	0	0	273,138		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,254,956		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B Part I Date/Time Prepared: 9/27/2018 2:18 pm

		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	2,589,541	2,589,541				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,050,567		1,050,567			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,974,575	12,334	2,826	3,989,735		4.00
5.01	00550	DATA PROCESSING	1,289,005	75,985	174,266	86,286	1,625,542	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	23,327	77,025	0	30,195	8,905	5.02
5.03	00570	ADMITTING	221,818	33,411	0	43,011	29,144	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	577,571	26,253	1,587	93,744	0	5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	2,458,155	104,839	11,650	139,930	280,922	5.05
7.00	00700	OPERATION OF PLANT	1,173,193	201,777	9,623	58,064	10,254	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	125,621	19,194	1,346	6,982	0	8.00
9.00	00900	HOUSEKEEPING	496,410	34,550	0	101,640	4,048	9.00
10.00	01000	DIETARY	722,451	87,527	11,030	121,210	24,611	10.00
11.00	01100	CAFETERIA	0	57,806	0	0	2,159	11.00
13.00	01300	NURSING ADMINISTRATION	169,684	15,058	11,920	44,590	21,858	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	41,190	0	0	0	0	14.00
15.00	01500	PHARMACY	435,410	41,510	1,977	55,994	49,923	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	439,819	40,593	9,246	99,178	87,973	16.00
17.00	01700	SOCIAL SERVICE	102,753	9,857	0	27,029	4,857	17.00
18.00	01080	INSERVICE EDUCATION	148,018	0	0	32,363	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,838,557	336,856	85,311	509,373	249,616	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,416,329	0	28,935	245,854	42,097	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,189,140	377,773	341,061	352,415	68,003	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	1,858,646	208,538	188,369	211,407	65,845	54.00
60.00	06000	LABORATORY	1,638,069	74,128	55,022	173,845	51,812	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	103,160	2,254	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,313,247	236,624	25,565	334,580	72,591	66.00
67.00	06700	OCCUPATIONAL THERAPY	351,640	91,613	875	89,086	3,778	67.00
68.00	06800	SPEECH PATHOLOGY	137,323	10,006	0	34,423	1,889	68.00
69.00	06900	ELECTROCARDIOLOGY	401,252	39,900	5,045	60,025	9,715	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	1,305,595	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,270,289	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	117,174	18,501	0	18,334	1,079	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	2,054,259	0	14,959	407,564	175,373	88.00
88.01	08801	WYOMING RHC	266,976	0	287	50,209	24,589	88.01
88.02	08802	GENESEO RHC	33,688	7,529	70	2,717	1,155	88.02
90.00	09000	CLINIC	477,372	0	15,417	79,229	74,847	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	626,339	6,489	19,913	12,842	28,324	90.03
90.04	09004	GENESEO CLINIC	278,032	73,211	1,051	44,356	17,368	90.04
91.00	09100	EMERGENCY	1,821,270	122,844	24,914	199,388	145,452	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	632,797	27,912	2,453	136,391	50,193	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,170,262	2,471,897	1,044,718	3,902,254	1,608,380	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	24,470	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	2,667	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	191,650	19,194	4,504	30,883	0	192.03
192.04	19204	ANNAWAN CLINIC	179,026	0	625	12,584	12,251	192.04
192.05	19205	CAMBRIDGE CLINIC	140,687	0	508	12,280	4,911	192.05
194.00	07955	FOUNDATION	0	9,833	0	0	0	194.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B Part I Date/Time Prepared: 9/27/2018 2:18 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
194.01	07950	SPORTS MEDICINE	145,626	0	212	31,734	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	64,147	0	0	0	194.06
194.07	07957	COMMUNITY HEALTH	8,737	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	37,838,655	2,589,541	1,050,567	3,989,735	1,625,542	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B Part I Date/Time Prepared: 9/27/2018 2:18 pm

		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	139,452					5.02
5.03	00570	ADMITTING	92	327,476				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	174	0	699,329			5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	454	0	0	2,995,950	2,995,950	5.05
7.00	00700	OPERATION OF PLANT	1,514	0	0	1,454,425	125,290	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	88	0	0	153,231	13,200	8.00
9.00	00900	HOUSEKEEPING	1,716	0	0	638,364	54,991	9.00
10.00	01000	DIETARY	1,069	0	0	967,898	83,379	10.00
11.00	01100	CAFETERIA	0	0	0	59,965	5,166	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	263,110	22,665	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,392	0	0	42,582	3,668	14.00
15.00	01500	PHARMACY	253	0	0	585,067	50,400	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	114	0	0	676,923	58,313	16.00
17.00	01700	SOCIAL SERVICE	4	0	0	144,500	12,448	17.00
18.00	01080	INSERVICE EDUCATION	116	0	0	180,497	15,549	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,314	16,147	31,116	3,071,290	264,573	30.00
43.00	04300	NURSERY	0	6	12	18	2	43.00
44.00	04400	SKILLED NURSING FACILITY	1,537	0	18,316	1,753,068	151,016	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	41,870	84,266	162,286	4,616,814	397,697	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,910	72,646	139,994	2,753,355	237,185	54.00
60.00	06000	LABORATORY	17,038	46,316	89,253	2,145,483	184,820	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	886	1,707	108,007	9,304	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	406	22,506	43,371	2,048,890	176,500	66.00
67.00	06700	OCCUPATIONAL THERAPY	98	6,718	12,946	556,754	47,961	67.00
68.00	06800	SPEECH PATHOLOGY	29	1,695	3,267	188,632	16,250	68.00
69.00	06900	ELECTROCARDIOLOGY	353	16,087	31,000	563,377	48,532	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,584	3,052	4,636	399	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42,803	11,770	22,682	1,382,850	119,124	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	21,099	40,659	1,332,047	114,748	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	140	3,403	6,558	165,189	14,230	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	3,414	0	26,132	2,681,701	231,012	88.00
88.01	08801	WYOMING RHC	313	0	3,663	346,037	29,809	88.01
88.02	08802	GENESEO RHC	162	147	284	45,752	3,941	88.02
90.00	09000	CLINIC	1,573	0	10,869	659,307	56,795	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	781	2,191	4,221	701,100	60,396	90.03
90.04	09004	GENESEO CLINIC	2,425	1,433	2,761	420,637	36,235	90.04
91.00	09100	EMERGENCY	3,967	18,576	35,796	2,372,207	204,351	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	1,386	0	6,827	857,959	73,908	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	137,505	327,476	696,772	36,937,622	2,923,857	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	24,470	2,108	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	85	0	0	2,752	237	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	126	0	0	246,357	21,222	192.03
192.04	19204	ANNAWAN CLINIC	768	0	1,825	207,079	17,839	192.04
192.05	19205	CAMBRIDGE CLINIC	691	0	732	159,809	13,767	192.05
194.00	07955	FOUNDATION	0	0	0	9,833	847	194.00
194.01	07950	SPORTS MEDICINE	237	0	0	177,809	15,317	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 - GENERAL SERVICE COSTS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B Part I Date/Time Prepared: 9/27/2018 2:18 pm

		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	
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	64,147	0	194.06
194.07	07957	COMMUNITY HEALTH	40	0	0	8,777	756	194.07
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	139,452	327,476	699,329	37,838,655	2,995,950	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B Part I Date/Time Prepared: 9/27/2018 2:18 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE						5.05
7.00	00700	OPERATION OF PLANT	1,579,715					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,437	178,868				8.00
9.00	00900	HOUSEKEEPING	22,387	18,637	734,379			9.00
10.00	01000	DIETARY	56,714	948	35,607	1,144,546		10.00
11.00	01100	CAFETERIA	37,456	0	8,101	670,162	780,850	11.00
13.00	01300	NURSING ADMINISTRATION	9,757	0	0	0	13,658	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	26,897	0	3,056	0	12,930	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	26,303	0	4,345	0	50,855	16.00
17.00	01700	SOCIAL SERVICE	6,387	0	1,841	0	8,696	17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	0	8,559	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	218,271	38,271	201,600	112,529	122,427	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	287,825	45,186	178,035	361,855	115,595	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	244,782	24,384	115,916	0	91,192	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	135,125	17,069	29,642	0	61,326	54.00
60.00	06000	LABORATORY	48,032	0	18,411	0	64,786	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	1,460	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	153,324	12,366	22,535	0	85,820	66.00
67.00	06700	OCCUPATIONAL THERAPY	59,362	0	4,971	0	21,307	67.00
68.00	06800	SPEECH PATHOLOGY	6,483	0	0	0	8,468	68.00
69.00	06900	ELECTROCARDIOLOGY	25,854	0	8,727	0	17,483	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	11,988	1,305	1,473	0	5,873	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0	0	0	0	0	88.00
88.01	08801	WYOMING RHC	0	0	0	0	0	88.01
88.02	08802	GENESEO RHC	0	6	810	0	1,002	88.02
90.00	09000	CLINIC	0	655	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	4,205	0	15,281	0	7,102	90.03
90.04	09004	GENESEO CLINIC	0	88	7,107	0	15,115	90.04
91.00	09100	EMERGENCY	79,599	19,953	34,539	0	55,681	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	18,086	0	2,762	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,492,734	178,868	694,759	1,144,546	767,875	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	15,856	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	64,754	0	31,814	0	4,917	192.03
192.04	19204	ANNAWAN CLINIC	0	0	0	0	0	192.04
192.05	19205	CAMBRIDGE CLINIC	0	0	0	0	0	192.05
194.00	07955	FOUNDATION	6,371	0	0	0	8,058	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

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B Part I Date/Time Prepared: 9/27/2018 2:18 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	7,806	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,579,715	178,868	734,379	1,144,546	780,850	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B Part I Date/Time Prepared: 9/27/2018 2:18 pm

		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	309,190					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	46,250				14.00
15.00	01500	PHARMACY	9,266	0	687,616			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	816,739		16.00
17.00	01700	SOCIAL SERVICE	6,231	0	0	0	180,103	17.00
18.00	01080	INSERVICE EDUCATION	6,134	0	0	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	87,729	0	0	37,529	85,388	30.00
43.00	04300	NURSERY	0	0	0	15	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	3,601	82,597	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	65,348	0	0	195,729	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	43,946	0	0	168,848	0	54.00
60.00	06000	LABORATORY	46,426	0	0	107,649	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	2,058	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	52,310	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	15,615	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,940	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	37,389	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	46,250	0	3,681	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	27,357	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	687,616	49,039	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	4,209	0	0	7,910	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	31,518	0	88.00
88.01	08801	WYOMING RHC	0	0	0	4,419	0	88.01
88.02	08802	GENESEO RHC	0	0	0	342	0	88.02
90.00	09000	CLINIC	0	0	0	13,110	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	5,091	0	90.03
90.04	09004	GENESEO CLINIC	0	0	0	3,330	0	90.04
91.00	09100	EMERGENCY	39,901	0	0	43,175	12,118	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	309,190	46,250	687,616	813,655	180,103	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	0	0	0	0	192.03
192.04	19204	ANNAWAN CLINIC	0	0	0	2,201	0	192.04
192.05	19205	CAMBRIDGE CLINIC	0	0	0	883	0	192.05
194.00	07955	FOUNDATION	0	0	0	0	0	194.00
194.01	07950	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B Part I Date/Time Prepared: 9/27/2018 2:18 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	309,190	46,250	687,616	816,739	180,103	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B Part I | Date/Time Prepared: 9/27/2018 2:18 pm

		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	210,739					18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,467	4,249,074	0	4,249,074		30.00
43.00	04300	NURSERY	4	39	0	39		43.00
44.00	04400	SKILLED NURSING FACILITY	5,572	2,984,350	0	2,984,350		44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0		46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	49,426	5,801,288	0	5,801,288		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,592	3,489,088	0	3,489,088		54.00
60.00	06000	LABORATORY	27,154	2,642,761	0	2,642,761		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	519	121,348	0	121,348		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	13,195	2,564,940	0	2,564,940		66.00
67.00	06700	OCCUPATIONAL THERAPY	3,939	709,909	0	709,909		67.00
68.00	06800	SPEECH PATHOLOGY	994	224,767	0	224,767		68.00
69.00	06900	ELECTROCARDIOLOGY	9,431	710,793	0	710,793		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	929	55,895	0	55,895		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,901	1,536,232	0	1,536,232		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,370	2,195,820	0	2,195,820		73.00
76.00	03020	ACUPUNCTURE	0	0	0	0		76.00
76.01	03610	SLEEP LAB	1,995	214,172	0	214,172		76.01
76.02	03950	IV THERAPY	0	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	7,950	2,952,181	0	2,952,181		88.00
88.01	08801	WYOMING RHC	1,115	381,380	0	381,380		88.01
88.02	08802	GENESEO RHC	86	51,939	0	51,939		88.02
90.00	09000	CLINIC	3,307	733,174	0	733,174		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	1,284	794,459	0	794,459		90.03
90.04	09004	GENESEO CLINIC	840	483,352	0	483,352		90.04
91.00	09100	EMERGENCY	10,891	2,872,415	0	2,872,415		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	952,715	0	952,715		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	209,961	36,722,091	0	36,722,091		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	42,434	0	42,434		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0		192.00
192.01	19203	MUSCATINE CLINIC	0	2,989	0	2,989		192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0		192.02
192.03	19202	LEASED SPACE	0	369,064	0	369,064		192.03
192.04	19204	ANNAWAN CLINIC	555	227,674	0	227,674		192.04
192.05	19205	CAMBRIDGE CLINIC	223	174,682	0	174,682		192.05
194.00	07955	FOUNDATION	0	25,109	0	25,109		194.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B Part I | Date/Time Prepared: 9/27/2018 2:18 pm

		Cost Center Description	OTHER GENERAL SERVICE INSERVICE EDUCATION	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			18.00	24.00	25.00	26.00		
194.01	07950	SPORTS MEDICINE	0	193,126	0	193,126		194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0		194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0		194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0		194.04
194.05	07954	COLONA CLINIC	0	0	0	0		194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	71,953	0	71,953		194.06
194.07	07957	COMMUNITY HEALTH	0	9,533	0	9,533		194.07
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	210,739	37,838,655	0	37,838,655		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B Part II | Date/Time Prepared: 9/27/2018 2:18 pm

		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	12,334	2,826	15,160	15,160	4.00
5.01	00550	DATA PROCESSING	0	75,985	174,266	250,251	328	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	77,025	0	77,025	115	5.02
5.03	00570	ADMITTING	0	33,411	0	33,411	163	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	26,253	1,587	27,840	356	5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	0	104,839	11,650	116,489	532	5.05
7.00	00700	OPERATION OF PLANT	0	201,777	9,623	211,400	221	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	19,194	1,346	20,540	27	8.00
9.00	00900	HOUSEKEEPING	0	34,550	0	34,550	386	9.00
10.00	01000	DIETARY	0	87,527	11,030	98,557	461	10.00
11.00	01100	CAFETERIA	0	57,806	0	57,806	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	15,058	11,920	26,978	169	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	41,510	1,977	43,487	213	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	40,593	9,246	49,839	377	16.00
17.00	01700	SOCIAL SERVICE	0	9,857	0	9,857	103	17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	0	123	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	336,856	85,311	422,167	1,931	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	28,935	28,935	934	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	377,773	341,061	718,834	1,339	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	208,538	188,369	396,907	803	54.00
60.00	06000	LABORATORY	0	74,128	55,022	129,150	661	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	2,254	0	2,254	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	236,624	25,565	262,189	1,272	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	91,613	875	92,488	339	67.00
68.00	06800	SPEECH PATHOLOGY	0	10,006	0	10,006	131	68.00
69.00	06900	ELECTROCARDIOLOGY	0	39,900	5,045	44,945	228	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	18,501	0	18,501	70	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	14,959	14,959	1,549	88.00
88.01	08801	WYOMING RHC	0	0	287	287	191	88.01
88.02	08802	GENESEO RHC	0	7,529	70	7,599	10	88.02
90.00	09000	CLINIC	0	0	15,417	15,417	301	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	6,489	19,913	26,402	49	90.03
90.04	09004	GENESEO CLINIC	0	73,211	1,051	74,262	169	90.04
91.00	09100	EMERGENCY	0	122,844	24,914	147,758	758	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	27,912	2,453	30,365	518	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,471,897	1,044,718	3,516,615	14,827	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	24,470	0	24,470	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	19,194	4,504	23,698	117	192.03
192.04	19204	ANNAWAN CLINIC	0	0	625	625	48	192.04
192.05	19205	CAMBRIDGE CLINIC	0	0	508	508	47	192.05
194.00	07955	FOUNDATION	0	9,833	0	9,833	0	194.00
194.01	07950	SPORTS MEDICINE	0	0	212	212	121	194.01

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B Part II Date/Time Prepared: 9/27/2018 2:18 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
194.02	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	64,147	0	64,147	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,589,541	1,050,567	3,640,108	15,160	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B Part II | Date/Time Prepared: 9/27/2018 2:18 pm

		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	250,579					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	1,373	78,513				5.02
5.03	00570	ADMITTING	4,493	52	38,119			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	98	0	28,294		5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	43,303	256	0	0	160,580	5.05
7.00	00700	OPERATION OF PLANT	1,581	853	0	0	6,715	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	50	0	0	707	8.00
9.00	00900	HOUSEKEEPING	624	966	0	0	2,947	9.00
10.00	01000	DIETARY	3,794	602	0	0	4,469	10.00
11.00	01100	CAFETERIA	333	0	0	0	277	11.00
13.00	01300	NURSING ADMINISTRATION	3,369	0	0	0	1,215	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	784	0	0	197	14.00
15.00	01500	PHARMACY	7,696	142	0	0	2,701	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,561	64	0	0	3,125	16.00
17.00	01700	SOCIAL SERVICE	749	3	0	0	667	17.00
18.00	01080	INSERVICE EDUCATION	0	66	0	0	833	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	38,479	2,429	1,880	1,258	14,180	30.00
43.00	04300	NURSERY	0	0	1	1	0	43.00
44.00	04400	SKILLED NURSING FACILITY	6,489	865	0	740	8,094	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	10,483	23,573	9,803	6,585	21,324	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	10,150	4,453	8,458	5,659	12,712	54.00
60.00	06000	LABORATORY	7,987	9,593	5,393	3,608	9,906	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	103	69	499	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	11,190	229	2,620	1,753	9,460	66.00
67.00	06700	OCCUPATIONAL THERAPY	582	55	782	523	2,571	67.00
68.00	06800	SPEECH PATHOLOGY	291	16	197	132	871	68.00
69.00	06900	ELECTROCARDIOLOGY	1,498	199	1,873	1,253	2,601	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	184	123	21	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	24,097	1,370	917	6,385	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,457	1,644	6,150	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	166	79	396	265	763	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	27,034	1,922	0	1,056	12,381	88.00
88.01	08801	WYOMING RHC	3,790	176	0	148	1,598	88.01
88.02	08802	GENESEO RHC	178	91	17	11	211	88.02
90.00	09000	CLINIC	11,538	886	0	439	3,044	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	4,366	440	255	171	3,237	90.03
90.04	09004	GENESEO CLINIC	2,677	1,365	167	112	1,942	90.04
91.00	09100	EMERGENCY	22,422	2,233	2,163	1,447	10,952	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	7,737	781	0	276	3,961	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	247,933	77,418	38,119	28,190	156,716	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	113	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	48	0	0	13	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	71	0	0	1,137	192.03
192.04	19204	ANNAWAN CLINIC	1,889	432	0	74	956	192.04
192.05	19205	CAMBRIDGE CLINIC	757	389	0	30	738	192.05
194.00	07955	FOUNDATION	0	0	0	0	45	194.00
194.01	07950	SPORTS MEDICINE	0	133	0	0	821	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B Part II Date/Time Prepared: 9/27/2018 2:18 pm

		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	
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	22	0	0	41	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	250,579	78,513	38,119	28,294	160,580	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B Part II Date/Time Prepared: 9/27/2018 2:18 pm

		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	220,770					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,738	23,062				8.00
9.00	00900	HOUSEKEEPING	3,129	2,403	45,005			9.00
10.00	01000	DIETARY	7,926	122	2,182	118,113		10.00
11.00	01100	CAFETERIA	5,235	0	496	69,158	133,305	11.00
13.00	01300	NURSING ADMINISTRATION	1,364	0	0	0	2,332	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	3,759	0	187	0	2,207	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,676	0	266	0	8,682	16.00
17.00	01700	SOCIAL SERVICE	893	0	113	0	1,485	17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	0	1,461	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,504	4,934	12,354	11,613	20,901	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	40,223	5,827	10,911	37,342	19,734	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	34,209	3,144	7,104	0	15,568	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	18,884	2,201	1,817	0	10,469	54.00
60.00	06000	LABORATORY	6,713	0	1,128	0	11,060	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	204	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	21,427	1,594	1,381	0	14,651	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,296	0	305	0	3,637	67.00
68.00	06800	SPEECH PATHOLOGY	906	0	0	0	1,446	68.00
69.00	06900	ELECTROCARDIOLOGY	3,613	0	535	0	2,985	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	1,675	168	90	0	1,003	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0	0	0	0	0	88.00
88.01	08801	WYOMING RHC	0	0	0	0	0	88.01
88.02	08802	GENESEO RHC	0	1	50	0	171	88.02
90.00	09000	CLINIC	0	84	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	588	0	936	0	1,212	90.03
90.04	09004	GENESEO CLINIC	0	11	436	0	2,580	90.04
91.00	09100	EMERGENCY	11,124	2,573	2,117	0	9,506	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	2,528	0	169	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	208,614	23,062	42,577	118,113	131,090	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	2,216	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	9,050	0	1,950	0	839	192.03
192.04	19204	ANNAWAN CLINIC	0	0	0	0	0	192.04
192.05	19205	CAMBRIDGE CLINIC	0	0	0	0	0	192.05
194.00	07955	FOUNDATION	890	0	0	0	1,376	194.00
194.01	07950	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B Part II Date/Time Prepared: 9/27/2018 2:18 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	478	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	220,770	23,062	45,005	118,113	133,305	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B Part II Date/Time Prepared: 9/27/2018 2:18 pm

		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	35,427					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	981				14.00
15.00	01500	PHARMACY	1,062	0	61,454			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	79,590		16.00
17.00	01700	SOCIAL SERVICE	714	0	0	0	14,584	17.00
18.00	01080	INSERVICE EDUCATION	703	0	0	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,052	0	0	3,658	6,915	30.00
43.00	04300	NURSERY	0	0	0	1	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	351	6,688	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,488	0	0	19,062	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	5,035	0	0	16,457	0	54.00
60.00	06000	LABORATORY	5,319	0	0	10,492	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	201	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,098	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,522	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	384	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,644	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	981	0	359	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,666	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	61,454	4,780	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	482	0	0	771	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	3,072	0	88.00
88.01	08801	WYOMING RHC	0	0	0	431	0	88.01
88.02	08802	GENESEO RHC	0	0	0	33	0	88.02
90.00	09000	CLINIC	0	0	0	1,278	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	496	0	90.03
90.04	09004	GENESEO CLINIC	0	0	0	325	0	90.04
91.00	09100	EMERGENCY	4,572	0	0	4,208	981	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,427	981	61,454	79,289	14,584	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	0	0	0	0	192.03
192.04	19204	ANNAWAN CLINIC	0	0	0	215	0	192.04
192.05	19205	CAMBRIDGE CLINIC	0	0	0	86	0	192.05
194.00	07955	FOUNDATION	0	0	0	0	0	194.00
194.01	07950	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B Part II Date/Time Prepared: 9/27/2018 2:18 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	35,427	981	61,454	79,590	14,584	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B Part II | Date/Time Prepared: 9/27/2018 2:18 pm

		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	3,186					18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	142	583,397	0	583,397		30.00
43.00	04300	NURSERY	0	3	0	3		43.00
44.00	04400	SKILLED NURSING FACILITY	84	167,217	0	167,217		44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0		46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	762	879,278	0	879,278		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	640	494,645	0	494,645		54.00
60.00	06000	LABORATORY	408	201,418	0	201,418		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	8	3,338	0	3,338		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	198	333,062	0	333,062		66.00
67.00	06700	OCCUPATIONAL THERAPY	59	111,159	0	111,159		67.00
68.00	06800	SPEECH PATHOLOGY	15	14,395	0	14,395		68.00
69.00	06900	ELECTROCARDIOLOGY	142	63,516	0	63,516		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	14	1,682	0	1,682		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	104	35,539	0	35,539		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	186	76,671	0	76,671		73.00
76.00	03020	ACUPUNCTURE	0	0	0	0		76.00
76.01	03610	SLEEP LAB	30	24,459	0	24,459		76.01
76.02	03950	IV THERAPY	0	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	119	62,092	0	62,092		88.00
88.01	08801	WYOMING RHC	17	6,638	0	6,638		88.01
88.02	08802	GENESEO RHC	1	8,373	0	8,373		88.02
90.00	09000	CLINIC	50	33,037	0	33,037		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	19	38,171	0	38,171		90.03
90.04	09004	GENESEO CLINIC	13	84,059	0	84,059		90.04
91.00	09100	EMERGENCY	164	222,978	0	222,978		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	46,335	0	46,335		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,175	3,491,462	0	3,491,462		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	26,799	0	26,799		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0		192.00
192.01	19203	MUSCATINE CLINIC	0	61	0	61		192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0		192.02
192.03	19202	LEASED SPACE	0	36,862	0	36,862		192.03
192.04	19204	ANNAWAN CLINIC	8	4,247	0	4,247		192.04
192.05	19205	CAMBRIDGE CLINIC	3	2,558	0	2,558		192.05
194.00	07955	FOUNDATION	0	12,144	0	12,144		194.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B Part II | Date/Time Prepared: 9/27/2018 2:18 pm

		Cost Center Description	OTHER GENERAL SERVICE INSERVICE EDUCATION	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			18.00	24.00	25.00	26.00		
194.01	07950	SPORTS MEDICINE	0	1,287	0	1,287		194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0		194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0		194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0		194.04
194.05	07954	COLONA CLINIC	0	0	0	0		194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	64,625	0	64,625		194.06
194.07	07957	COMMUNITY HEALTH	0	63	0	63		194.07
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	3,186	3,640,108	0	3,640,108		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B-1 | Date/Time Prepared: 9/27/2018 2:18 pm

		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 COS T)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	104,556					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,059,464				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	498	2,850	15,057,630			4.00
5.01	00550	DATA PROCESSING	3,068	175,742	325,651	150,594		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	3,110	0	113,958	825	4,253,991	5.02
5.03	00570	ADMITTING	1,349	0	162,327	2,700	2,805	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,060	1,600	353,800	0	5,304	5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	4,233	11,749	528,108	26,025	13,848	5.05
7.00	00700	OPERATION OF PLANT	8,147	9,705	219,141	950	46,196	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	775	1,357	26,350	0	2,696	8.00
9.00	00900	HOUSEKEEPING	1,395	0	383,599	375	52,360	9.00
10.00	01000	DIETARY	3,534	11,123	457,460	2,280	32,614	10.00
11.00	01100	CAFETERIA	2,334	0	0	200	0	11.00
13.00	01300	NURSING ADMINISTRATION	608	12,021	168,288	2,025	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	42,475	14.00
15.00	01500	PHARMACY	1,676	1,994	211,327	4,625	7,719	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,639	9,324	374,309	8,150	3,471	16.00
17.00	01700	SOCIAL SERVICE	398	0	102,009	450	137	17.00
18.00	01080	INSERVICE EDUCATION	0	0	122,142	0	3,553	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,601	86,034	1,922,395	23,125	131,612	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	29,180	927,877	3,900	46,872	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,253	343,948	1,330,050	6,300	1,277,260	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,420	189,964	797,872	6,100	241,285	54.00
60.00	06000	LABORATORY	2,993	55,488	656,107	4,800	519,761	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	91	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	9,554	25,782	1,262,736	6,725	12,397	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,699	882	336,221	350	2,990	67.00
68.00	06800	SPEECH PATHOLOGY	404	0	129,916	175	892	68.00
69.00	06900	ELECTROCARDIOLOGY	1,611	5,088	226,540	900	10,781	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,305,595	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	747	0	69,195	100	4,259	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0	15,086	1,538,185	16,247	104,150	88.00
88.01	08801	WYOMING RHC	0	289	189,495	2,278	9,544	88.01
88.02	08802	GENESEO RHC	304	71	10,256	107	4,931	88.02
90.00	09000	CLINIC	0	15,548	299,019	6,934	47,987	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	262	20,082	48,466	2,624	23,840	90.03
90.04	09004	GENESEO CLINIC	2,956	1,060	167,405	1,609	73,972	90.04
91.00	09100	EMERGENCY	4,960	25,125	752,510	13,475	121,014	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	1,127	2,474	514,754	4,650	42,295	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	99,806	1,053,566	14,727,468	149,004	4,194,615	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	988	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	2,597	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	775	4,542	116,555	0	3,838	192.03
192.04	19204	ANNAWAN CLINIC	0	630	47,494	1,135	23,430	192.04
192.05	19205	CAMBRIDGE CLINIC	0	512	46,347	455	21,082	192.05
194.00	07955	FOUNDATION	397	0	0	0	0	194.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B-1 | Date/Time Prepared: 9/27/2018 2:18 pm

		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 COS T)	
			1.00	2.00	4.00	5.01	5.02	
194.01	07950	SPORTS MEDICINE	0	214	119,766	0	7,216	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	2,590	0	0	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	0	1,213	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,589,541	1,050,567	3,989,735	1,625,542	139,452	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.767024	0.991602	0.264964	10.794202	0.032781	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			15,160	250,579	78,513	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001007	1.663937	0.018456	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B-1 | Date/Time Prepared: 9/27/2018 2:18 pm

		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	90,129,728					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	99,894,701				5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	0	0	-2,995,950	34,778,558		5.05
7.00	00700	OPERATION OF PLANT	0	0	0	1,454,425	98,436	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	153,231	775	8.00
9.00	00900	HOUSEKEEPING	0	0	0	638,364	1,395	9.00
10.00	01000	DIETARY	0	0	0	967,898	3,534	10.00
11.00	01100	CAFETERIA	0	0	0	59,965	2,334	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	263,110	608	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	42,582	0	14.00
15.00	01500	PHARMACY	0	0	0	585,067	1,676	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	676,923	1,639	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	144,500	398	17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	180,497	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,444,469	4,444,469	0	3,071,290	13,601	30.00
43.00	04300	NURSERY	1,783	1,783	0	18	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	2,616,162	0	1,753,068	17,935	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,185,224	23,185,224	0	4,616,814	15,253	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	19,996,226	19,996,226	0	2,753,355	8,420	54.00
60.00	06000	LABORATORY	12,748,589	12,748,589	0	2,145,483	2,993	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	243,757	243,757	0	108,007	91	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	6,194,967	6,194,967	0	2,048,890	9,554	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,849,189	1,849,189	0	556,754	3,699	67.00
68.00	06800	SPEECH PATHOLOGY	466,592	466,592	0	188,632	404	68.00
69.00	06900	ELECTROCARDIOLOGY	4,427,927	4,427,927	0	563,377	1,611	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	435,943	435,943	0	4,636	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,239,800	3,239,800	0	1,382,850	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,807,584	5,807,584	0	1,332,047	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	936,772	936,772	0	165,189	747	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0	3,732,577	0	2,681,701	0	88.00
88.01	08801	WYOMING RHC	0	523,276	0	346,037	0	88.01
88.02	08802	GENESEO RHC	40,524	40,524	0	45,752	0	88.02
90.00	09000	CLINIC	0	1,552,555	0	659,307	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	602,953	602,953	0	701,100	262	90.03
90.04	09004	GENESEO CLINIC	394,388	394,388	0	420,637	0	90.04
91.00	09100	EMERGENCY	5,113,041	5,113,041	0	2,372,207	4,960	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	975,078	0	857,959	1,127	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	90,129,728	99,529,376	-2,995,950	33,941,672	93,016	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	24,470	988	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	2,752	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	0	0	246,357	4,035	192.03
192.04	19204	ANNAWAN CLINIC	0	260,708	0	207,079	0	192.04
192.05	19205	CAMBRIDGE CLINIC	0	104,617	0	159,809	0	192.05
194.00	07955	FOUNDATION	0	0	0	9,833	397	194.00
194.01	07950	SPORTS MEDICINE	0	0	0	177,809	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B-1 | Date/Time Prepared: 9/27/2018 2:18 pm

		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	
194.03	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	-64,147	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	8,777	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)	327,476	699,329		2,995,950	1,579,715	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.003633	0.007001		0.086144	16.048143	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	38,119	28,294		160,580	220,770	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000423	0.000283		0.004617	2.242777	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B-1 | Date/Time Prepared: 9/27/2018 2:18 pm

		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	263,623					8.00
9.00	00900	HOUSEKEEPING	27,468	498,600				9.00
10.00	01000	DIETARY	1,397	24,175	121,342			10.00
11.00	01100	CAFETERIA	0	5,500	71,049	17,151		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	300	9,477	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	2,075	0	284	284	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,950	0	1,117	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,250	0	191	191	17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	188	188	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	56,405	136,875	11,930	2,689	2,689	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	66,598	120,875	38,363	2,539	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	35,938	78,700	0	2,003	2,003	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	25,157	20,125	0	1,347	1,347	54.00
60.00	06000	LABORATORY	0	12,500	0	1,423	1,423	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	18,226	15,300	0	1,885	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,375	0	468	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	186	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,925	0	384	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	1,923	1,000	0	129	129	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0	0	0	0	0	88.00
88.01	08801	WYOMING RHC	0	0	0	0	0	88.01
88.02	08802	GENESEO RHC	9	550	0	22	0	88.02
90.00	09000	CLINIC	965	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	10,375	0	156	0	90.03
90.04	09004	GENESEO CLINIC	129	4,825	0	332	0	90.04
91.00	09100	EMERGENCY	29,408	23,450	0	1,223	1,223	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	1,875	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	263,623	471,700	121,342	16,866	9,477	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	21,600	0	108	0	192.03
192.04	19204	ANNAWAN CLINIC	0	0	0	0	0	192.04
192.05	19205	CAMBRIDGE CLINIC	0	0	0	0	0	192.05
194.00	07955	FOUNDATION	0	0	0	177	0	194.00
194.01	07950	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B-1 | Date/Time Prepared: 9/27/2018 2:18 pm

		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	
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	5,300	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)	178,868	734,379	1,144,546	780,850	309,190	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.678499	1.472882	9.432398	45.527958	32.625303	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	23,062	45,005	118,113	133,305	35,427	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.087481	0.090263	0.973389	7.772433	3.738208	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B-1 | Date/Time Prepared: 9/27/2018 2:18 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQ UIS)	PHARMACY (COSTED REQ UIS)	MEDICAL RECORDS & LIBRARY (GROSS PT. CHARGES)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE INSERVICE EDUCATION (GROSS CHARGES)	
			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	96,729,876			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	56,475		17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	0	98,919,623	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	4,444,469	26,775	4,444,469	30.00
43.00	04300	NURSERY	0	0	1,783	0	1,783	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	426,415	25,900	2,616,162	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	23,185,224	0	23,185,224	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	19,996,226	0	19,996,226	54.00
60.00	06000	LABORATORY	0	0	12,748,589	0	12,748,589	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	243,757	0	243,757	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	6,194,967	0	6,194,967	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,849,189	0	1,849,189	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	466,592	0	466,592	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	4,427,927	0	4,427,927	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	100	0	435,943	0	435,943	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	3,239,800	0	3,239,800	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	5,807,584	0	5,807,584	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	936,772	0	936,772	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0	0	3,732,577	0	3,732,577	88.00
88.01	08801	WYOMING RHC	0	0	523,276	0	523,276	88.01
88.02	08802	GENESEO RHC	0	0	40,524	0	40,524	88.02
90.00	09000	CLINIC	0	0	1,552,555	0	1,552,555	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	602,953	0	602,953	90.03
90.04	09004	GENESEO CLINIC	0	0	394,388	0	394,388	90.04
91.00	09100	EMERGENCY	0	0	5,113,041	3,800	5,113,041	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	96,364,551	56,475	98,554,298	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	0	0	0	0	192.03
192.04	19204	ANNAWAN CLINIC	0	0	260,708	0	260,708	192.04
192.05	19205	CAMBRIDGE CLINIC	0	0	104,617	0	104,617	192.05
194.00	07955	FOUNDATION	0	0	0	0	0	194.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet B-1 | Date/Time Prepared: 9/27/2018 2:18 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQ UIS)	PHARMACY (COSTED REQ UIS)	MEDICAL RECORDS & LIBRARY (GROSS PT. CHARGES)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE INSERVICE EDUCATION (GROSS CHAR GES)	
			14.00	15.00	16.00	17.00	18.00	
194.01	07950	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	46,250	687,616	816,739	180,103	210,739	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	462.500000	6,876.160000	0.008444	3.189075	0.002130	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	981	61,454	79,590	14,584	3,186	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	9.810000	614.540000	0.000823	0.258238	0.000032	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet C Part I Date/Time Prepared: 9/27/2018 2:18 pm

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	4,249,074		4,249,074	0	4,249,074	30.00
43.00	04300	NURSERY	39		39	0	39	43.00
44.00	04400	SKILLED NURSING FACILITY	2,984,350		2,984,350	0	2,984,350	44.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,801,288		5,801,288	0	5,801,288	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,489,088		3,489,088	0	3,489,088	54.00
60.00	06000	LABORATORY	2,642,761		2,642,761	0	2,642,761	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	121,348		121,348	0	121,348	62.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	2,564,940	0	2,564,940	0	2,564,940	66.00
67.00	06700	OCCUPATIONAL THERAPY	709,909	0	709,909	0	709,909	67.00
68.00	06800	SPEECH PATHOLOGY	224,767	0	224,767	0	224,767	68.00
69.00	06900	ELECTROCARDIOLOGY	710,793		710,793	0	710,793	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	55,895		55,895	0	55,895	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,536,232		1,536,232	0	1,536,232	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,195,820		2,195,820	0	2,195,820	73.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	214,172		214,172	0	214,172	76.01
76.02	03950	IV THERAPY	0		0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	2,952,181		2,952,181	0	2,952,181	88.00
88.01	08801	WYOMING RHC	381,380		381,380	0	381,380	88.01
88.02	08802	GENESEO RHC	51,939		51,939	0	51,939	88.02
90.00	09000	CLINIC	733,174		733,174	0	733,174	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	794,459		794,459	0	794,459	90.03
90.04	09004	GENESEO CLINIC	483,352		483,352	0	483,352	90.04
91.00	09100	EMERGENCY	2,872,415		2,872,415	0	2,872,415	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1,105,829		1,105,829		1,105,829	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	952,715		952,715		952,715	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	37,827,920	0	37,827,920	0	37,827,920	200.00
201.00		Less Observation Beds	1,105,829		1,105,829		1,105,829	201.00
202.00		Total (see instructions)	36,722,091	0	36,722,091	0	36,722,091	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet C Part I Date/Time Prepared: 9/27/2018 2:18 pm

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	3,351,540		3,351,540			30.00
43.00	04300	NURSERY	1,783		1,783			43.00
44.00	04400	SKILLED NURSING FACILITY	2,616,162		2,616,162			44.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,335,343	15,849,881	23,185,224	0.250215	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	955,035	19,041,191	19,996,226	0.174487	0.000000	54.00
60.00	06000	LABORATORY	1,077,360	11,671,229	12,748,589	0.207298	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	125,532	118,225	243,757	0.497824	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	744,889	5,450,078	6,194,967	0.414036	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	382,073	1,467,116	1,849,189	0.383903	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	87,767	378,825	466,592	0.481721	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	328,361	4,099,566	4,427,927	0.160525	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	333,939	102,004	435,943	0.128216	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,665,551	574,249	3,239,800	0.474175	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,241,580	3,566,004	5,807,584	0.378095	0.000000	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	936,772	936,772	0.228628	0.000000	76.01
76.02	03950	IV THERAPY	0	0	0	0.000000	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0	3,732,577	3,732,577			88.00
88.01	08801	WYOMING RHC	0	523,276	523,276			88.01
88.02	08802	GENESEO RHC	0	40,524	40,524			88.02
90.00	09000	CLINIC	0	1,552,555	1,552,555	0.472237	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	602,953	602,953	1.317613	0.000000	90.03
90.04	09004	GENESEO CLINIC	0	394,388	394,388	1.225575	0.000000	90.04
91.00	09100	EMERGENCY	165,451	4,947,590	5,113,041	0.561782	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	60,152	1,032,777	1,092,929	1.011803	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	975,078	975,078			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	22,472,518	77,056,858	99,529,376			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	22,472,518	77,056,858	99,529,376			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet C Part I Date/Time Prepared: 9/27/2018 2:18 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		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
88.02	08802	GENESEO RHC			88.02
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
90.04	09004	GENESEO CLINIC	0.000000		90.04
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF			99.10
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet C Part I Date/Time Prepared: 9/27/2018 2:18 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,249,074		4,249,074	0	4,249,074	30.00
43.00	04300	NURSERY	39		39	0	39	43.00
44.00	04400	SKILLED NURSING FACILITY	2,984,350		2,984,350	0	2,984,350	44.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,801,288		5,801,288	0	5,801,288	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,489,088		3,489,088	0	3,489,088	54.00
60.00	06000	LABORATORY	2,642,761		2,642,761	0	2,642,761	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	121,348		121,348	0	121,348	62.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	2,564,940	0	2,564,940	0	2,564,940	66.00
67.00	06700	OCCUPATIONAL THERAPY	709,909	0	709,909	0	709,909	67.00
68.00	06800	SPEECH PATHOLOGY	224,767	0	224,767	0	224,767	68.00
69.00	06900	ELECTROCARDIOLOGY	710,793		710,793	0	710,793	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	55,895		55,895	0	55,895	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,536,232		1,536,232	0	1,536,232	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,195,820		2,195,820	0	2,195,820	73.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	214,172		214,172	0	214,172	76.01
76.02	03950	IV THERAPY	0		0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	2,952,181		2,952,181	0	2,952,181	88.00
88.01	08801	WYOMING RHC	381,380		381,380	0	381,380	88.01
88.02	08802	GENESEO RHC	51,939		51,939	0	51,939	88.02
90.00	09000	CLINIC	733,174		733,174	0	733,174	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	794,459		794,459	0	794,459	90.03
90.04	09004	GENESEO CLINIC	483,352		483,352	0	483,352	90.04
91.00	09100	EMERGENCY	2,872,415		2,872,415	0	2,872,415	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1,105,829		1,105,829		1,105,829	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	952,715		952,715		952,715	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	37,827,920	0	37,827,920	0	37,827,920	200.00
201.00		Less Observation Beds	1,105,829		1,105,829		1,105,829	201.00
202.00		Total (see instructions)	36,722,091	0	36,722,091	0	36,722,091	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet C Part I Date/Time Prepared: 9/27/2018 2:18 pm

Title XIX | 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	3,351,540		3,351,540			30.00
43.00	04300	NURSERY	1,783		1,783			43.00
44.00	04400	SKILLED NURSING FACILITY	2,616,162		2,616,162			44.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,335,343	15,849,881	23,185,224	0.250215	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	955,035	19,041,191	19,996,226	0.174487	0.000000	54.00
60.00	06000	LABORATORY	1,077,360	11,671,229	12,748,589	0.207298	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	125,532	118,225	243,757	0.497824	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	744,889	5,450,078	6,194,967	0.414036	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	382,073	1,467,116	1,849,189	0.383903	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	87,767	378,825	466,592	0.481721	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	328,361	4,099,566	4,427,927	0.160525	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	333,939	102,004	435,943	0.128216	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,665,551	574,249	3,239,800	0.474175	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,241,580	3,566,004	5,807,584	0.378095	0.000000	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	936,772	936,772	0.228628	0.000000	76.01
76.02	03950	IV THERAPY	0	0	0	0.000000	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0	3,732,577	3,732,577	0.790923	0.000000	88.00
88.01	08801	WYOMING RHC	0	523,276	523,276	0.728831	0.000000	88.01
88.02	08802	GENESEO RHC	0	40,524	40,524	1.281685	0.000000	88.02
90.00	09000	CLINIC	0	1,552,555	1,552,555	0.472237	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	602,953	602,953	1.317613	0.000000	90.03
90.04	09004	GENESEO CLINIC	0	394,388	394,388	1.225575	0.000000	90.04
91.00	09100	EMERGENCY	165,451	4,947,590	5,113,041	0.561782	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	60,152	1,032,777	1,092,929	1.011803	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	975,078	975,078			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	22,472,518	77,056,858	99,529,376			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	22,472,518	77,056,858	99,529,376			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet C Part I Date/Time Prepared: 9/27/2018 2:18 pm

Title XIX | 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	0.000000		88.00
88.01	08801	WYOMING RHC	0.000000		88.01
88.02	08802	GENESEO RHC	0.000000		88.02
90.00	09000	CLINIC	0.000000		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
90.04	09004	GENESEO CLINIC	0.000000		90.04
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF			99.10
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part II Date/Time Prepared: 9/27/2018 2:18 pm

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	879,278	23,185,224	0.037924	3,359,361	127,400	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	494,645	19,996,226	0.024737	400,918	9,918	54.00
60.00	06000	LABORATORY	201,418	12,748,589	0.015799	498,904	7,882	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	3,338	243,757	0.013694	72,568	994	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
66.00	06600	PHYSICAL THERAPY	333,062	6,194,967	0.053763	142,278	7,649	66.00
67.00	06700	OCCUPATIONAL THERAPY	111,159	1,849,189	0.060112	67,292	4,045	67.00
68.00	06800	SPEECH PATHOLOGY	14,395	466,592	0.030851	19,978	616	68.00
69.00	06900	ELECTROCARDIOLOGY	63,516	4,427,927	0.014344	190,113	2,727	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,682	435,943	0.003858	204,627	789	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	35,539	3,239,800	0.010970	1,239,180	13,594	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,671	5,807,584	0.013202	940,442	12,416	73.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	24,459	936,772	0.026110	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	62,092	3,732,577	0.016635	0	0	88.00
88.01	08801	WYOMING RHC	6,638	523,276	0.012685	0	0	88.01
88.02	08802	GENESEO RHC	8,373	40,524	0.206618	0	0	88.02
90.00	09000	CLINIC	33,037	1,552,555	0.021279	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	38,171	602,953	0.063307	0	0	90.03
90.04	09004	GENESEO CLINIC	84,059	394,388	0.213138	0	0	90.04
91.00	09100	EMERGENCY	222,978	5,113,041	0.043610	5,448	238	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	151,830	1,092,929	0.138920	9,762	1,356	92.00
200.00		Total (lines 50 through 199)	2,846,340	92,584,813		7,150,871	189,624	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part IV Date/Time Prepared: 9/27/2018 2:18 pm

Title XVIII | Hospital | Cost

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part IV Date/Time Prepared: 9/27/2018 2:18 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	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)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	23,185,224	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	19,996,226	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	12,748,589	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	243,757	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,194,967	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,849,189	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	466,592	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,427,927	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	435,943	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,239,800	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,807,584	0.000000	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	936,772	0.000000	76.01
76.02	03950	IV THERAPY	0	0	0	0	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0	0	0	3,732,577	0.000000	88.00
88.01	08801	WYOMING RHC	0	0	0	523,276	0.000000	88.01
88.02	08802	GENESEO RHC	0	0	0	40,524	0.000000	88.02
90.00	09000	CLINIC	0	0	0	1,552,555	0.000000	90.00
90.01	09001	OB CLINIC	0	0	0	0	0.000000	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0.000000	90.02
90.03	09003	SURGICAL CLINIC	0	0	0	602,953	0.000000	90.03
90.04	09004	GENESEO CLINIC	0	0	0	394,388	0.000000	90.04
91.00	09100	EMERGENCY	0	0	0	5,113,041	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	1,092,929	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	92,584,813		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part IV Date/Time Prepared: 9/27/2018 2:18 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	3,359,361	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	400,918	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	498,904	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.000000	72,568	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.000000	142,278	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67,292	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	19,978	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	190,113	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	204,627	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,239,180	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	940,442	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0.000000	0	0	0	0	88.00
88.01	08801	WYOMING RHC	0.000000	0	0	0	0	88.01
88.02	08802	GENESEO RHC	0.000000	0	0	0	0	88.02
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	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	0.000000	0	0	0	0	90.03
90.04	09004	GENESEO CLINIC	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.000000	5,448	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000	9,762	0	0	0	92.00
200.00		Total (lines 50 through 199)		7,150,871	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part V Date/Time Prepared: 9/27/2018 2:18 pm

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	0.250215	0	4,345,031	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174487	0	5,890,695	0	0	54.00
60.00	06000	LABORATORY	0.207298	0	3,924,757	380	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.497824	0	58,113	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.414036	0	1,590,546	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.383903	0	318,998	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.481721	0	29,469	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.160525	0	1,738,150	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.128216	0	39,017	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.474175	0	139,299	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.378095	0	1,660,553	11,773	0	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.228628	0	197,376	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0.000000				0	88.00
88.01	08801	WYOMING RHC	0.000000				0	88.01
88.02	08802	GENESEO RHC	0.000000				0	88.02
90.00	09000	CLINIC	0.472237	0	123,178	2,264	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	1.317613	0	20,079	0	0	90.03
90.04	09004	GENESEO CLINIC	1.225575	0	61,444	0	0	90.04
91.00	09100	EMERGENCY	0.561782	0	1,460,917	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.011803	0	382,681	0	0	92.00
200.00		Subtotal (see instructions)		0	21,980,303	14,417	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	21,980,303	14,417	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part V Date/Time Prepared: 9/27/2018 2:18 pm

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	1,087,192	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,027,850	0		54.00
60.00	06000	LABORATORY	813,594	79		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	28,930	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	658,543	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	122,464	0		67.00
68.00	06800	SPEECH PATHOLOGY	14,196	0		68.00
69.00	06900	ELECTROCARDIOLOGY	279,017	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	5,003	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	66,052	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	627,847	4,451		73.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	45,126	0		76.01
76.02	03950	IV THERAPY	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	KEWANEE RHC	0	0		88.00
88.01	08801	WYOMING RHC	0	0		88.01
88.02	08802	GENESEO RHC	0	0		88.02
90.00	09000	CLINIC	58,169	1,069		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	26,456	0		90.03
90.04	09004	GENESEO CLINIC	75,304	0		90.04
91.00	09100	EMERGENCY	820,717	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	387,198	0		92.00
200.00		Subtotal (see instructions)	6,143,658	5,599		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,143,658	5,599		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1319 | Component CCN: 14-Z319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part V | Date/Time Prepared: 9/27/2018 2:18 pm

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	0.250215	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174487	0	0	0	0	54.00
60.00	06000	LABORATORY	0.207298	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.497824	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.414036	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.383903	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.481721	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.160525	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.128216	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.474175	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.378095	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.228628	0	0	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0.000000				0	88.00
88.01	08801	WYOMING RHC	0.000000				0	88.01
88.02	08802	GENESEO RHC	0.000000				0	88.02
90.00	09000	CLINIC	0.472237	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	1.317613	0	0	0	0	90.03
90.04	09004	GENESEO CLINIC	1.225575	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.561782	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.011803	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 06/01/2017 To 05/31/2018 | Worksheet D Part V | Date/Time Prepared: 9/27/2018 2:18 pm

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
88.02	08802	GENESEO RHC	0	0		88.02
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
90.04	09004	GENESEO CLINIC	0	0		90.04
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1319 | Component CCN: 14-5464 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part IV Date/Time Prepared: 9/27/2018 2:18 pm

Title XVIII | Skilled Nursing Facility | PPS

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1319 | Component CCN: 14-5464 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part IV Date/Time Prepared: 9/27/2018 2:18 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	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)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	23,185,224	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	19,996,226	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	12,748,589	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	243,757	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,194,967	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,849,189	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	466,592	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,427,927	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	435,943	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,239,800	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,807,584	0.000000	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	936,772	0.000000	76.01
76.02	03950	IV THERAPY	0	0	0	0	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0	0	0	3,732,577	0.000000	88.00
88.01	08801	WYOMING RHC	0	0	0	523,276	0.000000	88.01
88.02	08802	GENESEO RHC	0	0	0	40,524	0.000000	88.02
90.00	09000	CLINIC	0	0	0	1,552,555	0.000000	90.00
90.01	09001	OB CLINIC	0	0	0	0	0.000000	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0.000000	90.02
90.03	09003	SURGICAL CLINIC	0	0	0	602,953	0.000000	90.03
90.04	09004	GENESEO CLINIC	0	0	0	394,388	0.000000	90.04
91.00	09100	EMERGENCY	0	0	0	5,113,041	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	1,092,929	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	92,584,813		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1319 | Component CCN: 14-5464 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part IV Date/Time Prepared: 9/27/2018 2:18 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	14,585	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	6,304	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	9,743	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.000000	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.000000	263,163	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	154,248	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	36,320	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,259	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	98,906	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0.000000	0	0	0	0	88.00
88.01	08801	WYOMING RHC	0.000000	0	0	0	0	88.01
88.02	08802	GENESEO RHC	0.000000	0	0	0	0	88.02
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	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	0.000000	0	0	0	0	90.03
90.04	09004	GENESEO CLINIC	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		585,528	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1319 | Component CCN: 14-5464 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part V | Date/Time Prepared: 9/27/2018 2:18 pm

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	0.250215	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174487	0	0	0	0	54.00
60.00	06000	LABORATORY	0.207298	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.497824	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.414036	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.383903	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.481721	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.160525	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.128216	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.474175	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.378095	0	0	316	0	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.228628	0	0	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0.000000				0	88.00
88.01	08801	WYOMING RHC	0.000000				0	88.01
88.02	08802	GENESEO RHC	0.000000				0	88.02
90.00	09000	CLINIC	0.472237	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	1.317613	0	0	0	0	90.03
90.04	09004	GENESEO CLINIC	1.225575	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.561782	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.011803	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	316	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	316	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1319 | Component CCN: 14-5464 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D Part V | Date/Time Prepared: 9/27/2018 2:18 pm

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	119		73.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.02	03950	IV THERAPY	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	KEWANEE RHC	0	0		88.00
88.01	08801	WYOMING RHC	0	0		88.01
88.02	08802	GENESEO RHC	0	0		88.02
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OB CLINIC	0	0		90.01
90.02	09002	SPECIALTY CLINIC	0	0		90.02
90.03	09003	SURGICAL CLINIC	0	0		90.03
90.04	09004	GENESEO CLINIC	0	0		90.04
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0		92.00
200.00		Subtotal (see instructions)	0	119		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	119		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D-1 | Date/Time Prepared: 9/27/2018 2:18 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,077	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,503	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,444	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)	408	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)	2	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,344	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)	171	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)	4,249,074	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)	267	25.00
26.00	Total swing-bed cost (see instructions)	591,185	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,657,889	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,657,889	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)	1,044.22	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,403,432	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)	1,403,432	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D-1 | Date/Time Prepared: 9/27/2018 2:18 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	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)	2,157,288	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,560,720	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)	131,572	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	178,562	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	310,134	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,059	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,044.22	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,105,829	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D-1 | Date/Time Prepared: 9/27/2018 2:18 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	583,397	4,249,074	0.137300	1,105,829	151,830	90.00
91.00	Nursing School cost	0	4,249,074	0.000000	1,105,829	0	91.00
92.00	Allied health cost	0	4,249,074	0.000000	1,105,829	0	92.00
93.00	All other Medical Education	0	4,249,074	0.000000	1,105,829	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1319 Component CCN: 14-5464	Period: From 06/01/2017 To 05/31/2018	Worksheet D-1 Date/Time Prepared: 9/27/2018 2:18 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	12,823	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,823	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)	12,823	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)	853	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)	2,984,350	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)	2,984,350	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)	2,984,350	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D-1

Component CCN: 14-5464 | Date/Time Prepared: 9/27/2018 2:18 pm

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	2,984,350	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	232.73	71.00
72.00	Program routine service cost (line 9 x line 71)	198,519	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)	198,519	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)	198,519	83.00
84.00	Program inpatient ancillary services (see instructions)	230,199	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)	428,718	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 06/01/2017 To 05/31/2018	Worksheet D-1 Date/Time Prepared: 9/27/2018 2:18 pm
	Title XVIII	Skilled Nursing Facility	PPS

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D-3 | Date/Time Prepared: 9/27/2018 2:18 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,475,536		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.250215	3,359,361	840,563	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174487	400,918	69,955	54.00
60.00	06000	LABORATORY	0.207298	498,904	103,422	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.497824	72,568	36,126	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.414036	142,278	58,908	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.383903	67,292	25,834	67.00
68.00	06800	SPEECH PATHOLOGY	0.481721	19,978	9,624	68.00
69.00	06900	ELECTROCARDIOLOGY	0.160525	190,113	30,518	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.128216	204,627	26,236	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.474175	1,239,180	587,588	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.378095	940,442	355,576	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.228628	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	KEWANEE RHC	0.000000		0	88.00
88.01	08801	WYOMING RHC	0.000000		0	88.01
88.02	08802	GENESEO RHC	0.000000		0	88.02
90.00	09000	CLINIC	0.472237	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	1.317613	0	0	90.03
90.04	09004	GENESEO CLINIC	1.225575	0	0	90.04
91.00	09100	EMERGENCY	0.561782	5,448	3,061	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.011803	9,762	9,877	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,150,871	2,157,288	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		7,150,871		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1319 | Component CCN: 14-Z319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D-3 | Date/Time Prepared: 9/27/2018 2:18 pm

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	0.250215	44,075	11,028	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174487	2,774	484	54.00
60.00	06000	LABORATORY	0.207298	26,449	5,483	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.497824	1,132	564	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.414036	85,789	35,520	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.383903	27,967	10,737	67.00
68.00	06800	SPEECH PATHOLOGY	0.481721	858	413	68.00
69.00	06900	ELECTROCARDIOLOGY	0.160525	6,966	1,118	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.128216	774	99	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.474175	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.378095	82,038	31,018	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.228628	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	KEWANEE RHC	0.000000		0	88.00
88.01	08801	WYOMING RHC	0.000000		0	88.01
88.02	08802	GENESEO RHC	0.000000		0	88.02
90.00	09000	CLINIC	0.472237	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	1.317613	0	0	90.03
90.04	09004	GENESEO CLINIC	1.225575	0	0	90.04
91.00	09100	EMERGENCY	0.561782	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.011803	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		278,822	96,464	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)		278,822		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1319 | Component CCN: 14-5464 | Period: From 06/01/2017 To 05/31/2018 | Worksheet D-3 | Date/Time Prepared: 9/27/2018 2:18 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.250215	14,585	3,649	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174487	6,304	1,100	54.00
60.00	06000	LABORATORY	0.207298	9,743	2,020	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.497824	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.414036	263,163	108,959	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.383903	154,248	59,216	67.00
68.00	06800	SPEECH PATHOLOGY	0.481721	36,320	17,496	68.00
69.00	06900	ELECTROCARDIOLOGY	0.160525	2,259	363	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.128216	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.474175	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.378095	98,906	37,396	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.228628	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	KEWANEE RHC	0.000000		0	88.00
88.01	08801	WYOMING RHC	0.000000		0	88.01
88.02	08802	GENESEO RHC	0.000000		0	88.02
90.00	09000	CLINIC	0.472237	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	1.317613	0	0	90.03
90.04	09004	GENESEO CLINIC	1.225575	0	0	90.04
91.00	09100	EMERGENCY	0.561782	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.011803	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		585,528	230,199	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)		585,528		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1319	Period: From 06/01/2017 To 05/31/2018	Worksheet E Part B Date/Time Prepared: 9/27/2018 2:18 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,149,257	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,149,257	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	6,210,750	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	89,250	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,557,468	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)	2,564,032	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)	2,564,032	30.00
31.00	Primary payer payments	210	31.00
32.00	Subtotal (line 30 minus line 31)	2,563,822	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)	40,526	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	26,342	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	2,590,164	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)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,590,164	40.00
40.01	Sequestration adjustment (see instructions)	51,803	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	3,321,067	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-782,706	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1319 Component CCN: 14-5464	Period: From 06/01/2017 To 05/31/2018	Worksheet E Part B Date/Time Prepared: 9/27/2018 2:18 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	119	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
4.01	Outlier reconciliation amount (see instructions)		4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	119	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	316	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)	316	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)	316	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	197	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	119	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (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)	119	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)	119	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	119	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)	119	37.00
38.00	MSP-LCC reconciliation amount from PS&R		38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	119	40.00
40.01	Sequestration adjustment (see instructions)	2	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	248	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-131	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet E-1 Part I Date/Time Prepared: 9/27/2018 2:18 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,039,841		3,429,537	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	12/07/2017	172,792		0	3.01
3.02		05/03/2018	52,293		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	12/07/2017	84,162	3.50
3.51			0	05/03/2018	24,308	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)		225,085		-108,470	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)		3,264,926		3,321,067	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		161,716		782,706	6.02
7.00	Total Medicare program liability (see instructions)		3,103,210		2,538,361	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 06/01/2017 To 05/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 9/27/2018 2:18 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		417,659		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	12/07/2017	24,808		0	3.01
3.02		05/03/2018	5,181		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)		29,989		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)		447,648		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		63,898		0	6.02
7.00	Total Medicare program liability (see instructions)		383,750		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 06/01/2017 To 05/31/2018	Worksheet E-1 Part I Date/Time Prepared: 9/27/2018 2:18 pm
	Title XVIII	Skilled Nursing Facility	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		308,989		248	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)		308,989		248	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		2,493		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		131	6.02
7.00	Total Medicare program liability (see instructions)		311,482		117	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 06/01/2017 To 05/31/2018	Worksheet E-1 Part II Date/Time Prepared: 9/27/2018 2:18 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 14-1319 Component CCN: 14-Z319	Period: From 06/01/2017 To 05/31/2018	Worksheet E-2 Date/Time Prepared: 9/27/2018 2:18 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	313,235	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)	97,429	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	297	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)	410,664	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	410,664	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)	410,664	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	19,082	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)	391,582	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	391,582	0	19.00
19.01	Sequestration adjustment (see instructions)	7,832	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	447,648	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)	-63,898	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1319	Period: From 06/01/2017 To 05/31/2018	Worksheet E-3 Part V Date/Time Prepared: 9/27/2018 2:18 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,560,720	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)	3,560,720	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,596,327	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)	3,596,327	19.00
20.00	Deductibles (exclude professional component)	428,615	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,167,712	22.00
23.00	Coinsurance	6,909	23.00
24.00	Subtotal (line 22 minus line 23)	3,160,803	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	8,828	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	5,738	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)	3,166,541	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	3,166,541	30.00
30.01	Sequestration adjustment (see instructions)	63,331	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	3,264,926	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-161,716	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 06/01/2017 To 05/31/2018	Worksheet E-3 Part VI Date/Time Prepared: 9/27/2018 2:18 pm
	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)	357,461	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)	357,461	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	39,622	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)	317,839	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	317,839	15.00
15.01	Sequestration adjustment (see instructions)	6,357	15.01
15.02	Demonstration payment adjustment amount after sequestration	2,494	15.02
16.00	Interim payments	308,989	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)	-1	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet G | Date/Time Prepared: 9/27/2018 2:18 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	11,288,548	0	0	0	1.00
2.00	Temporary investments	15,894,983	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	24,739,350	0	0	0	4.00
5.00	Other receivable	912,799	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-21,504,684	0	0	0	6.00
7.00	Inventory	814,360	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	1,461,194	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)	33,606,550	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	-930,952	0	0	0	14.00
15.00	Buildings	43,155,516	0	0	0	15.00
16.00	Accumulated depreciation	-22,189,938	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	13,788,290	0	0	0	19.00
20.00	Accumulated depreciation	-10,083,311	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	1,844,531	0	0	0	23.00
24.00	Accumulated depreciation	-858,658	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	151,511	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	27,823,594	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	849,692	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	5,329,174	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,178,866	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	67,609,010	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	0	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,107,905	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	435,337	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	2,857,309	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,400,551	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	2,098,967	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	24,461,149	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	26,560,116	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	32,960,667	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	34,648,343				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)	34,648,343	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	67,609,010	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet G-1 | Date/Time Prepared: 9/27/2018 2:18 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		30,527,028		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,964,156				2.00
3.00	Total (sum of line 1 and line 2)		34,491,184		0		3.00
4.00	NET INCOME FROM FOUNDATION	157,159		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)		157,159		0		10.00
11.00	Subtotal (line 3 plus line 10)		34,648,343		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)		34,648,343		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 9/27/2018 2:18 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,351,540		3,351,540	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	2,616,162		2,616,162	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)	5,967,702		5,967,702	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)	5,967,702		5,967,702	17.00
18.00	Ancillary services	16,503,034	70,788,060	87,291,094	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	KEWANEE RHC	0	3,732,577	3,732,577	20.00
20.01	WYOMING RHC	0	523,276	523,276	20.01
20.02	GENESEO RHC	0	40,524	40,524	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		975,078	975,078	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	1,783	0	1,783	27.00
27.01	SURGICAL CLINIC	0	602,953	602,953	27.01
27.02	GENESEO CLINIC	0	394,388	394,388	27.02
27.03	PROFESSIONAL FEES	1,587,487	10,687,638	12,275,125	27.03
27.04	CAMBRIDGE CLINIC	0	104,617	104,617	27.04
27.05	ANNAWAN CLINIC	0	260,708	260,708	27.05
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	24,060,006	88,109,819	112,169,825	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		42,526,555		29.00
30.00	PROVISION FOR BAD DEBT	1,417,585			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)		1,417,585		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)		43,944,140		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1319 | Period: From 06/01/2017 To 05/31/2018 | Worksheet G-3 | Date/Time Prepared: 9/27/2018 2:18 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	112,169,825	1.00
2.00	Less contractual allowances and discounts on patients' accounts	68,700,210	2.00
3.00	Net patient revenues (line 1 minus line 2)	43,469,615	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	43,944,140	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-474,525	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	77,593	6.00
7.00	Income from investments	291,829	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	416	10.00
11.00	Rebates and refunds of expenses	94,074	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	173,343	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	1,122	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	CHANGE IN IMRF PENSION	2,593,939	24.00
24.01	RENTAL INCOME	376,872	24.01
24.02	PROPERTY INCOME	714,594	24.02
24.03	OTHER OPERATING REVENUE	114,687	24.03
25.00	Total other income (sum of lines 6-24)	4,438,681	25.00
26.00	Total (line 5 plus line 25)	3,964,156	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
27.02	OTHER EXPENSES (SPECIFY)	0	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,964,156	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-1319 HHA CCN: 14-7450 | Period: From 06/01/2017 To 05/31/2018 | Worksheet H Date/Time Prepared: 9/27/2018 2:18 pm

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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	106,448	0	161	12,772	9,770	129,151	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	367,177	0	51,238	0	2,200	420,615	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	3,015	0	0	3,015	10.00
11.00	Home Health Aide	41,129	0	338	0	0	41,467	11.00
12.00	Supplies (see instructions)	0	0	0	0	38,549	38,549	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)	514,754	0	54,752	12,772	50,519	632,797	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	129,151	0	129,151			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	420,615	0	420,615			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	3,015	0	3,015			10.00
11.00	Home Health Aide	0	41,467	0	41,467			11.00
12.00	Supplies (see instructions)	0	38,549	0	38,549			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	632,797	0	632,797			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 06/01/2017 To 05/31/2018 | Worksheet H-1 Part I | Date/Time Prepared: 9/27/2018 2:18 pm

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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	129,151	0	0	0	0	129,151	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	420,615	0	0	0	0	420,615	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	3,015	0	0	0	0	3,015	10.00
11.00	Home Health Aide	41,467	0	0	0	0	41,467	11.00
12.00	Supplies (see instructions)	38,549	0	0	0	0	38,549	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)	632,797	0	0	0	0	632,797	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	129,151			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	107,860	528,475		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	773	3,788		10.00
11.00	Home Health Aide	10,633	52,100		11.00
12.00	Supplies (see instructions)	9,885	48,434		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)		632,797		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 14-1319 HHA CCN: 14-7450 | Period: From 06/01/2017 To 05/31/2018 | Worksheet H-1 Part II Date/Time Prepared: 9/27/2018 2:18 pm

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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	-129,151	503,646	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	420,615	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	3,015	10.00
11.00	Home Health Aide	0	0	0	0	0	41,467	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	38,549	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	-129,151	503,646	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		129,151	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.256432	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

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

Period: From 06/01/2017 To 05/31/2018

Worksheet H-2 Part I Date/Time Prepared: 9/27/2018 2:18 pm

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	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	27,912	2,453	136,391	50,193	1,386	1.00
2.00	Skilled Nursing Care	528,475	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	3,788	0	0	0	0	0	6.00
7.00	Home Health Aide	52,100	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	48,434	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)	632,797	27,912	2,453	136,391	50,193	1,386	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	6,827	225,162	19,396	18,086	0	1.00
2.00	Skilled Nursing Care	0	0	528,475	45,526	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	3,788	326	0	0	6.00
7.00	Home Health Aide	0	0	52,100	4,488	0	0	7.00
8.00	Supplies (see instructions)	0	0	48,434	4,172	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	6,827	857,959	73,908	18,086	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 06/01/2017 To 05/31/2018

Worksheet H-2 Part I Date/Time Prepared: 9/27/2018 2:18 pm

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	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	2,762	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)	2,762	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	265,406	0	265,406	1.00
2.00	Skilled Nursing Care	0	0	0	574,001	0	574,001	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	4,114	0	4,114	6.00
7.00	Home Health Aide	0	0	0	56,588	0	56,588	7.00
8.00	Supplies (see instructions)	0	0	0	52,606	0	52,606	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	952,715	0	952,715	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 06/01/2017 To 05/31/2018

Worksheet H-2 Part I
Date/Time Prepared: 9/27/2018 2:18 pm

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	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	221,651	795,652				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	1,589	5,703				6.00
7.00	Home Health Aide	21,852	78,440				7.00
8.00	Supplies (see instructions)	20,314	72,920				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)	265,406	952,715				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.	0.386152					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 06/01/2017 To 05/31/2018

Worksheet H-2 Part II Date/Time Prepared: 9/27/2018 2:18 pm

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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 COS T)	ADMITTING (GROSS CHAR GES)	
		1.00	2.00	4.00	5.01	5.02	5.03	
1.00	Administrative and General	1,127	2,474	514,754	4,650	42,295	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,127	2,474	514,754	4,650	42,295	0	20.00
21.00	Total cost to be allocated	27,912	2,453	136,391	50,193	1,386	0	21.00
22.00	Unit cost multiplier	24.766637	0.991512	0.264963	10.794194	0.032770	0.000000	22.00

	Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHAR GES)	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	975,078	0	225,162	1,127	0	1,875	1.00
2.00	Skilled Nursing Care	0	0	528,475	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	3,788	0	0	0	6.00
7.00	Home Health Aide	0	0	52,100	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	48,434	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)	975,078		857,959	1,127	0	1,875	20.00
21.00	Total cost to be allocated	6,827		73,908	18,086	0	2,762	21.00
22.00	Unit cost multiplier	0.007001		0.086144	16.047915	0.000000	1.473067	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

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

Period: From 06/01/2017 To 05/31/2018

Worksheet H-2 Part II Date/Time Prepared: 9/27/2018 2:18 pm

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	Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQ UIS)	PHARMACY (COSTED REQ UIS)	MEDICAL RECORDS & LIBRARY (GROSS PT. CHARGES)	
		10.00	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	0	0					6.00
7.00	Home Health Aide	0	0					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
19.50	Telemedicine	0	0					19.50
20.00	Total (sum of lines 1-19)	0	0					20.00
21.00	Total cost to be allocated	0	0					21.00
22.00	Unit cost multiplier	0.000000	0.000000					22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-1319 | HHA CCN: 14-7450 | Period: From 06/01/2017 To 05/31/2018 | Worksheet H-3 Part I | Date/Time Prepared: 9/27/2018 2:18 pm

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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	795,652		795,652	5,038	157.93	1.00
2.00	Physical Therapy	3.00	0	126,328	126,328	1,837	68.77	2.00
3.00	Occupational Therapy	4.00	0	59,040	59,040	1,066	55.38	3.00
4.00	Speech Pathology	5.00	0	18,214	18,214	196	92.93	4.00
5.00	Medical Social Services	6.00	5,703		5,703	73	78.12	5.00
6.00	Home Health Aide	7.00	78,440		78,440	1,214	64.61	6.00
7.00	Total (sum of lines 1-6)		879,795	203,582	1,083,377	9,424		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	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	72,920	0	72,920	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	Part B Not Subject to Deductibles & Coinsurance	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	377,926		1.00
2.00	Physical Therapy	0	1,046		0	71,933		2.00
3.00	Occupational Therapy	0	655		0	36,274		3.00
4.00	Speech Pathology	0	101		0	9,386		4.00
5.00	Medical Social Services	0	13		0	1,016		5.00
6.00	Home Health Aide	0	674		0	43,547		6.00
7.00	Total (sum of lines 1-6)	0	4,882		0	540,082		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1319 HHA CCN: 14-7450 | Period: From 06/01/2017 To 05/31/2018 | Worksheet H-3 Part I Date/Time Prepared: 9/27/2018 2:18 pm

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	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

		Program Covered Charges			Cost of Services			
			Part B			Part B		
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)		
		12.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION			
	Cost Per Visit Computation			
1.00	Skilled Nursing Care	377,926		1.00
2.00	Physical Therapy	71,933		2.00
3.00	Occupational Therapy	36,274		3.00
4.00	Speech Pathology	9,386		4.00
5.00	Medical Social Services	1,016		5.00
6.00	Home Health Aide	43,547		6.00
7.00	Total (sum of lines 1-6)	540,082		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 06/01/2017
To 05/31/2018

Worksheet H-3
Part II
Date/Time Prepared:
9/27/2018 2:18 pm

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	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	0.414036	305,114	126,328	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.383903	153,788	59,040	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.481721	37,810	18,214	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.128216	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.378095	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 14-1319 | HHA CCN: 14-7450 | Period: From 06/01/2017 To 05/31/2018 | Worksheet H-4 Part I-II | Date/Time Prepared: 9/27/2018 2:18 pm

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B 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
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	780,876	31.00
31.01	Sequestration adjustment (see instructions)	0	15,632	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
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 06/01/2017 To 05/31/2018

Worksheet H-5

Date/Time Prepared: 9/27/2018 2:18 pm

Home Health Agency I

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		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 06/01/2017 To 05/31/2018 | Worksheet M-1 | Date/Time Prepared: 9/27/2018 2:18 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	848,856	0	848,856	0	848,856	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	209,197	0	209,197	0	209,197	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	167,998	0	167,998	0	167,998	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	106,753	0	106,753	0	106,753	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,332,804	0	1,332,804	0	1,332,804	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	76,538	76,538	0	76,538	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	76,538	76,538	0	76,538	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,332,804	76,538	1,409,342	0	1,409,342	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	38,993	38,993	0	38,993	29.00
30.00	Administrative Costs	205,381	400,543	605,924	0	605,924	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	205,381	439,536	644,917	0	644,917	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,538,185	516,074	2,054,259	0	2,054,259	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1319 | Component CCN: 14-8576 | Period: From 06/01/2017 To 05/31/2018 | Worksheet M-1 | Date/Time Prepared: 9/27/2018 2:18 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	848,856		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	209,197		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	167,998		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	106,753		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,332,804		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	76,538		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	76,538		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,409,342		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	38,993		29.00
30.00	Administrative Costs	0	605,924		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	644,917		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,054,259		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1319 | Component CCN: 14-8577 | Period: From 06/01/2017 To 05/31/2018 | Worksheet M-1 | Date/Time Prepared: 9/27/2018 2:18 pm

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	3,117	0	3,117	0	3,117	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	85,036	0	85,036	0	85,036	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	39,235	0	39,235	0	39,235	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	2,884	0	2,884	0	2,884	9.00
10.00	Subtotal (sum of lines 1 through 9)	130,272	0	130,272	0	130,272	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	20,391	20,391	0	20,391	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	20,391	20,391	0	20,391	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	130,272	20,391	150,663	0	150,663	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	6,450	6,450	0	6,450	29.00
30.00	Administrative Costs	59,223	50,640	109,863	0	109,863	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	59,223	57,090	116,313	0	116,313	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	189,495	77,481	266,976	0	266,976	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1319 | Component CCN: 14-8577 | Period: From 06/01/2017 To 05/31/2018 | Worksheet M-1 | Date/Time Prepared: 9/27/2018 2:18 pm

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	3,117		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	85,036		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	39,235		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	2,884		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	130,272		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	20,391		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	20,391		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	150,663		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	6,450		29.00
30.00	Administrative Costs	0	109,863		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	116,313		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	266,976		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1319 | Component CCN: 14-8587 | Period: From 06/01/2017 To 05/31/2018 | Worksheet M-1 | Date/Time Prepared: 9/27/2018 2:18 pm

RHC III | 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	10,553	0	10,553	2,091	12,644	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	4,713	0	4,713	934	5,647	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	3,458	0	3,458	0	3,458	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	791	0	791	0	791	9.00
10.00	Subtotal (sum of lines 1 through 9)	19,515	0	19,515	3,025	22,540	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	4,050	4,050	0	4,050	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	4,050	4,050	0	4,050	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	19,515	4,050	23,565	3,025	26,590	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	0	0	0	0	29.00
30.00	Administrative Costs	3,431	3,667	7,098	0	7,098	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	3,431	3,667	7,098	0	7,098	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	22,946	7,717	30,663	3,025	33,688	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1319 | Component CCN: 14-8587 | Period: From 06/01/2017 To 05/31/2018 | Worksheet M-1 | Date/Time Prepared: 9/27/2018 2:18 pm

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	12,644		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	5,647		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	3,458		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	791		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	22,540		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	4,050		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	4,050		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	26,590		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	0		29.00
30.00	Administrative Costs	0	7,098		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	7,098		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	33,688		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1319 | Component CCN: 14-8576 | Period: From 06/01/2017 To 05/31/2018 | Worksheet M-2 | Date/Time Prepared: 9/27/2018 2:18 pm

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC I Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.00	8,911	4,200	8,400		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.49	7,626	2,100	3,129		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.49	16,537		11,529	16,537	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.49	16,537			16,537	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,409,342	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,409,342	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)					644,917	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					897,922	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,542,839	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,542,839	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,542,839	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,952,181	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

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

Period: From 06/01/2017 To 05/31/2018

Worksheet M-2

Date/Time Prepared: 9/27/2018 2:18 pm

RHC II

Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.01	460	4,200	42		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.44	1,987	2,100	924		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.45	2,447		966	2,447	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)	0.45	2,447			2,447	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)					150,663	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)					150,663	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)					116,313	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					114,404	15.00
16.00	Total overhead (sum of lines 14 and 15)					230,717	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					230,717	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					230,717	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					381,380	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1319 | Component CCN: 14-8587 | Period: From 06/01/2017 To 05/31/2018 | Worksheet M-2 | Date/Time Prepared: 9/27/2018 2:18 pm

RHC III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.03	79	4,200	126		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.03	79	2,100	63		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.06	158		189	189	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)	0.06	158			189	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)					26,590	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)					26,590	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)					7,098	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					18,251	15.00
16.00	Total overhead (sum of lines 14 and 15)					25,349	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					25,349	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					25,349	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					51,939	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1319 Component CCN: 14-8576	Period: From 06/01/2017 To 05/31/2018	Worksheet M-3 Date/Time Prepared: 9/27/2018 2:18 pm
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,952,181	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,952,181	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			16,537	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			16,537	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			178.52	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	82.30	83.45		8.00
9.00	Rate for Program covered visits (see instructions)	178.52	178.52		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,771		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	494,679		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	494,679		16.00
16.01	Total program charges (see instructions)(from contractor's records)		554,776		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		41,263		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		36,793		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		330,420		16.04
16.05	Total program cost (see instructions)	0	367,213		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		44,861		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		93,731		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		367,213		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		367,213		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		367,213		26.00
26.01	Sequestration adjustment (see instructions)		7,344		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		281,323		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		78,546		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1319 Component CCN: 14-8577	Period: From 06/01/2017 To 05/31/2018	Worksheet M-3 Date/Time Prepared: 9/27/2018 2:18 pm
	Title XVIII	RHC II	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		381,380	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		381,380	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		2,447	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		2,447	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		155.86	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	82.30	83.45	8.00
9.00	Rate for Program covered visits (see instructions)	155.86	155.86	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	804	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	125,311	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	125,311	16.00
16.01	Total program charges (see instructions)(from contractor's records)		148,043	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		6,128	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		5,187	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		85,542	16.04
16.05	Total program cost (see instructions)	0	90,729	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		13,197	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		25,744	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		90,729	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		90,729	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		90,729	26.00
26.01	Sequestration adjustment (see instructions)		1,815	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		80,592	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		8,322	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1319 Component CCN: 14-8587	Period: From 06/01/2017 To 05/31/2018	Worksheet M-3 Date/Time Prepared: 9/27/2018 2:18 pm
	Title XVIII	RHC III	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			51,939	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			51,939	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			189	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			189	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			274.81	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	82.30	83.45		8.00
9.00	Rate for Program covered visits (see instructions)	274.81	274.81		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	40	40		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	10,992	10,992		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	21,984		16.00
16.01	Total program charges (see instructions)(from contractor's records)		0		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		17,587		16.04
16.05	Total program cost (see instructions)	0	17,587		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		0		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		17,587		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		17,587		22.00
23.00	Allowable bad debts (see instructions)		0		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		17,587		26.00
26.01	Sequestration adjustment (see instructions)		352		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		4,400		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		12,835		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1319 Component CCN: 14-8576	Period: From 06/01/2017 To 05/31/2018	Worksheet M-5 Date/Time Prepared: 9/27/2018 2:18 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		281,323	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		281,323	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		78,546	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		359,869	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1319 Component CCN: 14-8577	Period: From 06/01/2017 To 05/31/2018	Worksheet M-5 Date/Time Prepared: 9/27/2018 2:18 pm
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		80,592	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		80,592	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		8,322	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		88,914	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1319 Component CCN: 14-8587	Period: From 06/01/2017 To 05/31/2018	Worksheet M-5 Date/Time Prepared: 9/27/2018 2:18 pm
		RHC III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		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		4,400	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		4,400	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		12,835	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		17,235	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00