Health Financial Systems

In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 14-1319 Peri od: Worksheet S From 06/01/2022 Parts I-III AND SETTLEMENT SUMMARY 05/31/2023 Date/Time Prepared:

10/24/2023 5: 18 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 10/24/2023 5: 18 pm Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
(1) As Submitted
(2) Settled without Audit
(3) Settled with Audit
(4) Provided CCN
(5) Initial Report for this Provider CCN
(6) Date Received:
(7) As Submitted
(8) Date Received:
(9) Contractor No.
(10) NPR Date:
(11) Contractor's Vendor Code:
(12) If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit (4) Reopened

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(5) Amended

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 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 06/01/2022 and ending 05/31/2023 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.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
	1			SIGNATURE STATEMENT	
1	Jod	ie Criswell	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Jodie Criswell			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

	·		Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	-382, 299	42, 209	0	0	1.00
2.00	SUBPROVI DER - I PF	0	0	0		0	2.00
3.00	SUBPROVI DER - I RF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	-208, 140	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	-1		0	9.00
10.00	KEWANEE RHC I	0		17, 129		0	10.00
10.01	WYOMING RHC II	0		0		0	10.01
10.02	GENESEO RHC III	0		3, 254		0	10.02
10. 03	ANNAWAN RHC IV	0		2, 128		0	10.03
10.04	CAMBRI DGE RHC V	0		7, 043		0	10.04
200.00	TOTAL	0	-590, 439	71, 762	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1319

In Lieu of Form CMS-2552-10

Period: Worksheet S-2
From 06/01/2022 Part I
To 05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm

								10/24/2	1023 3.	то рііі
	1.00	2.00		3. 00			1. 00			
1. 00	Hospital and Hospital Health Care Co Street: 600 N. COLLEGE AVENUE	PO Box:								1.00
2. 00	Ci ty: GENESEO	State: IL	Zip Cod	e: 61254-1	1099 Count	v: HENRY				2.00
		Component Name	CCN	CBSA	Provi der		Paymer	nt Syst	em (P,	
			Number	Number	Туре	Certi fi ed	_	0, or		
		1.00	2. 00	3. 00	4.00	5. 00	V 6. 00	7. 00		
	Hospital and Hospital-Based Componer		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
3.00	Hospi tal	HAMMOND-HENRY HOSPI TAL	141319	19340	1	06/04/2002	N	0	0	3.00
4.00	Subprovi der - IPF									4. 00
5. 00	Subprovi der - IRF									5.00
6. 00 7. 00	Subprovi der - (Other) Swing Beds - SNF	HAMMOND-HENRY SWING BED	14Z319	99914		05/21/2003	N	0	N	6. 00 7. 00
8. 00	Swing Beds - NF	TIANNIONE TIENKT SWING BEE	142317	77714		037 2 17 2003			"	8.00
9. 00	Hospital -Based SNF	HAMMOND-HENRY SKILLED	145464	99914		06/01/1983	N	Р	N	9. 00
40.00		NURSI NG								40.00
10. 00 11. 00	Hospi tal -Based NF Hospi tal -Based OLTC									10.00 11.00
12. 00	Hospital -Based HHA	HAMMOND-HENRY HOME	147450	99914		06/05/1986	N	P	N	12.00
		HEALTH SERVICES						'		
13.00	Separately Certified ASC									13.00
14. 00 15. 00	Hospital-Based Hospice Hospital-Based Health Clinic - RHC	HAMMOND-HENRY HOSPITAL	148576	99914		05/01/2017	l N	0	l N	14. 00 15. 00
15.00	Hospital-Based Health Cithic - RHC	RHP-KEWANEE	148576	99914		05/01/201/	IN	0	IN IN	15.00
15. 01	Hospital-Based Health Clinic - RHC	HAMMOND-HENRY HOSPITAL	148577	99914		05/01/2017	N	0	N	15. 01
	П	RHP-WYOMI NG								
15. 02	Hospital-Based Health Clinic - RHC	HAMMOND-HENRY HOSPITAL RHP-GENESEO	148587	99914		05/16/2018	N	0	N	15. 02
15. 03	Hospital-Based Health Clinic - RHC	ANNAWAN URGENT CARE	148615	99914		07/28/2020	l N	0	N	15. 03
	IV	CLINIC								
15. 04	Hospital-Based Health Clinic - RHC V		148628	99914		02/07/2022	N	0	N	15. 04
16. 00	Hospital-Based Health Clinic - FQHC	RHP-CAMBRI DGE								16. 00
17. 00	Hospital -Based (CMHC) I									17.00
17. 10	Hospital -Based (CORF) I									17. 10
18.00										
	Renal Dialysis									18.00
	Renal Dialysis Other					Erom:		To		18. 00 19. 00
						From: 1.00		To		
						From: 1.00 06/01/2		To 2. ( 05/31/	00	
20. 00	Other					1.00		2. (	00	19. 00
20. 00	Other  Cost Reporting Period (mm/dd/yyyy)				1.00	1. 00 06/01/20 11		2. ( 05/31/	00 /2023	19. 00
20. 00	Other  Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)				1.00	1.00		2. (	00 /2023	19. 00
20. 00	Other  Cost Reporting Period (mm/dd/yyyy)	currently receiving pa	yments fo	r	1.00 N	1. 00 06/01/20 11		2. ( 05/31/	00 /2023	19. 00
20. 00 21. 00	Other  Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)  Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju	ıstment, in accordance wi	th 42 CF			1. 00 06/01/20 11 2. 00		2. ( 05/31/	00 /2023	20. 00 21. 00
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20. 00 21. 00 22. 00	Other  Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)  Inpatient PPS Information  Does this facility qualify and is it disproportionate share hospital adjug412.106? In column 1, enter "Y" facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" foolid this hospital receive interim UC this cost reporting period? Enter in	ustment, in accordance with the person of th	th 42 CF this endment tal UCPs, or "N" fo	for r no	N	1. 00 06/01/2 11 2. 00		2. ( 05/31/	00 /2023	20. 00 21. 00 22. 00
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20. 00 21. 00 22. 00 22. 01	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)  Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju \$412.106? In column 1, enter "Y" for facility subject to 42 CFR Section 8 hospital?) In column 2, enter "Y" for Did this hospital receive interim UC this cost reporting period? Enter in for the portion of the cost reportin 1. Enter in column 2, "Y" for yes or cost reporting period occurring on cost reporting period occurring on constructions) Is this a newly merged hospital that determined at cost report settlement 1, "Y" for yes or "N" for no, for the period prior to October 1. Enter in for the portion of the cost reporting Did this hospital receive a geograph	ustment, in accordance with a system of the	th 42 CF this endment tal UCPs, or "N" for to Octo tion of to be ter in coeporting "N" for tober 1.	for r no ber he	N N	1. 00 06/01/20 11 2. 00 N		2. ( 05/31/	000 72023 000	20. 00 21. 00 22. 00
20. 00 21. 00 22. 00 22. 01	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)  Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adjugs412.106? In column 1, enter "Y" for facility subject to 42 CFR Section 58 hospital?) In column 2, enter "Y" for Did this hospital receive interim UC this cost reporting period? Enter infor the portion of the cost reporting. Enter in column 2, "Y" for yes or cost reporting period occurring on coinstructions) Is this a newly merged hospital that determined at cost report settlement 1, "Y" for yes or "N" for no, for the period prior to October 1. Enter in for the portion of the cost reporting Did this hospital receive a geograph rural as a result of the OMB standar	ustment, in accordance with a system of the	th 42 CF this endment tal UCPs, or "N" for to Octo tion of to be ter in coeporting - "N" for tober 1. In urban t stical a	for r no ber he I umn no, o reas	N N	1. 00 06/01/20 11 2. 00 N		2. ( 05/31, 3. (	000 72023 000	20. 00 21. 00 22. 00 22. 01
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20. 00 21. 00 22. 00 22. 01	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)  Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju \$\frac{5}{2}\$ 412.106? In column 1, enter "Y" for facility subject to 42 CFR Section \$\frac{5}{2}\$ hospital?) In column 2, enter "Y" for Did this hospital receive interim UC this cost reporting period? Enter in for the portion of the cost reporting 1. Enter in column 2, "Y" for yes or cost reporting period occurring on constructions) Is this a newly merged hospital that determined at cost report settlement 1, "Y" for yes or "N" for no, for the period prior to October 1. Enter in for the portion of the cost reporting in the cost reporting in the cost reporting the cost reporting the cost reporting in the cost reporting for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least	ustment, in accordance with a system of the properties of the portion of the cost recolumn 2, "Y" for yes on the portion of the cost recolumn 2, "Y" for yes on the portion of the portion but not more than 400 but not more	th 42 CF this endment tal UCPs, or "N" for to Octo tion of to be ter in coeporting "N" for tober 1. In urban t stical a "N" for er 1. Ent the cost ructions) 99 beds (	for r no ber he I umn no, o reas no er	N N	1. 00 06/01/20 11 2. 00 N		2. ( 05/31, 3. (	000 72023	20. 00 21. 00 22. 00 22. 01
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Health Financial Systems Provi der CCN: 14-1319 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

In Lieu of Form CMS-2552-10 Peri od: Worksheet S-2

From 06/01/2022 Part I 05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm 2.00 1. 00 3.00 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for ves or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 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. In-State 0ther In-State Out-of Out-of Medi cai d Medi cai d HMO days Medi cai d State State Medi cai d paid days Medicai d Medi cai d el i gi bl e days unpai d paid days el i gi bl e days unpai d 1.00 2.00 3. 00 4 00 5. 00 6 00 24.00 If this provider is an IPPS hospital, enter the 24.00 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. 25.00 If this provider is an IRF, enter the in-state 0 25.00 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. 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. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost 27.00 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. 35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1 00 2 00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number 36.00 of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37.00 is in effect in the cost reporting period. 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 37.01 37.01 instructions) If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume N 39. 00 hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or 40.00 Ν Ν '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)

Provider CCN: 14-1319

						10/24/2	023 5:	18 pm
					V	XVIII		
Prospective Payment System (PPS)-Capital					1.00	2. 00	3. 00	
45.00 Does this facility qualify and receive Capital payme	ent for d	li sproporti ona	te share in ac	cordance	N	N	N	45.00
with 42 CFR Section §412.320? (see instructions)								
46.00 Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks					N	N	N	46.00
Pt. III.	, c, i c	. III and wks	t. L 1, 1 t. 1	tili ougii				
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS					N	N	N	47.00
48.00 Is the facility electing full federal capital paymen	nt? Ente	r "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	annrove	d GME program	s2 For cost re	nortina	l N			]   56. 00
periods beginning prior to December 27, 2020, enter					"			30.00
cost reporting periods beginning on or after Decembe								
the instructions. For column 2, if the response to c								
involved in training residents in approved GME progrand are you are impacted by CR 11642 (or applicable								
"Y" for yes; otherwise, enter "N" for no in column 2		urrect dwil pa	ymerit reductio	III LIILEI				
57.00 For cost reporting periods beginning prior to Decemb		020, if line	56, column 1,	is yes,				57.00
is this the first cost reporting period during which								
at this facility? Enter "Y" for yes or "N" for no i								
residents start training in the first month of this "N" for no in column 2. If column 2 is "Y", complet								
complete Wkst. D, Parts III & IV and D-2, Pt. II, if								
beginning on or after December 27, 2020, under 42 CF								
which month(s) of the cost report the residents were								
for yes, enter "Y" for yes in column 1, do not compl 58.00 If line 56 is yes, did this facility elect cost reim					N			   58. 00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes,			ans services	us	'`			30.00
59.00 Are costs claimed on line 100 of Worksheet A? If ye	es, compl	ete Wkst. D-2			N			59.00
			NAHE 413.85	Workshe		Pass-Th		
			Y/N	Li ne	#	Qualific Crite		
						Cod		
			1. 00	2. 00	)	3. 0	00	
60.00 Are you claiming nursing and allied health education			N					60.00
any programs that meet the criteria under 42 CFR 413 instructions) Enter "Y" for yes or "N" for no in co								
is "Y", are you impacted by CR 11642 (or subsequent								
adjustment? Enter "Y" for yes or "N" for no in colu		. ,						
	Y/N	I ME	Direct GME	IME		Di rect	GME	
	1.00	2. 00	3. 00	4. 00	)	5. 0	00	<u> </u>
61.00 Did your hospital receive FTE slots under ACA	N		9. 9.9		0.00			61.00
section 5503? Enter "Y" for yes or "N" for no in								
column 1. (see instructions)								(1.01
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports								61.01
ending and submitted before March 23, 2010. (see								
instructions)								
61.02 Enter the current year total unweighted primary care	;							61.02
FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of								
ACA). (see instructions)								
61.03 Enter the base line FTE count for primary care								61.03
and/or general surgery residents, which is used for								
determining compliance with the 75% test. (see								
instructions) 61.04 Enter the number of unweighted primary care/or								61. 04
surgery allopathic and/or osteopathic FTEs in the								51.04
current cost reporting period. (see instructions).								
61.05 Enter the difference between the baseline primary								61.05
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)								
61.06 Enter the amount of ACA §5503 award that is being								61.06
used for cap relief and/or FTEs that are nonprimary								
care or general surgery. (see instructions)								

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				To	05/31/2023	Date/Time Pre 10/24/2023 5:	
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	ГО РІІІ
			1. 00	2. 00	3. 00	4. 00	
61. 20	specialty, if any, and the number for each new program. (see instruction of the program code. Enter in column 3, unweighted count. Enter in column FTE unweighted count.	er of FTE residents ructions) Enter in ructions. Enter in the IME FTE in 4, the direct GME fy each expanded he number of FTE ram. (see the program name. The in column Enter in column 4,			0.00		61. 10
						1.00	
	ACA Provisions Affecting the Hea	olth Resources and Se	rvices Administration	(HRSA)		1.00	
62. 00	Enter the number of FTE resident				iod for which	0.00	62.00
	your hospital received HRSA PCRE	funding (see instru	ctions)				
62. 01	Enter the number of FTE resident during in this cost reporting pe	eriod of HRSA THC prog	gram. (see instructio	` ,	your hospital	0.00	62.01
63. 00	Teaching Hospitals that Claim Re Has your facility trained reside			ost reporting	period? Enter	N	63.00
	"Y" for yes or "N" for no in col					14	00.00
				Unwei ghted	Unwei ghted	Ratio (col.	
				FTEs Nonprovider	FTEs in Hospital	1/ (col . 1 + col . 2))	
				Si te	·		
				1.00	2. 00	3. 00	
	Section 5504 of the ACA Base Year period that begins on or after 2			This base year	is your cost	reporting	
64.00	Enter in column 1, if line 63 is			0.00	0.00	0. 000000	64.00
	in the base year period, the num	ber of unweighted nor	n-primary care				
	resident FTEs attributable to ro						
	settings. Enter in column 2 the resident FTEs that trained in you						
	of (column 1 divided by (column						
		Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
				FTEs	FTEs in	3/ (col. 3 +	
				Nonprovider Site	Hospi tal	col. 4))	
		1. 00	2.00	3. 00	4. 00	5. 00	-
65.00				0.00			65.00
	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)						
				i e			1

In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 14-1319 Peri od: Worksheet S-2

From 06/01/2022 Part I 05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm Unwei ghted Unwei ghted Ratio (col. FTEs FTEs in 1/ (col. 1 + col. 2)) Nonprovi der Hospi tal Si te 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 0.00 0.00 0.000000 66.00 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) Program Name Unwei ghted Unwei ghted Program Code Ratio (col. FTEs in FTEs 3/(col. 3 +Nonprovi der Hospi tal col. 4)) Si te 1.00 2.00 3.00 4.00 5.00 67.00 Enter in column 1, the program 0.00 0.00 0.000000 67.00 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) 1.00 Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your 68.00 N MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)? 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. 70 00 N 70 00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 0 71.00 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) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75 00 subprovider? Enter "Y" for yes and "N" for no.

If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 0 76.00 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) 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. 80.00 N 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. 85.00 Ν Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 87.00 Is this hospital an extended neoplastic disease care hospital classified under section 87.00 Ν

1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.

Health Financial Systems
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 14-1319

	To	05/31/2023	Date/Time Pre 10/24/2023 5:	
		Approved for	Number of	To piii
		Permanent Adjustment	Approved Permanent	
		(Y/N)	Adjustments	
		1.00	2. 00	
88.00 Column 1: Is this hospital approved for a permanent adjustment to the TEF amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete c 89. (see instructions)  Column 2: Enter the number of approved permanent adjustments.	RA target ol. 2 and line		(	88.00
Cordinal 2. Effer the humber of approved permanent adjustments.	Wkst. A Line	Effecti ve	Approved	
	No.	Date	Permanent Adjustment Amount Per Discharge	
	1.00	2. 00	3. 00	20.00
89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based.  Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge.  Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.	0.00		C	89.00
		V	XI X	
Title V and XIX Services		1.00	2. 00	
90.00 Does this facility have title V and/or XIX inpatient hospital services? Eyes or "N" for no in the applicable column.	nter "Y" for	N	Y	90. 00
91.00 Is this hospital reimbursed for title V and/or XIX through the cost reportfull or in part? Enter "Y" for yes or "N" for no in the applicable column	l.	N	N	91.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certificat instructions) Enter "Y" for yes or "N" for no in the applicable column. 93.00 Does this facility operate an ICF/IID facility for purposes of title V an	, ,	N	Y	92.00
93.00 Does this facility operate an ICF/IID facility for purposes of title V an "Y" for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for n		N N	N N	94.00
applicable column.  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 n applicable column.		N N	N N	96.00
97.00 If line 96 is "Y", enter the reduction percentage in the applicable colum 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and res stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" column 1 for title V, and in column 2 for title XIX.	idents post	0. 00 Y	0. 00 Y	97. 00 98. 00
98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of ch C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in title XIX.		Y	Υ	98. 01
98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no 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 h reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for		N	N	98. 03
for title V, and in column 2 for title XIX.  98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 10 outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for 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 di Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for t column 2 for title XIX.		Y	Y	98. 05
98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed fo Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title column 2 for title XIX.  Rural Providers		Y	Y	98.06
105.00 Does this hospital qualify as a CAH? 106.00 of this facility qualifies as a CAH, has it elected the all-inclusive met	hod of payment	Y Y		105. 00 106. 00
for outpatient services? (see instructions)  107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursem training programs? Enter "Y" for yes or "N" for no in column 1. (see ins		N		107. 00
Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&R approved medical education program in the CAH's excluded IPF and/or IRF Enter "Y" for yes or "N" for no in column 2. (see instructions)	s in an unit(s)?			
108.00 Is this a rural hospital qualifying for an exception to the CRNA fee sche CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	dul e? See 42	N		108. 00

Health Financial Systems
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1319

			To 05/31/2023		epared:
	Physi cal	Occupati onal	Speech	Respiratory	
109.00  f this hospital qualifies as a CAH or a cost provider, are	1. 00 N	2. 00 N	3. 00 N	4. 00 N	109. (
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	IV	IN	IN .	10	109.0
				1.00	
110.00 Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter "complete Worksheet E, Part A, lines 200 through 218, and Worapplicable.	Y" for yes or	"N" for no.	lf yes,	N	110.0
			1 00	2.00	_
111.00   f this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this compared by the response to the response to compared by the response to the response to the response to compared by the response to the r	ost reporting Dlumn 1 is Y, rticipating ir	period? Enter enter the n column 2.	1. 00 N	2.00	111. C
		1.00	2.00	3. 00	_
112.00 Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If co "Y", enter in column 2, the date the hospital began particip demonstration. In column 3, enter the date the hospital ceaparticipation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information	eporting Dumn 1 is Dating in the	N N	2.00	3.00	112.0
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub.15-1, chapter 22, §2208.1.	3, or E only) 3" percent includes	N			0115.0
116.00 Is this facility classified as a referral center? Enter "Y"	for yes or	N			116. 0
"N" for no.  117.00 Is this facility legally-required to carry malpractice insur- "Y" for yes or "N" for no.	ance? Enter	Y			117. C
118.00 Is the malpractice insurance a claims-made or occurrence polif the policy is claim-made. Enter 2 if the policy is occurr			1		118.0
The portey is craim made. Enter 2 in the portey is edeal.	crice.	Premi ums	Losses	Insurance	
		1.00	2. 00	3. 00	_
118.01 List amounts of malpractice premiums and paid losses:		656, 86			0118.0
			1.00	2. 00	_
Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.  119.00 DO NOT USE THIS LINE			N N	2.00	118.0
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu. Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no.	n column 1, "\ ualifies for t	/" for yes or the Outpatient	N	N	120. 0
121.00 Did this facility incur and report costs for high cost implaidation patients? Enter "Y" for yes or "N" for no.	ntable device	es charged to	Y		121. (
122.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.			N		122.0
123.00 Did the facility and/or its subproviders (if applicable) purservices, e.g., legal, accounting, tax preparation, bookkeep management/consulting services, from an unrelated organization for yes or "N" for no.  If column 1 is "Y", were the majority of the expenses, i.e.,	oing, payroll, on? In columr greater thar	and/or n 1, enter "Y" n 50% of total gani zations			123. (
professional services expenses, for services purchased from located in a CBSA outside of the main hospital CBSA? In column' N'' for no.	ımn 2, enter "	Tor yes or			
professional services expenses, for services purchased from located in a CBSA outside of the main hospital CBSA? In column''N'' for no.  Certified Transplant Center Information		•	N		125 (
professional services expenses, for services purchased from located in a CBSA outside of the main hospital CBSA? In coluun "N" for no.  Certified Transplant Center Information 125.00 Does this facility operate a Medicare-certified transplant country and "N" for no. If yes, enter certification date(s) (mm/dd/y	center? Enter	"Y" for yes	N		
professional services expenses, for services purchased from located in a CBSA outside of the main hospital CBSA? In column's for no.  Certified Transplant Center Information  125.00 Does this facility operate a Medicare-certified transplant compared to the content of the cont	center? Enter yyyy) below. enter the cert	"Y" for yes	е		125. 0 126. 0

Health Financial Systems In Lieu of Form CMS-2552-10 Provi der CCN: 14-1319 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Peri od: Worksheet S-2 From 06/01/2022 Part I Date/Time Prepared: 05/31/2023 10/24/2023 5:18 pm 1. 00 2.00 128.00||f this is a Medicare-certified liver transplant program, enter the certification date 128.00 in column 1 and termination date, if applicable, in column 2. 129.00|If this is a Medicare-certified lung transplant program, enter the certification date 129.00 in column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare-certified pancreas transplant program, enter the certification 130.00 date in column 1 and termination date, if applicable, in column 2. 131.00|If this is a Medicare-certified intestinal transplant program, enter the certification 131.00 date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a Medicare-certified islet transplant program, enter the certification date 132.00 in column 1 and termination date, if applicable, in column 2. 133. 00 133,00 Removed and reserved 134.00 If this is a hospital-based organ procurement organization (OPO), enter the OPO number 134.00 in column 1 and termination date, if applicable, in column 2 All Providers 140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, N 140.00 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) 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: 141. 00 Contractor's Name: Contractor's Number: 142.00 Street: PO Box: 142.00 143.00 Ci ty: State: Zip Code: 143.00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144.00 1. 00 2.00 145.00|| f 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 145.00 no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146 00 Ν 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. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 147.00 N 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148. 00 149.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Title XIX Part B Title V 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 Hospi tal N 155.00 Ν 156.00 Subprovi der - IPF N Ν N 156.00 Ν 157.00 Subprovi der - IRF Ν Ν Ν Ν 157. 00 158. 00 SUBPROVI DER 158.00 159. 00 SNF N Ν N N 159 00 160.00 HOME HEALTH AGENCY Ν Ν Ν Ν 160.00 161.00 CMHC Ν Ν 161.00 Ν 161. 10 CORF Ν N Ν 161. 10 1.00 Mul ti campus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? 165 00

recorded the time heapt tar part of a martineampas heapt tar that has one or more campasse in arriverent essent.								1.00.00
Enter "Y" for yes or "N" for no.								
		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						0. 00	166. 00
	campus enter the name in column							
	O, county in column 1, state in							
	column 2, zip code in column 3,							
	CBSA in column 4, FTE/Campus in							
	column 5 (see instructions)							

In Lieu of Form CMS-2552-10

Period: Worksheet S-2
From 06/01/2022 Part I
To 05/31/2023 Date/Time Prepared: Health Financial Systems
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 14-1319

	To	05/31/2023	Date/Time Pr 10/24/2023	
			1. 00	
Health Information Technology (HIT) incentive in the American Rec	overy and Reinvestment	Act		
167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for	yes or "N" for no.		Υ	167. 00
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful u reasonable cost incurred for the HIT assets (see instructions)	ser (line 167 is "Y"),	enter the		168. 00
168.01 If this provider is a CAH and is not a meaningful user, does this exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for n		a hardshi p		168. 01
169.00 If this provider is a meaningful user (line 167 is "Y") and is no transition factor. (see instructions)	t a CAH (line 105 is "N	N"), enter the	0.	00169.00
		Begi nni ng	Endi ng	
		1.00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date f period respectively (mm/dd/yyyy)	or the reporting			170. 00
		1.00	2. 00	
171.00 If line 167 is "Y", does this provider have any days for individu section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, Ii "Y" for yes and "N" for no in column 1. If column 1 is yes, enter 1876 Medicare days in column 2. (see instructions)	ne 2, col. 6? Enter	N		0171.00

Health Financial Systems Provi der CCN: 14-1319 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

In Lieu of Form CMS-2552-10 Peri od: Worksheet S-2

From 06/01/2022 Part II Date/Time Prepared: 05/31/2023 10/24/2023 5:18 pm Y/N Date 1.00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE 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 Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If N 2 00 yes, enter in column 2 the date of termination and in column  $\hat{\textbf{3}},$  "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Ν 3.00 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) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 10/09/2023 4.00 Α 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from Υ 5.00 those on the filed financial statements? If yes, submit reconciliation Legal Oper. Y/N 1.00 2.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7 00 7 00 N 8.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 N 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved 11.00 Ν Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 12.00 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. 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? Ν N 16.00 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) Was the cost report prepared using the PS&R Report for 10/12/2023 17.00 Υ 10/12/2023 γ 17.00 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) If line 16 or 17 is yes, were adjustments made to PS&R 18.00 Ν 18.00 N 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. If line 16 or 17 is yes, were adjustments made to PS&R 19.00 Ν Ν Report data for corrections of other PS&R Report

information? If yes, see instructions.

Worksheet S-2 From 06/01/2022 Part II Date/Time Prepared: 05/31/2023 10/24/2023 5:18 pm Description Y/N 1.00 3.00 20.00 | If line 16 or 17 is yes, were adjustments made to PS&R N Ν 20.00 Report data for Other? Describe the other adjustments: Y/N Date Y/N Date 3.00 1.00 2.00 4.00 21.00 Was the cost report prepared only using the provider's 21 00 N N records? If yes, see instructions. 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 22.00 Ν Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost Ν 23 00 reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entered into during this cost reporting period? Ν 24.00 24.00 If yes, see instructions 25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see Ν 25.00 i nstructi ons. Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Ν 26,00 26,00 instructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit Ν 27.00 сору. Interest Expense Were new loans, mortgage agreements or letters of credit entered into during the cost reporting N 28.00 28.00 period? If yes, see instructions. Υ Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) 29.00 29.00 treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see Ν 30.00 instructions. 31 00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see Ν 31 00 <u>i nstructi ons</u> Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual 32.00 arrangements with suppliers of services? If yes, see instructions.

If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If Υ 33.00 33.00 no, see instructions. Provi der-Based Physi ci ans Were services furnished at the provider facility under an arrangement with provider-based physicians? 34.00 If ves see instructions If line 34 is yes, were there new agreements or amended existing agreements with the provider-based Υ 35 00 physicians during the cost reporting period? If yes, see instructions. Date 1. 00 2.00 Home Office Costs 36.00 Were home office costs claimed on the cost report? N 36 00 If line 36 is yes, has a home office cost statement been prepared by the home office? 37.00 Ν If yes, see instructions. 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. 38.00 Ν 38.00 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 39.00 see instructions. 40 00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position DAVI D GOODMAN 41.00 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y.

WIPFLI, LLP

608-270-2962

In Lieu of Form CMS-2552-10

42.00

43.00

DGOODMAN@WI PFLI . COM

42.00

preparer.

Enter the employer/company name of the cost report

report preparer in columns 1 and 2, respectively.

Enter the telephone number and email address of the cost

Heal th Financial Systems STATE COPY

In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1319

Peri od: Worksheet S-2
From 06/01/2022 Part II
To 05/31/2023 Date/Time Prepared: 10/24/2023 5: 18 pm

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.

42.00 Enter the employer/company name of the cost report preparer.

43.00 Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.

Health Financial Systems
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

In Lieu of Form CMS-2552-10 Provider CCN: 14-1319

Peri od: Worksheet S-3
From 06/01/2022 Part I
To 05/31/2023 Date/Time Prepared: 10/24/2023 5: 18 pm

_							10/24/2023 5:	18 pm_
							I/P Days /	
							0/P Visits /	
							Tri ps	
		Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
			Li ne No.		Avai I abl e			
			1. 00	2. 00	3. 00	4. 00	5. 00	
		PART I - STATISTICAL DATA						
	1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	23	8, 395	29, 280. 00	0	1.00
		8 exclude Swing Bed, Observation Bed and						
		Hospice days) (see instructions for col. 2						
		for the portion of LDP room available beds)						
	2. 00	HMO and other (see instructions)						2.00
	3. 00	HMO I PF Subprovi der						3. 00
	4.00	HMO I RF Subprovi der					_	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		23	8, 395	29, 280. 00	0	7. 00
	0.00	beds) (see instructions)						0.00
	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)	42.00				0	12.00
	13.00	NURSERY	43. 00	22	0.205	20, 200, 00	0	13.00
	14. 00 15. 00	Total (see instructions) CAH visits		23	8, 395	29, 280. 00	0	14. 00 15. 00
	15. 00	REH hours and visits					U	15. 00
	16. 00	SUBPROVIDER - IPF						16. 00
	17. 00	SUBPROVIDER - I RF						17. 00
	18. 00	SUBPROVI DER						18.00
	19. 00	SKILLED NURSING FACILITY	44.00	38	13, 870		0	19. 00
	20.00	NURSING FACILITY	44.00		13,070		O	20.00
	21. 00	OTHER LONG TERM CARE	46. 00	c				21. 00
	22. 00	HOME HEALTH AGENCY	101. 00				0	22. 00
	23. 00	AMBULATORY SURGICAL CENTER (D. P.)	101.00				o l	23. 00
	24. 00	HOSPI CE						24. 00
	24. 10	HOSPICE (non-distinct part)	30.00					24. 10
	25. 00	CMHC - CMHC		•				25. 00
	25. 10	CMHC - CORF	99. 10				0	25. 10
	26. 00	KEWANEE RHC	88. 00				0	26. 00
	26. 02	GENESEO RHC	88. 02				0	26. 02
	26. 03	ANNAWAN RHC	88. 03				0	26. 03
	26. 04	CAMBRI DGE RHC	88. 04				0	26. 04
	26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
	27. 00	Total (sum of lines 14-26)		61				27. 00
	28. 00	Observation Bed Days					0	28. 00
	29. 00	Ambul ance 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)		C	0			32.00
	32. 01	Total ancillary labor & delivery room						32. 01
		outpatient days (see instructions)						
	33.00	LTCH non-covered days			1			33.00
	33. 01	LTCH site neutral days and discharges						33. 01
	34. 00	Temporary Expansion COVID-19 PHE Acute Care	30. 00	C	)  C		0	34.00

Health Financial Systems
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1319

In Lieu of Form CMS-2552-10

Peri od: Worksheet S-3

From 06/01/2022 Part I
To 05/31/2023 Date/Time Prepared: 10/24/2023 5: 18 pm

		I/P Days	s / O/P Visits	/ Tri ps	Full Time	<u>  10/24/2023 5:</u> Equi val ents	18 pm
		,-					
	C	T: +1 - V/// 1 1	T: +1 - VIV	T-+-1 All	Tatal lataura	[	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA	'					
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	654	0	1, 220			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2. 00	for the portion of LDP room available beds) HMO and other (see instructions)	108	39				2.00
3. 00	HMO IPF Subprovider	0	0				3.00
4. 00	HMO I RF Subprovi der	ol	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	402	0	506			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation	1, 056	0	1, 726			7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT						8.00
9. 00 10. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						9. 00 10. 00
11. 00	4						11.00
12. 00							12.00
13. 00			0	0			13.00
14. 00	1	1, 056	0	1, 726	0. 00	223. 25	
15.00		0	0	0			15.00
15. 10							15. 10
16. 00							16. 00
17.00							17.00
18.00		4.4.1	0	10.074	0.00	24 50	18.00
19. 00 20. 00		441	0	12, 864	0. 00	24. 59	19. 00 20. 00
21. 00				0	0.00	0.00	1
22. 00	1	5, 137	0			l .	1
23. 00		0, 10,	3	.0,02.	0.00	, , , ,	23.00
24.00							24.00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25. 00	CMHC - CMHC						25. 00
25. 10	· •	0	0	0	0. 00	l e	
26. 00		2, 740	0	16, 764		18. 93	
26. 02 26. 03	GENESEO RHC ANNAWAN RHC	2, 800 252	0			20. 48 4. 36	
26. 03	1	381	0	3, 957		ł	
26. 25		0	0				
27. 00		J	· ·	Ĭ	0.00	302. 77	27.00
28. 00			0	769			28. 00
29. 00	Ambul ance Trips	o					29. 00
30. 00				0			30.00
31.00	1 ' 3			0			31.00
32.00	7 7 1	0	0				32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days						33.00
33. 00	LTCH site neutral days and discharges	0					33.00
	Temporary Expansi on COVID-19 PHE Acute Care	Ö	0	О			34.00

Health Financial Systems
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

In Lieu of Form CMS-2552-10

Peri od: Worksheet S-3
From 06/01/2022 Part I
To 05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm Provider CCN: 14-1319

						10/24/2023 5:	18 piii
		Full Time		Di sch	arges		
		Equi val ents		I			
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	10.00	10.00	11.00	Pati ents	
	DADT I CTATICTICAL DATA	11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	PART I - STATISTICAL DATA		C	202	0	335	1. 00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		C	202	U	335	1.00
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)			23	5		2. 00
3. 00	HMO IPF Subprovider			23	0		3.00
4. 00	HMO IRF Subprovider				0		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF				O		5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
7.00	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	SURGI CAL INTENSI VE CARE UNI T						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	0.00	C	202	0	335	14.00
15.00	CAH vi si ts						15.00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVI DER - I RF						17.00
18. 00	SUBPROVI DER						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	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC	0.00					25. 00
25. 10 26. 00	CMHC - CORF KEWANEE RHC	0. 00 0. 00					25. 10 26. 00
26. 00	GENESEO RHC	0.00					26. 00
26. 02	ANNAWAN RHC	0.00					26. 02
26. 04	CAMBRI DGE RHC	0.00					26. 03
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days	0.00					28. 00
29. 00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see Thisti detroit)						31.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
- · · - ·	outpatient days (see instructions)						
33.00	LTCH non-covered days			0			33.00
33. 01	LTCH site neutral days and discharges			0			33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00
		·		•	· ·		

Heal th Fi nancial Systems
HOME HEALTH AGENCY STATISTICAL DATA

Provider CCN: 14-1319 | Period:

From 06/01/2022 Component CCN: 14-7450 То 05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm Home Health **PPS** Agency I 1.00 0.00 County HENRY 0.00 Title V Title XVIII Title XIX 0ther Total 1 00 2.00 3 00 4 00 5 00 HOME HEALTH AGENCY STATISTICAL DATA 1.00 Home Health Aide Hours 13, 709 13, 709 1.00 178. 00 2.00 Unduplicated Census Count (see instructions) 0.00 19.00 41.00 238.00 2.00 Number of Employees (Full Time Equivalent) Enter the number of hours in Staff Contract Total vour normal work week 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 Director(s) and Assistant Director(s) 0.00 0.00 0.00 4.00 4.00 5.00 Other Administrative Personnel 1.01 0.00 1.01 5.00 Direct Nursing Service 6.00 0.000.00 0.006.00 7.00 Nursing Supervisor 1.02 0.00 1.02 7.00 8.00 Physical Therapy Service 0.00 0.00 0.00 8.00 Physical Therapy Supervisor 9.00 0.00 0.00 0.00 9.00 0.00 0.00 10.00 10.00 Occupational Therapy Service 0.00 11.00 Occupational Therapy Supervisor 0.00 0.00 0.00 11.00 Speech Pathology Service 12.00 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 Medical Social Service Supervisor 15.00 0.00 0.00 0.00 15.00 16.00 Home Heal th Aide 6.59 0.00 6.59 16.00 Home Health Aide Supervisor 0.00 17.00 0.000.00 17 00 18.00 Other (specify) 0.00 0.00 0.00 18.00 CBSA Data 1 00 HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where you provided services during the cost reporting period. 19.00 20.00 List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the 19340 20.00 first code) 99914 20.01 20.01 Full Episodes Wi thout With Outliers LUPA Epi sodes PEP Only Total (cols. Outliers Epi sodes 1-4)1.00 2.00 3.00 4.00 5.00 PPS ACTIVITY DATA 21.00 Skilled Nursing Visits 1, 381 2, 199 21.00 Skilled Nursing Visit Charges 22.00 236, 013 126, 979 7, 349 375, 810 5.469 22.00 23.00 Physical Therapy Visits 916 694 ρ 37 1,655 23.00 24.00 Physical Therapy Visit Charges 200, 054 151, 570 1,747 8,081 361, 452 24.00 25.00 Occupational Therapy Visits 194 359 22 579 25.00 Occupational Therapy Visit Charges 124, 707 26.00 40.622 78, 406 874 4.805 26.00 27.00 Speech Pathology Visits 15 49 0 64 27.00 28.00 Speech Pathology Visit Charges 3, 276 10, 702 0 0 13, 978 28.00 29.00 Medical Social Service Visits 0 11 29.00 0 30.00 Medical Social Service Visit Charges 1, 300 1, 300 0 2 600 30 00 31.00 Home Health Aide Visits 409 212 1 629 31.00 Home Health Aide Visit Charges 38, 855 20, 140 95 475 59, 565 32.00 32.00 33.00 Total visits (sum of lines 21, 23, 25, 27, 2,920 2.062 45 110 5, 137 33.00 29, and 31) 34 00 Other Charges 0 O 34 00 Total Charges (sum of lines 22, 24, 26, 28, 520, 120 389, 097 8, 185 20, 710 938, 112 35.00 35.00 30, 32, and 34) Total Number of Episodes (standard/non 30 350 36.00 315 5 36.00 outlier) 37.00 Total Number of Outlier Episodes 113 117 37.00 38.00 Total Non-Routine Medical Supply Charges 0 0 0 0 38.00

In Lieu of Form CMS-2552-10

Worksheet S-4

Heal th Fi nanci al Systems
HOSPI TAL-BASED RHC/FQHC STATI STI CAL DATA

HEALTH FI NANCI AL SYSTEMS
Provi der CCN: 14-1319
Peri od:

From 06/01/2022 Component CCN: 14-8576 То 05/31/2023 Date/Time Prepared: 10/24/2023 5:18 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 Community Health Center (Section 330(d), PHS Act) 4.00 4.00 5.00 Migrant Health Center (Section 329(d), PHS Act) 5.00 Health Services for the Homeless (Section 340(d), PHS Act) 6.00 6.00 Appalachian Regional Commission 7 00 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 0 10.00 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.) Sunday Monday Tuesday from from from 1.00 2.00 3.00 4.00 5.00 Facility hours of operations (1) 11. 00 CLINIC 07: 00 07: 00 17: 30 11.00 1.00 2.00 12.00 Have you received an approval for an exception to the productivity standard? N 12.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section N 0 13.00 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. Provi der name CCN 1.00 2.00 14.00 RHC/FQHC name, CCN 14. 00 Total Visits Y/N V XVIII XIX 1.00 2.00 3.00 4.00 5.00 Have you provided all or substantially all 15.00 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) County 4.00 2.00 City, State, ZIP Code, County HENRY 2.00 Tuesday Wednesday Thursday to from to from to

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In Lieu of Form CMS-2552-10

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Worksheet S-8

11. 00 CLINI C

Facility hours of operations (1)

Health Financial Systems
HOSPITAL-BASED RHC/FOHC STATISTICAL DATA In Lieu of Form CMS-2552-10

Provider CCN: 14-1319 Peri od: From 06/01/2022 To 05/31/2023 Worksheet S-8

Date/Time Prepared: 10/24/2023 5:18 pm Cost Component CCN: 14-8576 RHC I

				KIIC I	COST	
	Fri	day	Satu	rday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)						
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Heal th Fi nanci al Systems
HOSPI TAL-BASED RHC/FQHC STATI STI CAL DATA

HOSPI TAL-BASED RHC/FQHC STATI STI CAL DATA

Provi der CCN: 14-1319 | Peri od:

From 06/01/2022 Component CCN: 14-8587 05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm RHC III Cost 1.00 Clinic Address and Identification 1.00 Street 600 N. COLLEGE AVENUE 1.00 City State ZIP Code 2.00 1.00 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 Community Health Center (Section 330(d), PHS Act) 4.00 4.00 5.00 Migrant Health Center (Section 329(d), PHS Act) 5.00 Health Services for the Homeless (Section 340(d), PHS Act) 6.00 6.00 Appalachian Regional Commission 7 00 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 0 10.00 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.) Sunday Monday Tuesday from from from 1.00 2.00 3.00 4.00 5.00 Facility hours of operations (1) 11. 00 CLINIC 07: 00 07: 00 17: 30 11.00 1.00 2.00 12.00 Have you received an approval for an exception to the productivity standard? N 12.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section N 0 13.00 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. Provi der name CCN 1.00 2.00 14.00 RHC/FQHC name, CCN 14. 00 Total Visits Y/N V XVIII XIX 1.00 2.00 3.00 4.00 5.00 Have you provided all or substantially all 15.00 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) County 4.00 2.00 City, State, ZIP Code, County HENRY 2.00 Tuesday Wednesday Thursday to from to from to

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In Lieu of Form CMS-2552-10

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Worksheet S-8

11. 00 CLINI C

Facility hours of operations (1)

eal th Financial Systems STATE COPY

Health Financial Systems

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1319 | Period: | Worksheet S-8

 Heal th Fi nanci al Systems
HOSPI TAL-BASED RHC/FQHC STATI STI CAL DATA

HEALTH FI NANCI AL SYSTEMS
Provi der CCN: 14-1319
Peri od:

From 06/01/2022 Component CCN: 14-8615 05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm RHC IV Cost 1.00 Clinic Address and Identification 1.00 Street 203 W FRONT STREET 1.00 City ZIP Code State 1.00 2.00 3.00 2.00 City, State, ZIP Code, County ANNAWAN IL 61234 2.00 1. 00 3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban 0 3.00 Grant Award Date 1.00 2.00 Source of Federal Funds Community Health Center (Section 330(d), PHS Act) 4.00 4.00 5.00 Migrant Health Center (Section 329(d), PHS Act) 5.00 Health Services for the Homeless (Section 340(d), PHS Act) 6.00 6.00 Appalachian Regional Commission 7 00 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 0 10.00 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.) Sunday Monday Tuesday from from from 1.00 2.00 3.00 4.00 5.00 Facility hours of operations (1) 11. 00 CLINIC 07: 00 07: 00 19: 00 11.00 1.00 2.00 12.00 Have you received an approval for an exception to the productivity standard? N 12.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section N 0 13.00 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. Provi der name CCN 1.00 2.00 14.00 RHC/FQHC name, CCN 14. 00 Total Visits Y/N V XVIII XIX 1.00 2.00 3.00 4.00 5.00 Have you provided all or substantially all 15.00 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) County 4.00 2.00 City, State, ZIP Code, County HENRY 2.00 Tuesday Wednesday Thursday

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In Lieu of Form CMS-2552-10

Worksheet S-8

11. 00 CLINI C

Facility hours of operations (1)

Health Financial Systems
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA In Lieu of Form CMS-2552-10 Provider CCN: 14-1319 Worksheet S-8

Peri od: From 06/01/2022 To 05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm Component CCN: 14-8615

RHC IV Cost Fri day Saturday to 12. 00 from from to 11.00 13.00 14.00

Facility hours of operations (1) 07: 00 19: 00 08: 00 14: 00 11.00 Heal th Fi nanci al Systems
HOSPI TAL-BASED RHC/FQHC STATI STI CAL DATA

HEALTH FI NANCI AL SYSTEMS
Provi der CCN: 14-1319
Peri od:

From 06/01/2022 Component CCN: 14-8628 То 05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm RHC V Cost 1.00 Clinic Address and Identification 1.00 Street 106 N EAST ST 1.00 City ZIP Code State 1.00 2.00 2.00 City, State, ZIP Code, County CAMBRI DGE IL 61238 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 Community Health Center (Section 330(d), PHS Act) 4.00 4.00 5.00 Migrant Health Center (Section 329(d), PHS Act) 5.00 Health Services for the Homeless (Section 340(d), PHS Act) 6.00 6.00 Appalachian Regional Commission 7 00 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 0 10.00 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.) Sunday Monday Tuesday from from from 1.00 2.00 3.00 4.00 5.00 Facility hours of operations (1) 11. 00 CLINIC 08: 00 08: 00 16: 30 11.00 1.00 2.00 12.00 Have you received an approval for an exception to the productivity standard? N 12.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section N 0 13.00 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. Provi der name CCN 1.00 2.00 14.00 RHC/FQHC name, CCN 14. 00 Total Visits Y/N V XVIII XIX 1.00 2.00 3.00 4.00 5.00 Have you provided all or substantially all 15.00 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) County 4.00 2.00 City, State, ZIP Code, County HENRY 2.00 Tuesday Wednesday Thursday

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In Lieu of Form CMS-2552-10

Worksheet S-8

11. 00 CLINI C

Facility hours of operations (1)

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Health Financial Systems

H. WOYD-HENRY GOT ITAL

In Lieu of Form CMS-2552-10

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1319

Period:
Form CV (2012)

Worksheet S-8

Provider CCN: 14-1319 | Period: | Worksheet S-8 | From 06/01/2022 | Component CCN: 14-8628 | To 05/31/2023 | Date/Time Prepions

Component CCN: 14-8628 To 05/31/2023 Date/Ti me Prepared: 10/24/2023 5: 18 pm

				KILC V	COST	
	Fri	day	Satı	irday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	16: 30				11. 00

Health Financial Systems H. WOND-HENRY WOOFLTAL In Lieu of Form CMS-2552-10
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA Provider CCN: 14-1319 Period: From 06/01/2022 Worksheet S-10

05/31/2023

Date/Time Prepared:

10/24/2023 5:18 pm 1. 00 Uncompensated and indigent care cost computation
Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8) 1.00 0.381613 1.00 Medicaid (see instructions for each line) 2.00 Net revenue from Medicaid 1, 480, 041 2.00 Did you receive DSH or supplemental payments from Medicaid? 3.00 3.00 4.00 If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid? Υ 4.00 If line 4 is no, then enter DSH and/or supplemental payments from Medicaid 5.00 5.00 6.00 Medicaid charges 8, 306, 801 6.00 3, 169, 983 7.00 Medicaid cost (line 1 times line 6) 7.00 8.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 1, 689, 942 8.00 < zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions for each line) 9 00 9 00 Net revenue from stand-alone CHIP 0 Stand-alone CHIP charges 10.00 0 10.00 11.00 Stand-alone CHIP cost (line 1 times line 10) 0 11.00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then 12.00 0 12.00 enter zero) Other state or local government indigent care program (see instructions for each line) Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 13.00 13.00 0 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 14.00 O 14.00 15.00 State or local indigent care program cost (line 1 times line 14) 0 15.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 16.00 16.00 0 13; if < zero then enter zero) 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 Ω 17.00 Government grants, appropriations or transfers for support of hospital operations 18.00 18.00 0 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 19.00 1, 689, 942 19.00 12 and 16) Uni nsured Insured Total (col. 1 pati ents pati ents + col. 2) 3. 00 1.00 2.00 Uncompensated Care (see instructions for each line) 104, 120 20.00 20.00 Charity care charges and uninsured discounts for the entire facility 0 104, 120 (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see 39, 734 0 39, 734 21.00 instructions) Payments received from patients for amounts previously written off as 0 22.00 22.00 0 0 charity care 23.00 Cost of charity care (line 21 minus line 22) 39, 734 39, 734 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 24 00 Ν imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of 25.00 0 25.00 stay limit Total bad debt expense for the entire hospital complex (see instructions) 1, 755, 103 26.00 26.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 27.00 58, 326 27.00 Medicare allowable bad debts for the entire hospital complex (see instructions) 89, 732 27.01 28.00 Non-Medicare bad debt expense (see instructions) 1, 665, 371 28.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 29 00 666, 933 29 00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 706, 667 30.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30) 2, 396, 609 31.00 Heal th Financial Systems STATE HENRY OF TALL PHYSICAL SYSTEMS STATE OF THE STATE OF TALL PHYSICAL SYSTEMS SYSTEMS STATE OF TALL PHYSICAL SYSTEMS STATE OF TALL PHYSICAL SYSTEMS SYSTEM

From 06/01/2022

05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm Recl assi fi ed Cost Center Description Sal ari es 0ther 1 Reclassi fi cat Total (col. + col. 2) ions (See Trial Balance (col. 3 +-col. 4) A-62.00 4. 00 5.00 1.00 3.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1, 553, 479 1, 553, 479 217, 645 1, 771, 124 1.00 2 00 00200 CAP REL COSTS-MVBLE EQUIP 1, 817, 844 1, 817, 844 195, 228 2, 013, 072 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 225, 215 5, 264, 435 5, 489, 650 -1, 310, 384 4, 179, 266 4.00 00550 DATA PROCESSING 386, 358 1, 366, 829 1, 753, 187 1, 753, 187 5.01 5.01 5.02 00560 PURCHASING RECEIVING AND STORES 204, 240 13, 341 217, 581 0 217, 581 5.02 00570 ADMITTING 284, 697 284, 697 5.03 237.357 47.340 0 5.03 5.04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 553, 172 454, 675 1,007,847 1,007,847 5.04 5.05 00590 ALL OTHER ADMINISTRATIVE AND GE 1, 470, 823 2, 293, 326 3, 764, 149 -114, 589 3, 649, 560 5.05 00700 OPERATION OF PLANT 1, 382, 069 7.00 286, 725 1,095,344 1.382.069 7.00 00800 LAUNDRY & LINEN SERVICE 77, 546 110, 921 8.00 33, 375 110, 921 0 8.00 9.00 00900 HOUSEKEEPI NG 442,032 148, 597 590, 629 0 590, 629 9.00 10.00 01000 DI ETARY 658, 199 506, 478 1, 164, 677 o 1, 164, 677 10.00 01100 CAFETERI A 0 11.00 11.00 0 01300 NURSING ADMINISTRATION 188, 239 13.00 138, 158 50,081 0 188, 239 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 77, 430 77, 430 77, 430 14.00 15.00 01500 PHARMACY 373, 742 164, 479 538, 221 52, 033 590, 254 15.00 01600 MEDICAL RECORDS & LIBRARY 222, 037 737. 770 737, 770 16,00 515, 733 16,00 17.00 01700 SOCIAL SERVICE 126, 334 1,877 128, 211 0 128, 211 17.00 01080 INSERVICE EDUCATION 18.00 1,826 1,826 1,826 18.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 2, 199, 914 158, 552 2, 358, 466 109, 104 2, 467, 570 30.00 43.00 04300 NURSERY 0 43.00 04400 SKILLED NURSING FACILITY 44.00 1, 517, 951 235, 057 1, 753, 008 253, 550 2,006,558 44.00 46.00 04600 OTHER LONG TERM CARE 46 00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 318, 004 1, 679, 786 2, 997, 790 -579, 140 2, 418, 650 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 0 0 05300 ANESTHESI OLOGY 53.00  $\cap$ 0 Λ 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 189, 541 1,030,469 2, 220, 010 30, 955 2, 250, 965 54.00 06000 LABORATORY 60.00 929, 987 1, 484, 127 2, 414, 114 24, 497 2, 438, 611 60.00 62 00 06200 WHOLE BLOOD & PACKED RED BLOOD 77, 524 77, 524 77, 524 62 00 06400 I NTRAVENOUS THERAPY 64.00 64.00 06600 PHYSI CAL THERAPY 1, 816, 839 92, 516 1, 909, 355 10,887 1, 920, 242 66.00 66.00 06700 OCCUPATI ONAL THERAPY 67.00 418, 774 29, 254 448, 028 448,028 67.00 06800 SPEECH PATHOLOGY 7, 844 159, 158 68 00 151, 314 0 159, 158 68 00 69.00 06900 ELECTROCARDI OLOGY 260, 586 86, 467 347, 053 0 347, 053 69.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 579, 140 579, 140 72.00 07300 DRUGS CHARGED TO PATIENTS 1, 225, 947 1, 225, 947 0 73.00 0 1, 225, 947 73 00 76.00 03020 ACUPUNCTURE 0 76.00 76.01 03610 SLEEP LAB 106, 776 57, 342 164, 118 164, 118 76.01 03950 IV THERAPY 76.02 76.02 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 KEWANEE RHC 1, 818, 340 492, 660 2, 311, 000 207, 377 2, 518, 377 88.00 88.01 08801 WYOMI NG RHC 88 01 1, 893, 327 2, 228, 373 2, 491, 391 88.02 08802 GENESEO RHC 335.046 263.018 88.02 398, 293 88.03 08803 ANNAWAN RHC 95, 903 494, 196 -6, 083 488, 113 88 03 08804 CAMBRIDGE RHC 321, 021 -38, 420 282, 601 42, 525 88.04 325, 126 88.04 90.00 09000 CLI NI C 696, 918 123, 557 820, 475 136, 175 956, 650 90.00 09001 PAIN CLINIC 66, 292 90.01 53, 176 119, 468 2, 188 121, 656 90.01 90.02 09002 SPECIALTY CLINIC O 90.02 90 03 09003 SURGICAL CLINIC 1, 150, 039 48, 111 1, 198, 150 200, 584 1, 398, 734 90 03 09004 GENESEO CLINIC 90.04 90.04 0 91.00 09100 EMERGENCY 2, 602, 302 844, 871 3, 447, 173 313, 156 3, 760, 329 91.00 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99. 10 09910 CORE 0 0 99.10 101.00 10100 HOME HEALTH AGENCY 598, 233 120, 675 718, 908 718, 908 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 577, 925 577, 925 -577, 925 0 113. 00 SUBTOTALS (SUM OF LINES 1 through 117) 25, 105, 914 23, 975, 353 49, 081, 267 49, 941 49, 131, 208 118. 00 118.00 NONREIMBURSABLE COST CENTERS 0 190. 00 190.00 19000 GIFT FLOWER COFFEE SHOP & CAN 192. 00 19200 PHYSICIANS PRIVATE OFFICES 0 C 0 0 0 192.00 192. 01 19203 MUSCATINE CLINIC 0 192.01 0 0 Ω 0 192. 02 19201 CARDI OLOGY CLINIC 0 192.02 192.03 19202 LEASED SPACE 544, 263 60, 494 604, 757 -124, 182 480, 575 192. 03 192. 04 19204 ANNAWAN CLINIC 0 192.04 0 192. 05 19205 CAMBRI DGE CLINI C 0 0 0 192.05 192.06 19206 PORT BYRON CLINIC 326, 232 73, 842 400,074 45, 698 445, 772 192. 06 192. 07 19207 ORI ON CLINIC 190, 283 102, 223 292, 506 28, 543 321, 049 192. 07

Health Financial Systems Hawaya-H RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

In Lieu of Form CMS-2552-10

Provi der CCN: 14-1319

					10/24/2023 3.	10 PIII
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
			+ col . 2)	ions (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1. 00	2.00	3. 00	4. 00	5. 00	
194. 00 07955 FOUNDATI ON	0	0	0	0	0	194.00
194. 01 07950 SPORTS MEDICINE	199, 636	18, 944	218, 580	0	218, 580	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	O	0	0	0	0	194. 04
194. 05 07954 COLONA CLINIC	o	0	0	0	0	194. 05
194.06 07956 TRINITY/DIALYSIS LEASED SPACE	o	0	0	0	0	194. 06
194. 07 07957 COMMUNITY HEALTH	6, 541	10, 731	17, 272	0	17, 272	194. 07
200.00   TOTAL (SUM OF LINES 118 through 199)	26, 372, 869	24, 241, 587	50, 614, 456	0	50, 614, 456	200. 00

	Financial Systems	HENR-HENR				ieu of Form CMS-	-2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	OF EXPENSES	Provi der CC	CN: 14-1319	Period: From 06/01/202		
					To 05/31/202	23 Date/Time Pro 10/24/2023 5	epared: :18 pm_
	Cost Center Description	Adjustments (See A-8)	Net Expenses For				
		(3ee A-6)	Allocation				
	GENERAL SERVICE COST CENTERS	6. 00	7. 00				
1. 00	00100 CAP REL COSTS-BLDG & FLXT	30, 033	1, 801, 157				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	,				2.00
4. 00 5. 01	OO4OO	0	4, 179, 266 1, 753, 187				4. 00 5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES	-157, 140					5. 02
5. 03	00570 ADMITTING	0	284, 697				5. 03
5. 04 5. 05	OO580   CASHI ERI NG/ACCOUNTS RECEIVABLE   OO590   ALL OTHER ADMINI STRATI VE AND GE	-68, 124 -117, 056					5. 04 5. 05
7. 00	00700 OPERATION OF PLANT	0	1, 382, 069				7. 00
8.00	00800 LAUNDRY & LI NEN SERVI CE	0					8.00
9. 00 10. 00	00900  HOUSEKEEPI NG  01000  DI ETARY	-192, 108	590, 629 972, 569				9.00
11. 00	01100 CAFETERI A	0					11.00
13.00	01300 NURSING ADMINISTRATION	0	,				13.00
14. 00 15. 00	O1400   CENTRAL SERVI CES & SUPPLY   O1500   PHARMACY	-43, 361	77, 430 546, 893				14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-3, 360					16.00
17. 00	01700 SOCIAL SERVICE	0					17. 00
18. 00	O1080   I NSERVI CE   EDUCATI ON     I NPATI ENT   ROUTI NE   SERVI CE   COST   CENTERS	0	1, 826				18. 00
30.00	03000 ADULTS & PEDIATRICS	-630, 174	1, 837, 396				30.00
43.00	04300 NURSERY	0	1 4				43.00
44. 00 46. 00	04400 SKILLED NURSING FACILITY 04600 OTHER LONG TERM CARE	-1, 419 0					44. 00 46. 00
40.00	ANCI LLARY SERVI CE COST CENTERS		<u> </u>				40.00
50.00	05000 OPERATING ROOM	-378, 485					50.00
52. 00 53. 00	O5200   DELIVERY ROOM & LABOR ROOM   O5300   ANESTHESI OLOGY	0					52. 00 53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	2, 250, 965				54.00
60.00	06000 LABORATORY	-1, 150					60.00
62. 00 64. 00	O6200   WHOLE BLOOD & PACKED RED BLOOD   O6400   NTRAVENOUS THERAPY	0	77, 524				62. 00 64. 00
66.00	06600 PHYSI CAL THERAPY	-184, 839	1, 735, 403				66. 00
67.00	06700 OCCUPATI ONAL THERAPY	-173					67.00
68. 00 69. 00	06800   SPEECH   PATHOLOGY   06900   ELECTROCARDI OLOGY	0 -3, 216	107, 100				68. 00 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0,210					71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0					72.00
73. 00 76. 00	O7300   DRUGS CHARGED TO PATIENTS   O3020   ACUPUNCTURE	0	, , , , ,				73. 00 76. 00
76. 01	03610 SLEEP LAB	-346	-				76. 01
76. 02	03950 I V THERAPY	0	0				76. 02
88. 00	OUTPATIENT SERVICE COST CENTERS  08800 KEWANEE RHC	0	2, 518, 377				88. 00
88. 01	08801 WYOMI NG RHC	0	0				88. 01
88. 02 88. 03	O8802   GENESEO RHC   O8803   ANNAWAN RHC	0	2, 491, 391				88. 02
88. 04	08804 CAMBRI DGE RHC		488, 113 325, 126				88. 03 88. 04
90.00	09000 CLI NI C	-494, 386	462, 264				90.00
90. 01	09001   PAIN CLINIC   09002   SPECIALTY CLINIC	-54, 589	67, 067				90. 01 90. 02
	09003 SURGI CAL CLI NI C	-1, 115, 441	-				90.02
90.04	09004 GENESEO CLINIC	0	0				90. 04
	09100 EMERGENCY	-1, 080, 756	2, 679, 573				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS						92.00
	09910 CORF	0					99. 10
101.00	10100 HOME HEALTH AGENCY   SPECIAL PURPOSE COST CENTERS	-5, 250	713, 658				101.00
113.00	11300 INTEREST EXPENSE	0	0				113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-4, 501, 340	44, 629, 868				118. 00
100.00	NONREIMBURSABLE COST CENTERS   19000 GIFT FLOWER COFFEE SHOP & CAN	0	ol				190.00
	19000 GIFT FLOWER COFFEE SHOP & CAIN 19200 PHYSI CLANS PRI VATE OFFI CES						190.00
192. 01	19203 MUSCATINE CLINIC	0					192. 01
	19201   CARDI OLOGY CLI NI C   19202   LEASED SPACE	0	100 575				192. 02 192. 03
	19202  LEASED SPACE   19204  ANNAWAN CLINIC	0	480, 575 0				192. 03
192.05	19205 CAMBRI DGE CLI NI C	0	ol ol				192. 05
	19206  PORT BYRON CLINIC  19207  ORION CLINIC	0					192. 06 192. 07
	07955 FOUNDATION	0	. ,				192.07
							•

Health Financial Systems Hawaya-H RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

In Lieu of Form CMS-2552-10 Provider CCN: 14-1319

Peri od: From 06/01/2022 To 05/31/2023

Worksheet A

Date/Time Prepared: 10/24/2023 5:18 pm Cost Center Description Adjustments Net Expenses

0001 0011101 00001 1 011 011	riaj ao imorrio	Expo		
	(See A-8)	For		
		Allocation		
	6. 00	7.00		
194. 01 07950 SPORTS MEDICINE	0	218, 580	19	94. 01
194. 02 07951 KELLY MEDICAL RENTAL AREA	0	0	19	94. 02
194. 03 07952 ANESTHESIA BILLNG	0	0	19	94. 03
194. 04 07953 SPECIALTY CLINIC	0	0	19	94.04
194. 05 07954 COLONA CLINIC	0	0	19	94. 05
194. 06 07956 TRI NI TY/DI ALYSI S LEASED SPACE	0	o	19	94.06
194. 07 07957 COMMUNI TY HEALTH	0	17, 272	19	94. 07
200.00   TOTAL (SUM OF LINES 118 through 199)	-4, 501, 340	46, 113, 116	20	00.00

Heal th	Financial Systems		HHENR	Y YOS, I TAL	In Lieu	u of Form CMS-2552-10
	SI FI CATI ONS			Provider CCN: 14-1319	Peri od:	Worksheet A-6
					From 06/01/2022 To 05/31/2023	Date/Time Prepared:
					10 03/31/2023	10/24/2023 5: 18 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2.00	3.00	4. 00	5. 00		
4 00	A - OFFSITE CLINIC BUILDING			25 (2)		1.00
1. 00 2. 00	CLINIC	90.00	0	35, 696		1.00
2.00	ORI ON CLINIC	192.07		<u>2, 897</u> 38, 593		2.00
	C - INTEREST EXPENSE		<u> </u>	30, 373		
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	0	395, 818		1.00
2. 00	CAP REL COSTS-MVBLE EQUIP	2. 00	Ö	182, 107		2.00
	TOTALS			577, 925		
	E - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FLXT	1.00	0	85, 342		1.00
2. 00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27, 295		2.00
3. 00	CLI NI C	90.00	0	1, 800		3.00
4. 00	ORI ON CLINIC	192.07	•	<u> </u>		4. 00
	TOTALS		0	114, 589		
1. 00	H - IMPLANT EXP RECLASS  IMPL. DEV. CHARGED TO	72.00	0	579, 140		1.00
1.00	PATIENTS	72.00	٥	579, 140		1.00
	TOTALS	++		57 <del>9</del> , 140		
	I - RECLASS PROVIDER BENEFIT	S	٥	377,110		
1.00	CLINIC	90.00	0	87, 334		1.00
2.00	PAIN CLINIC	90. 01	О	1, 994		2.00
3.00	PORT BYRON CLINIC	192. 06	0	39, 809		3.00
4.00	ORION CLINIC	192. 07	0	22, 402		4.00
5.00	KEWANEE RHC	88. 00	0	227, 729		5. 00
6. 00	GENESEO RHC	88. 02	0	229, 489		6. 00
7. 00	ANNAWAN RHC	88. 03	0	47, 745		7.00
8.00	CAMBRI DGE RHC	88. 04	0	34, 578		8.00
9.00	SURGI CAL CLI NI C	90. 03	0	197, 044		9.00
10. 00 11. 00	EMERGENCY ADULTS & PEDIATRICS	91. 00 30. 00	0	313, 156 109, 104		10. 00 11. 00
11.00	TOTALS	30.00		1, 310, 384		11.00
	J - RECLASS SNF DEPRECIATION	AND INTERST	U <sub>I</sub>	1, 310, 384		
1. 00	SKILLED NURSING FACILITY	44.00	0	161, 945		1.00
2. 00	SKILLED NURSING FACILITY	44.00	Ö	62, 977		2.00
3.00	SKILLED NURSING FACILITY	44.00	O	14, 174		3.00
	TOTALS			239, 096		
	L - RHC LAB AND RADIOLOGY CO					
1.00	LABORATORY	60.00	4, 262	0		1.00
2.00	RADI OLOGY-DI AGNOSTI C	54. 00	128, 564	O		2.00
3. 00		0.00	0	<u>0</u>		3.00
	TOTALS		132, 826	0		
1. 00	N - CLINIC ADMIN COSTS KEWANEE RHC	88.00	40, 490	5, 134		1.00
2. 00	GENESEO RHC	88. 02	33, 593	4, 259		2.00
3. 00	ANNAWAN RHC	88. 03	7, 720	979		3.00
4. 00	CAMBRI DGE RHC	88. 04	7, 053	894		4.00
5.00	CLINIC	90.00	10, 068	1, 277		5. 00
6.00	PAIN CLINIC	90. 01	172	22		6.00
7.00	SURGI CAL CLINIC	90. 03	3, 142	398		7.00
8.00	PORT BYRON CLINIC	192. 06	5, 226	663		8.00
9. 00	ORI ON CLINIC	1 <u>92.</u> 07		348		9. 00
	TOTALS		110, 208	13, 974		
4 0-	P - ANCILLARY SERVICE SALARY	,	401			
1.00	PHYSI CAL THERAPY	66.00	10, 887	0		1.00
2.00	SKILLED NURSING FACILITY	44.00	14, 454	0		2.00
3. 00 4. 00	PHARMACY PHARMACY	15. 00 15. 00	8, 672 43, 361	0		3. 00 4. 00
5. 00	LABORATORY	60.00	20, 235	0		5.00
5. 50	TOTALS		97, 609	— — <u>ö</u>		3.00
500.00	Grand Total: Increases		340, 643	2, 873, 701		500.00
	•	. '		ij		1

Heal th	Financial Systems		H. HENRY	uoc. I TAL		In Lieu	of Form CMS	-2552-10
	SI FI CATI ONS			Provi der CC		Peri od:	Worksheet A-	6
						From 06/01/2022 To 05/31/2023	Date/Time Pr	enared.
						10 03/31/2023	10/24/2023 5	: 18 pm
		Decreases						
	Cost Center	Li ne #	Sal ary		kst. A-7 Ref.			
	6.00	7.00	8. 00	9. 00	10. 00			
1. 00	A - OFFSITE CLINIC BUILDING I CAP REL COSTS-BLDG & FIXT	1. 00	0	38, 593	Ç			1.00
2. 00	CAP REL COSTS-BEDG & TTAT	0.00	o	30, 343	C			2. 00
2.00	TOTALS — — — —		— — <del>ŏ</del>	38, 593		1		2.00
	C - INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113. 00	0	577, 925	11	ł .		1. 00
2. 00		0.00	0	0_	11	_		2. 00
	TOTALS  E - OTHER CAPITAL COSTS		0	577, 925				-
1. 00	ALL OTHER ADMINISTRATIVE AND	5. 05	0	114, 589	12			1.00
1.00	GE	3.03	٩	114, 307	12	-		1.00
2.00		0.00	o	0	12			2.00
3.00		0.00	O	0	C			3.00
4.00		0.00		0	0			4. 00
	TOTALS		0	114, 589				4
1. 00	H - IMPLANT EXP RECLASS OPERATING ROOM	50.00	0	579, 140	C	\		1.00
1.00	TOTALS		— — <del>0</del>	<u>579, 140</u> 579, 140		7		1.00
	I - RECLASS PROVIDER BENEFITS	S	<u> </u>	377, 140				1
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 310, 384	C	)		1.00
2.00		0.00	0	0	C			2.00
3.00		0.00	0	0	C			3. 00
4.00		0.00	0	0	C			4.00
5. 00		0.00	0	0	C			5. 00
6. 00		0. 00	0	0	C	)		6. 00
7. 00		0.00	0	0	C	)		7.00
8.00		0.00	0	0				8. 00 9. 00
9. 00 10. 00		0. 00 0. 00	0	0	C			10.00
11. 00		0.00	0	0				11.00
11.00	TOTALS — — — —		— — <del> </del>	1, 310, 384		1		11.00
	J - RECLASS SNF DEPRECIATION	AND INTERST						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	161, 945	9	ł .		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	62, 977	11	1		2.00
3. 00	CAP REL COSTS-MVBLE EQUIP	2.00	0	14, 174	9	<u> </u>		3. 00
	TOTALS  L - RHC LAB AND RADI OLOGY CO:		0	239, 096				-
1. 00	KEWANEE RHC	88. 00	65, 976	0	C			1.00
2. 00	GENESEO RHC	88. 02	4, 323	0	C			2.00
3. 00	ANNAWAN RHC	88. 03	62, 527	Ō	C			3.00
	TOTALS		132, 826	0				_]
	N - CLINIC ADMIN COSTS							
1.00	LEASED SPACE	192. 03	110, 208	13, 974	C			1.00
2.00		0.00	0	0	C	)		2.00
3. 00 4. 00		0. 00 0. 00	0	0	C			3. 00 4. 00
5. 00		0.00	0	0	C	•		5. 00
6. 00		0.00	0	0				6. 00
7. 00		0.00	o	0	C			7. 00
8. 00		0.00	O	0	C			8.00
9.00	L	0.00	o	0				9. 00
	TOTALS		110, 208	13, 974		<u> </u>		_
	P - ANCILLARY SERVICE SALARY		ا					
1.00	RADI OLOGY-DI AGNOSTI C	54.00	97, 609	0	C	1		1.00
2.00		0. 00 0. 00	O	0	C			2.00
3. 00 4. 00		0.00	O O	0	(			3. 00 4. 00
5. 00		0.00	0	0	(			5. 00
	TOTALS — — — — —	<u> </u>	97, 609		<u></u>	1		5.00
500.00	Grand Total: Decreases		340, 643	2, 873, 701		7		500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS

Provi der CCN: 14-1319

In Lieu of Form CMS-2552-10

Period: Worksheet A-7
From 06/01/2022 Part I
To 05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm

						10/24/2023 5:	18 pili
				Acquisitions			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	1, 358, 669	0	0	0	0	1.00
2.00	Land Improvements	1, 658, 717	0	0	0	0	2.00
3.00	Buildings and Fixtures	46, 856, 473	1, 548, 885	0	1, 548, 885	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	15, 161, 740	819, 667	0	819, 667	327, 260	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	65, 035, 599	2, 368, 552	0	2, 368, 552	327, 260	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	65, 035, 599	2, 368, 552	0	2, 368, 552	327, 260	10.00
		Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	1, 358, 669	0				1.00
2.00	Land Improvements	1, 658, 717	0				2.00
3.00	Buildings and Fixtures	48, 405, 358	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	15, 654, 147	0				6.00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	67, 076, 891	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	67, 076, 891	0				10. 00

Health Financial Systems

In Lieu of Form CMS-2552-10 RECONCILIATION OF CAPITAL COSTS CENTERS

Provi der CCN: 14-1319

Worksheet A-7 Peri od: From 06/01/2022 Part II Date/Time Prepared: 10/24/2023 5:18 pm То 05/31/2023

SUMMARY OF CAPITAL Insurance Cost Center Description Depreciation Interest Taxes (see Lease (see instructions) instructions) 9. 00 10.00 13.00 11.00 12.00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP 1.00 1.00 1, 553, 479 0 0 0 2.00 1, 817, 844 0 0 2.00 0 3.00 Total (sum of lines 1-2) 3, 371, 323 0 3.00 SUMMARY OF CAPITAL Other Total (1) Capital-Relat (sum of cols Cost Center Description ed Costs (see 9 through 14) instructions) 14. 00 15. 00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 CAP REL COSTS-BLDG & FIXT 1, 553, 479 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 1, 817, 844 2.00 0 Total (sum of lines 1-2) 3, 371, 323 3.00 3.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1319

					0 03/31/2023	10/24/2023 5:	
		COMF	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Oct. Oct. December	0	0	I 0	D. H		
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio (col. 1 -	instructions)		
				col . 2)			
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FIXT	50, 064, 074	0	50, 064, 074	0. 761799	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15, 654, 147	0	15, 654, 147	0. 238201	0	2.00
3. 00	Total (sum of lines 1-2)	65, 718, 221	0	65, 718, 221			3.00
		ALLOCAT	TION OF OTHER (	CAPI TAL	SUMMARY C	F CAPITAL	
	0	<b>T</b>	0.11	T. I. I. (	D	1	
	Cost Center Description	Taxes	Other Capi tal -Rel at	Total (sum of cols. 5	Depreciation	Lease	
			ed Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C			2.00			
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1, 352, 941	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1, 803, 670	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3, 156, 611	0	3.00
			SL	JMMARY OF CAPIT	AL		
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
	cost center bescription	Titterest	(see		Capi tal -Rel at		
			instructions)	This true true to this j	ed Costs (see		
					instructions)	, oug ,	
		11. 00	12. 00	13. 00	14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FLXT	362, 874	85, 342	•	0	1, 801, 157	1.00
2. 00	CAP REL COSTS-MVBLE EQUIP	182, 107		•	0	2, 013, 072	2.00
3. 00	Total (sum of lines 1-2)	544, 981	112, 637	0	0	3, 814, 229	3. 00

Health Financial Systems ADJUSTMENTS TO EXPENSES

In Lieu of Form CMS-2552-10 Provider CCN: 14-1319 Peri od: Worksheet A-8 From 06/01/2022 To 05/31/2023 Date/Time Prepared:

				Ic	05/31/2023	Date/lime Prep 10/24/2023 5:	
				Expense Classification on			
				To/From Which the Amount is t	to be Adjusted		
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		(2) 1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	Investment income - CAP REL			CAP REL COSTS-BLDG & FIXT	1. 00	0	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
2.00	COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	ď	2.00
3.00	Investment income - other		0		0. 00	0	3.00
4. 00	(chapter 2) Trade, quantity, and time	А	0	PURCHASING RECEIVING AND	5. 02	0	4. 00
4.00	di scounts (chapter 8)	^		STORES	3. 02	ď	4.00
5. 00	Refunds and rebates of	A		PURCHASING RECEIVING AND	5. 02	o	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0	STORES	0. 00	0	6. 00
0.00	suppliers (chapter 8)				0.00	ď	0.00
7. 00	Tel ephone servi ces (pay	А	-2, 063	ALL OTHER ADMINISTRATIVE AND	5. 05	0	7. 00
	stations excluded) (chapter 21)			GE			
8. 00	Television and radio service		0		0. 00	О	8. 00
0.00	(chapter 21)				0.00		0.00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-3, 748, 391		0. 00	0	
.0.00	adj ustment		0,,,0,0,,			J	
11. 00	Sale of scrap, waste, etc.		0		0. 00	0	11.00
12. 00	(chapter 23) Related organization	A-8-1	0			o	12. 00
	transactions (chapter 10)		_				
13.00	Laundry and linen service	D	101 507	DIETARY	0.00	0	
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-191, 587 0	DIETARY	10. 00 0. 00	0	14. 00 15. 00
	and others						
16. 00	Sale of medical and surgical supplies to other than		0		0. 00	0	16. 00
	patients						
17. 00	<u> </u>		0		0. 00	o	17. 00
18. 00	patients Sale of medical records and	В	-3 360	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
10.00	abstracts		0,000	MEST ONE RESORDS & ELDIVINI	10.00	Ĭ	10.00
19. 00	Nursing and allied health		0		0. 00	0	19. 00
	education (tuition, fees, books, etc.)						
20.00	Vendi ng machi nes	В	-521	DI ETARY	10. 00	0	20.00
21. 00	Income from imposition of		0		0. 00	0	21.00
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0. 00	O	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	*** Cost Center Deleted ***	65. 00		23. 00
	therapy costs in excess of						
24 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
24.00	therapy costs in excess of	A-0-3		FITTST CAL THERAFT	00.00		24.00
	limitation (chapter 14)		_				
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
	(chapter 21)						
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
	COSTS-MVBLE EQUIP					Ĭ	
28. 00 29. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00 0. 00	0	28. 00 29. 00
30.00		A-8-3	0	OCCUPATI ONAL THERAPY	67. 00	o <sub>l</sub>	30.00
	therapy costs in excess of				,		-
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		_	ADULTS & PEDIATRICS	30.00		30. 99
30. 77	instructions)			ADDETS & LEDIATRICS	30.00		30.77
		,		"	·	·	

Heal th Fi nanci al Systems

ADJUSTMENTS TO EXPENSES

Heal th Fi nanci al Systems

Provi der CCN: 14-1319

Per

In Lieu of Form CMS-2552-10

0.00

33.24

50.00

10/24/2023 5:18 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1.00 2.00 3.00 4.00 5.00 31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY 68.00 31.00 pathology costs in excess of limitation (chapter 14) CAH HIT Adjustment for 32.00 0.00 32.00 Depreciation and Interest ADVERTISING EXPENSE -97, 690 ALL OTHER ADMINISTRATIVE AND 33.00 Α 5.05 33.00 GE PART B BILLING -68, 124 CASHI ERI NG/ACCOUNTS 33.01 5.04 33.01 Α RECEI VABLE PHYSICIAN RECRUITING -1, 144 ALL OTHER ADMINISTRATIVE AND 33.02 5.05 33.02 Α UNAMMORTIZED BOND ISSUE COST 30, 033 CAP REL COSTS-BLDG & FIXT 33. 03 В 1.00 11 33.03 33 04 TV SERVICE - MED SURG -4. 328 ADULTS & PEDIATRICS 30 00 0 33 04 Α TV SERVICE - CARDIAC
TV SERVICE - LTC -346 ELECTROCARDI OLOGY 33.05 Α 69.00 0 33.05 33.06 -7,099 SKILLED NURSING FACILITY 44.00 33.06 Α TV SERVICE - OR -2, 770 OPERATING ROOM 33.07 Α 50.00 33.07 TV SERVICE - ER TV SERVICE - PT -1, 212 EMERGENCY 33.08 91.00 33.08 Α 33.09 Α -519 PHYSI CAL THERAPY 66.00 33.09 TV SERVICE - OT -173 OCCUPATIONAL THERAPY 33.10 Α 67.00 33.10 TV SERVICE - SLEEP 76.01 33 11 Α -346 SLEEP LAB O 33 11 SNF MI SCELLANEOUS REVENUE -41 SKILLED NURSING FACILITY 33. 12 В 44.00 33.12 33. 13 UNAMMORTIZED BOND ISSUE COST 5, 721 SKILLED NURSING FACILITY 44.00 33.13 Α 33.14 LOBBYI NG Α -16, 159 ALL OTHER ADMINISTRATIVE AND 5.05 33.14 GF -1, 150 LABORATORY EMPLOYEE LAB TEST REVENUE 33. 15 В 60.00 33.15 0 33. 16 PT SPECIAL EDUCATION REVENUE В -59, 475 PHYSI CAL THERAPY 66.00 33.16 LIFELINE REVENUE -5, 250 HOME HEALTH AGENCY 33.17 В 101.00 33.17 SUMMIT WELLNESS REVENUE -124, 845 PHYSI CAL THERAPY 66.00 33.18 33.18 В O -43, 361 PHARMACY 340B PHARMACY SALARY 33 19 Α 15.00 0 33 19 OTHER ADJUSTMENTS (SPECIFY) 0.00 33.21 33.21 OTHER ADJUSTMENTS (SPECIFY) 0 33. 23 33.23 0.00 (3)

0

-4, 501, 340

TOTAL (sum of lines 1 thru 49)

OTHER ADJUSTMENTS (SPECIFY)

(Transfer to Worksheet A,

33.24

50.00

<sup>(2)</sup> Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

<sup>(3)</sup> 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

Health Financial Systems In Lieu of Form CMS-2552-10

Provi der CCN: 14-1319

Peri od: Worksheet A-8-2 From 06/01/2022 05/31/2023 Date/Time Prepared:

3, 748, 391

200.00

10/24/2023 5:18 pm Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov I denti fi er der Component Remuneration Component Component Hours 1.00 2.00 3. 00 4.00 5. 00 7. 00 6 00 60. 00 LABORATORY 1.00 10,897 10, 897 1.00 1, 079, 544 0 2.00 91. 00 EMERGENCY 2, 414, 548 1, 335, 004 0 2.00 69. 00 ELECTROCARDI OLOGY 3.00 2,870 2,870 0 0 0 0 3.00 4.00 90. 00 CLI NI C 494, 386 494, 386 4.00 90. 03 SURGICAL CLINIC 5.00 1, 115, 441 1, 115, 441 0 0 5.00 6.00 50. 00 OPERATING ROOM 375, 715 375, 715 6.00 0 0 8, 221 0 7.00 30. 00 ADULTS & PEDIATRICS 8, 221 7.00 30.00 ADULTS & PEDIATRICS 617, 625 8.00 617, 625 8.00 0 0 9.00 90. 01 PAIN CLINIC 54, 589 54, 589 0 9.00 10.00 0 10.00 200.00 5, 094, 292 3, 748, 391 1, 345, 901 200.00 Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Provi der Physician Cost Cost of I denti fi er Li mi t Unadjusted RCE Memberships & Component of Malpractice Limit Conti nui ng Share of col Insurance Education 12.00 1.00 2.00 8. 00 9.00 13.00 14. 00 60. 00 LABORATORY 1.00 0 0 1.00 2.00 91. 00 EMERGENCY 0 0 0 0 2.00 0 0 3.00 69. 00 ELECTROCARDI OLOGY 0 0 3.00 0 0 0 0 4.00 90. 00 CLI NI C 4 00 0 5.00 90. 03 SURGICAL CLINIC 0 0 0 5.00 50. 00 OPERATING ROOM 0 0 6.00 0 0 0 0 6.00 7. 00 30.00 ADULTS & PEDIATRICS 0 0 7 00 0 30.00 ADULTS & PEDIATRICS 0 0 0 8.00 0 8.00 9.00 90. 01 PAIN CLINIC 0 0 9.00 0 10.00 0.00 0 0 0 0 10.00 o 200.00 200.00 Wkst. A Line # Cost Center/Physician Provi der Adjusted RCE RCE Adjustment I denti fi er Component Li mi t Di sal I owance Share of col. 14 16. 00 1.00 2.00 15.00 17.00 18.00 1.00 60. 00 LABORATORY 0 0 0 1.00 2.00 91. 00 EMERGENCY 0 0 0 1, 079, 544 2.00 0 3.00 69. OO ELECTROCARDI OLOGY 0 0 2.870 3.00 0| 4.00 4.00 90. 00 CLI NI C 0 494, 386 5.00 90. 03 SURGICAL CLINIC 0 0 0 1, 115, 441 5.00 6.00 50. 00 OPERATING ROOM 0 0 0 375, 715 6.00 7.00 30. 00 ADULTS & PEDIATRICS 0 0 7.00 0 8, 221 30.00 ADULTS & PEDIATRICS 0 0 0 8.00 617, 625 8.00 9.00 90. 01 PAIN CLINIC 54, 589 9.00 0 0 10.00 0.00 0 10.00

200.00

Provi der CCN: 14-1319

			11	05/31/2023	Date/lime Pre 10/24/2023 5:	
		CAPI TAL REI	ATED COSTS		10/21/2020 0.	ГО РІІІ
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	DATA	
	for Cost			BENEFI TS	PROCESSI NG	
	Allocation			DEPARTMENT		
	(from Wkst A					
	col. 7)	1 00	0.00	4.00	F 04	
CENEDAL CEDVICE COCT CENTERS	0	1.00	2.00	4. 00	5. 01	
GENERAL SERVICE COST CENTERS  1. 00 00100 CAP REL COSTS-BLDG & FLXT	1, 801, 157	1, 801, 157				1.00
2. 00   00200 CAP REL COSTS-MVBLE EQUIP	2, 013, 072	1,601,137	2, 013, 072			2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	4, 179, 266	8, 306		4, 208, 096		4.00
5. 01 00550 DATA PROCESSING	1, 753, 187	34, 174		83, 564	2, 008, 385	5. 01
5. 02 00560 PURCHASING RECEIVING AND STORES	60, 441	51, 870	· ·	44, 174	8, 178	5. 02
5. 03   00570 ADMI TTI NG	284, 697	22, 499		51, 337	22, 897	5. 03
5. 04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	939, 723	28, 671	2, 205		81, 885	5.04
5. 05 00590 ALL OTHER ADMINISTRATIVE AND GE	3, 532, 504	66, 231	28, 923	307, 204	198, 224	5. 05
7.00 00700 OPERATION OF PLANT	1, 382, 069	135, 881	11, 549	62, 015	31, 293	7.00
8.00   00800 LAUNDRY & LINEN SERVICE	110, 921	12, 926	0	7, 219	0	8. 00
9. 00   00900   HOUSEKEEPI NG	590, 629	23, 267	336	95, 606	4, 143	9. 00
10. 00   01000   DI ETARY	972, 569	58, 942	4, 133	142, 360	10, 031	10.00
11. 00   01100   CAFETERI A	0	38, 928	0	0	2, 726	11.00
13.00 O1300 NURSING ADMINISTRATION	188, 239	10, 141	0	29, 882	0	13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	77, 430	0	0	0	0	14.00
15. 00   01500   PHARMACY	546, 893	27, 953		- '	170, 638	15.00
16. 00   01600   MEDI CAL RECORDS & LI BRARY	734, 410				126, 087	16.00
17. 00   01700   SOCIAL SERVICE	128, 211	0	1, 672	27, 324	2, 181	17.00
18. 00 01080 I NSERVI CE EDUCATI ON	1, 826	0	825	0	0	18. 00
INPATIENT ROUTINE SERVICE COST CENTERS	1 007 20/	22/ 04/	40, 410	257 507	170 211	20.00
30. 00   03000   ADULTS & PEDI ATRI CS	1, 837, 396 0	226, 846	49, 419	357, 597	170, 311	30.00
43. 00   04300   NURSERY 44. 00   04400   SKI LLED   NURSI NG   FACI LI TY	J	0	0	221 420	0 26, 713	43. 00 44. 00
46.00 04600 OTHER LONG TERM CARE	2, 005, 139 0	0	] 0 0	331, 439	20, 713	46.00
ANCILLARY SERVICE COST CENTERS	U	0	0	<u> </u>	0	40.00
50. 00 05000 OPERATING ROOM	2, 040, 165	253, 965	713, 525	285, 067	51, 682	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2,010,100	200, 700	0	0	01,002	52.00
53. 00   05300   ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	2, 250, 965	149, 390	361, 724	263, 977	87, 772	54.00
60. 00   06000 LABORATORY	2, 437, 461	40, 946	· ·	206, 442	71, 417	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD	77, 524	1, 518		0	0	62.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00 06600 PHYSI CAL THERAPY	1, 735, 403	223, 227	24, 131	395, 312	61, 059	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	447, 855	11, 325	903	90, 575	14, 720	67.00
68.00 06800 SPEECH PATHOLOGY	159, 158	2, 702	0	32, 727	8, 178	68. 00
69. 00 06900 ELECTROCARDI OLOGY	343, 837	20, 431	119, 132	56, 361	7, 087	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	579, 140	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 225, 947	0	0	0	0	73.00
76. 00   03020   ACUPUNCTURE	0	0	0	0	0	76.00
76. 01   03610   SLEEP LAB	163, 772	12, 459		23, 094	6, 215	
76. 02 03950 I V THERAPY	0	0	0	0	0	76. 02
OUTPATIENT SERVICE COST CENTERS  88.00   08800   KEWANEE RHC	2 E10 277		65, 087	141, 022	02 124	00 00
88. 01   08801   WYOMI NG RHC	2, 518, 377	0	05,087	141, 022	92, 134 0	88. 00 88. 01
88. 02   08802   GENESEO RHC	2, 491, 391	54, 372	-	167, 178	112, 349	88. 02
88. 03   08803   ANNAWAN   RHC	488, 113	J4, 372	91, 637	22, 559	42, 632	88. 03
88. 04   08804   CAMBRI DGE   RHC	325, 126	0	150, 146	33, 492	25, 405	
90. 00   09000   CLINIC	462, 264	0	14, 198	58, 284	112, 196	90.00
90. 01   09001   PAIN CLINIC	67, 067	434	417	12, 215	22, 352	90. 01
90. 02 09002 SPECIALTY CLINIC	0	0	0	0	0	90.02
90. 03   09003   SURGI CAL   CLI NI C	283, 293	4, 370	0	35, 918	29, 984	90. 03
90. 04   09004 GENESEO CLINIC	0	0	0	0	0	90. 04
91. 00 09100 EMERGENCY	2, 679, 573	154, 027	50, 787	223, 534	202, 039	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS						
99. 10   09910   CORF	0		_	-	0	99. 10
101.00 10100 HOME HEALTH AGENCY	713, 658	18, 797	253	129, 390	67, 274	101.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	44, 629, 868	1, 721, 934	1, 983, 288	4, 023, 589	1, 869, 802	118. 00
NONREI MBURSABLE COST CENTERS				=1	-	100.55
190. 00 19000 GLFT FLOWER COFFEE SHOP & CAN	0	16, 478		0		190.00
192. 00 19200 PHYSICIANS PRIVATE OFFICES	0	0	0	0		192.00
192. 01 19203 MUSCATI NE CLI NI C	0	0	3, 101	O		192. 01 192. 02
192. 02 19201  CARDI OLOGY CLINI C 192. 03 19202  LEASED SPACE	480, 575	12, 926	l ~	93, 880		192. 02
192.04 19204 ANNAWAN CLINIC	480, 575 0					192. 03 192. 04
ו / ב. טדן ו זבטדן הויוויהוייהויי טבו ויוו ט	U	<u> </u>	ı	·	0	1172.04

Provider CCN: 14-1319

					10/24/2023 5:	18 pm_
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	DATA	
	for Cost			BENEFI TS	PROCESSI NG	
	Allocation			DEPARTMENT		
	(from Wkst A					
	col. 7)					
	0	1. 00	2. 00	4. 00	5. 01	
192. 05 19205 CAMBRI DGE CLI NI C	0	0	0	0		192. 05
192.06 19206 PORT BYRON CLINIC	445, 772	0	6, 898	28, 557	66, 947	192. 06
192.07   19207   ORION CLINIC	321, 049	0	12, 296	17, 476	62, 695	192. 07
194. 00 07955 FOUNDATI ON	0	6, 621	0	0	8, 941	194. 00
194. 01 07950 SPORTS MEDICINE	218, 580	0	0	43, 179	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 TRI NI TY/DI ALYSI S LEASED SPACE	0	43, 198	0	0	0	194. 06
194. 07 07957 COMMUNI TY HEALTH	17, 272	0	0	1, 415	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)	46, 113, 116	1, 801, 157	2, 013, 072	4, 208, 096	2, 008, 385	202. 00

Provi der CCN: 14-1319

						10/24/2023 5:	18 pm
	Cost Center Description	PURCHASI NG RECEI VI NG AND	ADMI TTI NG	CASHI ERI NG/AC COUNTS	Subtotal	ALL OTHER ADMINISTRATIV	
		STORES 5. 02	5. 03	RECEI VABLE 5. 04	5A. 04	E AND GE 5.05	
	GENERAL SERVICE COST CENTERS	5.02	5.05	5. 04	SA. U4	5.05	
1. 00 2. 00 4. 00 5. 01 5. 02 5. 03	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING	164, 663 147	385, 886				1.00 2.00 4.00 5.01 5.02 5.03
5. 04 5. 05 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 ALL OTHER ADMI NI STRATI VE AND GE 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	106 1, 416 4, 992 264 3, 063 3, 909 0 0 4, 398 482	0 0 0 0 0 0 0	1, 165, 054 0 0 0 0 0 0 0 0	4, 134, 502 1, 627, 799 131, 330 717, 044 1, 191, 944 41, 654 228, 262 81, 828 838, 155	160, 488 12, 948 70, 695 117, 516 4, 107 22, 505 8, 068	5. 04 5. 05 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00
16. 00 17. 00 18. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01080 INSERVICE EDUCATION INPATIENT ROUTINE SERVICE COST CENTERS	195 24 98	0 0 0	0 0 0	1, 002, 932 159, 412 2, 749	15, 717	16. 00 17. 00 18. 00
30. 00 43. 00	03000 ADULTS & PEDIATRICS	6, 546 0	11, 978 0	30, 209	2, 690, 302	265, 242 0	30. 00 43. 00
44. 00 46. 00	04400 SKI LLED NURSING FACILITY 04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	2, 899 0	0	30, 310 0	2, 396, 500 0		44. 00 46. 00
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	3, 922 0	58, 480 0	147, 487 0	3, 554, 293	350, 428 0	50.00 52.00
53. 00 54. 00 60. 00 62. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD	0 20, 066 48, 681 0	0 102, 975 101, 423 682	259, 854 255, 787 1, 719	3, 496, 723 3, 258, 639 81, 443	0 344, 749 321, 276 8, 030	53. 00 54. 00 60. 00 62. 00
64. 00 66. 00 67. 00 68. 00 69. 00	06400 I NTRAVENOUS THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0 1, 492 393 120 611	0 34, 200 9, 239 1, 855 18, 631	0 86, 251 23, 300 4, 678 46, 988	2, 561, 075 598, 310 209, 418 613, 078	20, 647	64. 00 66. 00 67. 00 68. 00 69. 00
71. 00 72. 00 73. 00 76. 00 76. 01	07100 MEDICAL SUPPLIES CHARGED TO PAT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03020 ACUPUNCTURE 03610 SLEEP LAB	0 31, 131 0 0 414	1, 474 2, 339 21, 053 0 3, 542	3, 717 5, 900 53, 095 0 8, 932	5, 191 618, 510 1, 300, 095 0 218, 428	128, 179 0 21, 535	71.00 72.00 73.00 76.00 76.01
76. 02	03950 IV THERAPY OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	76. 02
88. 00	08800 KEWANEE RHC	4, 079	0	57, 154	2, 877, 853	283, 733	88. 00
88. 01 88. 02 88. 03 88. 04	08801 WYOMI NG RHC 08802 GENESEO RHC 08803 ANNAWAN RHC 08804 CAMBRI DGE RHC	0 4, 703 1, 483 739	0 0 0	0 47, 419 10, 897 9, 955	0 2, 898, 087 657, 321 544, 863	0 285, 728 64, 807 53, 719	88. 01 88. 02 88. 03 88. 04
90. 00 90. 01 90. 02	09000 CLI NI C 09001 PAI N CLI NI C 09002 SPECI ALTY CLI NI C	3, 616 526 0	0	14, 215 243 0	664, 773 103, 254 0	65, 541 10, 180 0	90. 00 90. 01 90. 02
90. 03 90. 04 91. 00 92. 00	09003 SURGICAL CLINIC 09004 GENESEO CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT	1, 073 0 5, 987	0 0 18, 015	1, 619 0 45, 433	356, 257 0 3, 379, 395 0	35, 124 0 333, 181	90. 03 90. 04 91. 00 92. 00
	OTHER REIMBURSABLE COST CENTERS  09910 CORF 10100 HOME HEALTH AGENCY	0 2, 967	0	0 8, 641	940, 980	0 92, 773	99. 10 101. 00
113. 00 118. 00		160, 542	385, 886	1, 153, 803	44, 182, 399	3, 948, 407	113. 00 118. 00
192.00	NONREIMBURSABLE COST CENTERS 19000 GIFT FLOWER COFFEE SHOP & CAN 19200 PHYSICIANS PRIVATE OFFICES	0	0	0	16, 478	0	190. 00 192. 00
192. 02 192. 03 192. 04	19203 MUSCATINE CLINIC 219201 CARDIOLOGY CLINIC 319202 LEASED SPACE 19204 ANNAWAN CLINIC	0 0 1, 024 0	0 0 0	0 0 0	3, 101 0 595, 894 0	0 58, 750 0	192. 04
192. 06 192. 07	5 19205 CAMBRIDGE CLINIC 5 19206 PORT BYRON CLINIC 7 19207 ORION CLINIC 07955 FOUNDATION	0 1, 033 1, 962 0	0 0 0 0	0 7, 377 3, 874 0	0 556, 584 419, 352 15, 562	54, 875 41, 345	

Provi der CCN: 14-1319

					10/24/2023 5:	18 pm_
Cost Center Description	PURCHASI NG	ADMITTI NG	CASHI ERI NG/AC	Subtotal	ALL OTHER	
	RECEIVING AND		COUNTS		ADMI NI STRATI V	
	STORES		RECEI VABLE		E AND GE	
	5. 02	5. 03	5. 04	5A. 04	5. 05	
194. 01 07950 SPORTS MEDICINE	97	0	0	261, 856	25, 817	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	43, 198	0	194.06
194. 07 07957 COMMUNITY HEALTH	5	0	0	18, 692	1, 843	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)	164, 663	385, 886	1, 165, 054	46, 113, 116	4, 134, 502	202. 00

Provi der CCN: 14-1319

					) 05/31/2023	10/24/2023 5:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE				
	CENEDAL CEDIUCE COCT CENTERS	7. 00	8. 00	9. 00	10. 00	11. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 CAP REL COSTS-BLDG & FTXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00550 DATA PROCESSING						5. 01
5. 01	00560 PURCHASING RECEIVING AND STORES						5.01
5. 02	00570 ADMITTING						5.02
5. 04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.04
5. 05	00590 ALL OTHER ADMINISTRATIVE AND GE						5.05
7. 00	00700 OPERATION OF PLANT	1, 788, 287					7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	13, 522	157, 800				8.00
9. 00	00900 HOUSEKEEPI NG	24, 340	21, 167	833, 246			9.00
10.00	01000 DI ETARY	61, 660	375		1, 398, 649		10.00
11. 00	01100 CAFETERI A	40, 723	0	· ·	921, 663	1, 013, 001	11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	10, 608	0	0	7 <u>2</u> 1, 005	35, 508	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	10,000	0		0	0	14.00
15. 00	01500 PHARMACY	29, 242	0	3, 105	0	26, 380	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	28, 597	0	2, 023	0	53, 190	16.00
17. 00	01700 SOCIAL SERVICE	20, 377	0	2, 124	0	9, 701	
18. 00	01080 I NSERVI CE EDUCATI ON	0	0		0	0	18.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS			<u> </u>	<u> </u>	0	10.00
30. 00	03000 ADULTS & PEDIATRICS	237, 306	22, 173	167, 272	81, 714	110, 633	30.00
43. 00	04300 NURSERY	207,000	22, 170	0	01,711	0	43.00
44. 00	04400 SKILLED NURSING FACILITY	312, 926	39, 610	· ·	395, 272	131, 329	44.00
46. 00	04600 OTHER LONG TERM CARE	012, 720	0,,010	211,007	0,0,2,2	0	46.00
10.00	ANCILLARY SERVICE COST CENTERS			<u> </u>	٥,	<u> </u>	10.00
50.00	05000 OPERATI NG ROOM	265, 676	18, 733	154, 631	0	79, 761	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	200, 0, 0	0	0	0	0	52.00
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	156, 279	15, 956	"	0	78, 566	54.00
60.00	06000 LABORATORY	42, 834	0	37, 469	0	83, 011	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD	1, 588	0	0,, 10,	0	00,011	62.00
64.00	06400 I NTRAVENOUS THERAPY	0,000	0	o o	0	0	64.00
66. 00	06600 PHYSI CAL THERAPY	233, 520	13, 043	25, 839	0	111, 828	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	11, 847	0	4, 652	0	24, 707	67.00
68. 00	06800 SPEECH PATHOLOGY	2, 827	0	0	0	8, 793	68.00
69. 00	06900 ELECTROCARDI OLOGY	21, 373	0	7, 281	0	16, 726	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	o o	0	Ö	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	o o	0	Ö	73.00
76. 00	03020 ACUPUNCTURE	0	0	0	0	Ö	76.00
76. 01	03610 SLEEP LAB	13, 033	1. 895	1, 011	Ö	7, 503	76. 01
	03950 I V THERAPY	0	0	0	Ö	0	76. 02
	OUTPATIENT SERVICE COST CENTERS				-1		
88. 00	08800 KEWANEE RHC	0	0	0	0	0	88. 00
88. 01	08801 WYOMI NG RHC	0	0	O	0	0	88. 01
88. 02	08802 GENESEO RHC	56, 880	422	37, 065	0	111, 159	
88. 03		0	0	0	0	0	88. 03
88. 04	08804 CAMBRI DGE RHC	0	0	O	0	0	88. 04
90.00	09000 CLI NI C	0	0	o	0	0	90.00
90. 01	09001 PAIN CLINIC	454	621	l o	0	4, 110	90. 01
90. 02	09002 SPECIALTY CLINIC	0	0	O	0	0	90.02
90. 03	09003 SURGI CAL CLI NI C	4, 571	Ö	7, 737	ol	22, 557	90.03
90. 04	09004 GENESEO CLINIC	0	0	0	O	0	90.04
91.00	09100 EMERGENCY	161, 130	23, 805	57, 544	o	68, 531	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	19, 664	0	2, 427	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 750, 600	157, 800	790, 922	1, 398, 649	983, 993	118.00
	NONREI MBURSABLE COST CENTERS	,	,		,		
190.00	19000 GIFT FLOWER COFFEE SHOP & CAN	17, 238	0	0	0	0	190.00
	19200 PHYSICIANS PRIVATE OFFICES	0	0	0	o		192.00
	19203 MUSCATINE CLINIC	1 0	Ö	l o	ol		192. 01
	2 19201 CARDI OLOGY CLI NI C	1 0	Ö	l o	ol		192.02
	19202 LEASED SPACE	13, 522	0	25, 030	o	19, 928	
	19204 ANNAWAN CLINIC	0	Ö	0	o		192.04
	19205 CAMBRI DGE CLI NI C	0	Ö	0	o		192.05
	19206 PORT BYRON CLINIC	0	o n	ا	o		192.06
	7 19207 ORI ON CLINI C	0	Ö	l o	ol		192.07
	07955 FOUNDATION	6, 927	Ö	O	o		194.00
	07950 SPORTS MEDICINE	0	0	O	o		194. 01

Provi der CCN: 14-1319

					10/24/2023 3.	10 piii
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE				
	7. 00	8. 00	9. 00	10.00	11. 00	
194. 02 07951 KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194. 02
194. 03 07952 ANESTHESIA BILLNG	0	0	0	0	0	194. 03
194. 04 07953 SPECIALTY CLINIC	0	0	0	0	0	194. 04
194. 05 07954 COLONA CLINIC	0	0	0	0	0	194. 05
194. 06 07956 TRINITY/DIALYSIS LEASED SPACE	0	0	17, 294	0	0	194. 06
194. 07 07957 COMMUNI TY HEALTH	0	0	0	0	526	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, 788, 287	157, 800	833, 246	1, 398, 649	1, 013, 001	202. 00

Heal th Financial Systems STATE COPY

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1319

Peri od: Worksheet B From 06/01/2022 Part I To 05/31/2023 Date/Ti me Prepared:

In Lieu of Form CMS-2552-10

10/24/2023 5:18 pm Cost Center Description NURSI NG CENTRAL **PHARMACY** MEDI CAL SOCI AL ADMI NI STRATI O SERVI CE SERVICES & RECORDS & **SUPPLY** LI BRARY Ν 17.00 13 00 15 00 14.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.01 00550 DATA PROCESSING 5.01 00560 PURCHASING RECEIVING AND STORES 5.02 5.02 5.03 00570 ADMITTING 5.03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.04 5 04 5.05 00590 ALL OTHER ADMINISTRATIVE AND GE 5.05 7.00 00700 OPERATION OF PLANT 7 00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPING 9 00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 296, 883 14.00 01400 CENTRAL SERVICES & SUPPLY 89, 896 14.00 01500 PHARMACY 996, 245 15 00 16, 728 15.00 01600 MEDICAL RECORDS & LIBRARY 16,00 16,00 0 0 1, 185, 623 01700 SOCIAL SERVICE 6, 152 17 00 C 0 193, 106 17.00 01080 INSERVICE EDUCATION 18.00 0 18.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 136, 379 30.00 70, 152 C 0 31,720 30.00 43.00 04300 NURSERY C 0 Λ 43.00 49, 226 44.00 04400 SKILLED NURSING FACILITY 0 0 0 3, 219 44.00 04600 OTHER LONG TERM CARE 0 0 46.00 0 46.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50, 576 0 0 154, 865 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 52.00 0 53.00 05300 ANESTHESI OLOGY 0 53.00 0 0 0 05400 RADI OLOGY-DI AGNOSTI C 49, 819 0 0 54.00 272, 821 0 54.00 60.00 06000 LABORATORY 52, 637 0 268, 583 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD 62.00 0 0 0 1,805 0 62.00 06400 I NTRAVENOUS THERAPY 64 00 0 C 0 64 00 0 06600 PHYSI CAL THERAPY 0 0 66.00 C 90,566 0 66.00 06700 OCCUPATIONAL THERAPY 0 C 0 24, 466 0 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 4, 912 0 68.00 Ol 06900 ELECTROCARDI OLOGY O 49, 339 69 00 0 69 00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 89, 896 0 3,903 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 6, 195 0 72.00 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 0 0 996, 245 55, 751 Ω 73 00 03020 ACUPUNCTURE 76.00 0 C 0 0 76.00 03610 SLEEP LAB 4, 758 0 9, 378 0 76.01 76.01 76.02 03950 IV THERAPY 0 0 0 76.02 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 KEWANEE RHC 0 0 0 60, 013 0 88.00 88.01 08801 WYOMING RHC 0 C 0 0 88.01 08802 GENESEO RHC 0 0 49, 791 88.02 0 0 88.02 0 11, 442 08803 ANNAWAN RHC 0 88 03 88.03 0 0 88.04 08804 CAMBRIDGE RHC 0 0 0 10, 453 0 88.04 09000 CLI NI C 0 14, 926 90.00 90.00 09001 PAIN CLINIC 0 90.01 0 255 0 90.01 2.606 90 02 09002 SPECIALTY CLINIC 0 C 0 Ω 0 90 02 90.03 09003 SURGI CAL CLINIC 0 90.03 0 1, 700 0 90.04 09004 GENESEO CLINIC C 0 0 90.04 09100 EMERGENCY 7,501 91.00 43, 455 C 0 47, 706 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 OTHER REIMBURSABLE COST CENTERS 09910 CORF 0 0 0 n 99.10 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 0 0 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS 296, 883 89, 896 996, 245 1, 173, 809 193, 106 118. 00 118.00 190.00 19000 GIFT FLOWER COFFEE SHOP & CAN 0 190.00 0 0 0 0 192.00 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 0 0 192. 01 19203 MUSCATINE CLINIC 0 0 0 192, 01 C 192. 02 19201 CARDI OLOGY CLINI C C 0 0 192.02 192.03 19202 LEASED SPACE 0 o 0 192.03 0 0 0 192. 04 19204 ANNAWAN CLINIC 0 0 0 0 192.04 192. 05 19205 CAMBRIDGE CLINIC 0 0 192, 05 C 0 192.06 19206 PORT BYRON CLINIC 0 C 0 7,746 0 192.06 192.07 19207 ORION CLINIC 0 0 192.07 4,068 194. 00 07955 FOUNDATI ON 0 0 194.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 06/01/2022 Part I
To 05/31/2023 Date/Time Prepared: 10/24/2023 5: 18 pm

Provi der CCN: 14-1319

					10/24/2023 3.	TO PIII
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
	ADMI NI STRATI O	SERVICES &		RECORDS &	SERVI CE	
	N	SUPPLY		LI BRARY		
	13. 00	14. 00	15.00	16.00	17. 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	o	0	0	0	0	194. 07
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	O	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	296, 883	89, 896	996, 245	1, 185, 623	193, 106	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1319

					lo 05/31/2023	Date/lime Prepared:   10/24/2023 5:18 pm
		OTHER GENERAL	<b>'</b>			10, 21, 2020 0. 10 5
		SERVI CE				
	Cost Center Description	I NSERVI CE	Subtotal	Intern &	Total	
		EDUCATI ON		Residents		
				Cost & Post Stepdown		
				Adjustments		
		18. 00	24. 00	25.00	26.00	
	GENERAL SERVICE COST CENTERS					
1.00	00100 CAP REL COSTS-BLDG & FLXT					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2.00
4. 00 5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 00550 DATA PROCESSING					4.00
5. 02	00560 PURCHASING RECEIVING AND STORES					5. 02
5. 03	00570 ADMITTING					5. 03
5.04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE					5.04
5. 05	00590 ALL OTHER ADMINISTRATIVE AND GE					5.05
7. 00	00700 OPERATION OF PLANT					7.00
8. 00	00800 LAUNDRY & LI NEN SERVI CE					8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY					9.00
11. 00	01100 CAFETERI A					11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON					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 I NSERVI CE EDUCATI ON	3, 020				18. 00
30. 00	O3000 ADULTS & PEDIATRICS	78	3, 812, 971		3, 812, 971	30.00
43. 00	04300 NURSERY	70	3, 612, 9/1			
44. 00	04400 SKILLED NURSING FACILITY	79	3, 776, 106			
46. 00	04600 OTHER LONG TERM CARE	0	0			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	382	4, 629, 345	1		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0	
53. 00 54. 00	05300   ANESTHESI OLOGY   05400   RADI OLOGY-DI AGNOSTI C	0 697	0 4 452 475	1	0 4, 452, 675	
60.00	06000 LABORATORY	663	4, 452, 675 4, 065, 112		4, 452, 675 4, 065, 112	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD	4	92, 870		92, 870	
64.00	06400 I NTRAVENOUS THERAPY	Ö	0	1	0 0	I .
66.00	06600 PHYSI CAL THERAPY	223	3, 288, 596		3, 288, 596	66.00
67.00	06700 OCCUPATI ONAL THERAPY	60	723, 031	•	723, 031	
68.00	06800 SPEECH PATHOLOGY	12	246, 609		246, 609	
69. 00 71. 00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PAT	122	768, 364		768, 364	
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	10	99, 512 685, 700		99, 512 685, 700	
73. 00	07300 DRUGS CHARGED TO PATIENTS	138	2, 480, 408		2, 480, 408	
76. 00	03020 ACUPUNCTURE	0	0		0 0	
76. 01	03610 SLEEP LAB	23	277, 564		277, 564	76. 01
76. 02	03950 I V THERAPY	0	0	(	0	76. 02
	OUTPATIENT SERVICE COST CENTERS	1		1		
88. 00 88. 01	08800 KEWANEE RHC 08801 WYOMI NG RHC	148	3, 221, 747 0		3, 221, 747	
88. 02	08802 GENESEO RHC	123	3, 439, 255	•	3, 439, 255	
88. 03	08803 ANNAWAN RHC	28	733, 598		733, 598	
88. 04	08804 CAMBRI DGE RHC	26	609, 061		609, 061	
90.00	09000 CLI NI C	37	745, 277		745, 277	90.00
90. 01	09001 PAIN CLINIC	1	121, 481		121, 481	
90. 02	09002 SPECIALTY CLINIC	0	0		0	
90. 03 90. 04	09003 SURGI CAL CLI NI C	4	427, 950		427, 950	90. 03 90. 04
	09004 GENESEO CLI NI C 09100 EMERGENCY	118	4, 122, 366	1	0 4, 122, 366	
	09200 OBSERVATION BEDS (NON-DISTINCT	110	4, 122, 300		) 4, 122, 300	92.00
72.00	OTHER REIMBURSABLE COST CENTERS	I I			-1	72.00
	09910 CORF	0	0	(	0	99. 10
101.00	10100 HOME HEALTH AGENCY	0	1, 055, 844	(	1, 055, 844	101.00
	SPECIAL PURPOSE COST CENTERS	1		T	T	
	11300 INTEREST EXPENSE	0.004	40 075 440		40.075.440	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	2, 991	43, 875, 442	1	43, 875, 442	118.00
190 00	19000 GIFT FLOWER COFFEE SHOP & CAN		35, 341		35, 341	190.00
	19200 PHYSICIANS PRIVATE OFFICES		33, 341 N		0 0	1
	19203 MUSCATINE CLINIC		3, 407		3, 407	
	19201 CARDI OLOGY CLI NI C	0	0		0	192. 02
	19202 LEASED SPACE	0	713, 124		713, 124	
192.04	1 19204 ANNAWAN CLINIC	0	0	(	0	192. 04

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 06/01/2022 Part I Provi der CCN: 14-1319

			T	05/31/2023	Date/Time Prepared: 10/24/2023 5:18 pm
Cost Center Description	OTHER GENERAL SERVI CE I NSERVI CE	Subtotal	Intern &	Total	10/21/2020 0: 10 р
	EDUCATI ON		Residents Cost & Post Stepdown		
			Adjustments		
	18. 00	24. 00	25. 00	26. 00	
192. 05 19205 CAMBRI DGE CLI NI C	0	0	0	0	192. 05
192.06 19206 PORT BYRON CLINIC	19	619, 224		619, 224	
192. 07 19207 ORI ON CLI NI C	10	464, 775		464, 775	
194. 00 07955  FOUNDATI ON	0	32, 577		32, 577	
194. 01 07950 SPORTS MEDICINE	0	287, 673	0	287, 673	
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 CLI NI C	0	0	0	0	194. 05
194. 06 07956 TRI NI TY/DI ALYSI S LEASED SPACE	0	60, 492	0	60, 492	194. 06
194. 07 07957 COMMUNI TY HEALTH	0	21, 061	0	21, 061	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, 020	46, 113, 116	0	46, 113, 116	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 06/01/2022 Part II
To 05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm

Provider CCN: 14-1319

					10	05/31/2023	10/24/2023 5:	
				CAPI TAL REI	LATED COSTS			
		Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		cost center bescription	Assigned New	DLDG & ITAT	WVBLL LQUIF	Subtotal	BENEFITS	
			Capi tal				DEPARTMENT	
			Related Costs					
	CENED	AL SERVICE COST CENTERS	0	1. 00	2.00	2A	4. 00	
1. 00		CAP REL COSTS-BLDG & FLXT						1. 00
2.00		CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT	0	8, 306		28, 830	28, 830	4. 00
5. 01		DATA PROCESSING PURCHASING RECEIVING AND STORES	0	34, 174		171, 634	573	5. 01
5. 02 5. 03		ADMITTING	0	51, 870 22, 499		51, 870 26, 808	303 352	5. 02 5. 03
5. 04		CASHI ERI NG/ACCOUNTS RECEI VABLE	Ö	28, 671		30, 876	771	5. 04
5.05		ALL OTHER ADMINISTRATIVE AND GE	0	66, 231		95, 154	2, 105	5. 05
7.00		OPERATION OF PLANT	0	135, 881		147, 430	425	7.00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	0	12, 926 23, 267		12, 926 23, 603	49 655	8. 00 9. 00
10.00		DI ETARY	Ö	58, 942		63, 075	975	10.00
11.00	1	CAFETERI A	0	38, 928	0	38, 928	0	11.00
13.00		NURSING ADMINISTRATION	0	10, 141		10, 141	205	13.00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY   PHARMACY	0	0 27, 953	-	0  37, 431	0 567	14. 00 15. 00
16. 00		MEDICAL RECORDS & LIBRARY	ő	27, 336		30, 694	764	16. 00
17. 00	01700	SOCIAL SERVICE	0	0	1, 672	1, 672	187	17.00
18. 00		I NSERVI CE EDUCATI ON	0	0	825	825	0	18. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	O	226, 846	49, 419	276, 265	2, 450	30. 00
43. 00		NURSERY	o	220, 040		270, 203	2, 430	43. 00
44.00		SKILLED NURSING FACILITY	0	0		0	2, 271	44.00
46. 00		OTHER LONG TERM CARE	0	0	0	0	0	46. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	O	253, 965	713, 525	967, 490	1, 953	50. 00
52. 00		DELIVERY ROOM & LABOR ROOM	ő	233, 703		0	0	52. 00
53.00	1	ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00		RADI OLOGY-DI AGNOSTI C	0	149, 390		511, 114	1, 809	54.00
60. 00 62. 00	1	LABORATORY WHOLE BLOOD & PACKED RED BLOOD	0	40, 946 1, 518		137, 428 1, 518	1, 415 0	60. 00 62. 00
64. 00		INTRAVENOUS THERAPY	o	1, 518		1, 516	0	64.00
66.00		PHYSI CAL THERAPY	0	223, 227	24, 131	247, 358	2, 703	66.00
67.00	1	OCCUPATI ONAL THERAPY	0	11, 325		12, 228	621	67.00
68. 00 69. 00		SPEECH PATHOLOGY   ELECTROCARDI OLOGY	0	2, 702 20, 431		2, 702 139, 563	224 386	68. 00 69. 00
71.00		MEDICAL SUPPLIES CHARGED TO PAT	o	20, 431		134, 503	0	71.00
72.00	1	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	o	0	72.00
73.00		DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76. 00 76. 01		ACUPUNCTURE SLEEP LAB	0	0 12, 459	_	0 12, 459	0 158	76. 00 76. 01
76. 01		IV THERAPY	0	12, 439		12, 439	0	76. 01
		TIENT SERVICE COST CENTERS		-		-		
88.00	1	KEWANEE RHC	0	0		65, 087	966	
88. 01 88. 02		WYOMING RHC GENESEO RHC	0	0 54, 372	_	0 75, 047	0 1, 146	88. 01 88. 02
88. 03		ANNAWAN RHC	ő	0		91, 637	155	88. 03
88. 04		CAMBRI DGE RHC	0	0	150, 146	150, 146	229	88. 04
90.00		CLINIC	0	0	,	14, 198	399	90.00
90. 01 90. 02		PAIN CLINIC   SPECIALTY CLINIC	0	434 0		851 0	84 0	90. 01 90. 02
90. 03	1	SURGI CAL CLI NI C	ő	4, 370	_	4, 370	246	90. 03
90. 04	1	GENESEO CLINIC	0	0	0	0	0	90. 04
91.00		EMERGENCY	0	154, 027	50, 787	204, 814	1, 532	91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT REIMBURSABLE COST CENTERS				0		92.00
99. 10	09910		O	0	0	ol	0	99. 10
		HOME HEALTH AGENCY	0	18, 797		19, 050		101. 00
		AL PURPOSE COST CENTERS						
113. 00 118. 00	1	INTEREST EXPENSE	0	1 701 004	1 002 200	2 705 222	27, 565	113.00
116.00		SUBTOTALS (SUM OF LINES 1 through 117)   IMBURSABLE COST CENTERS	<u> </u>	1, 721, 934	1, 983, 288	3, 705, 222	27, 505	116.00
190.00		GIFT FLOWER COFFEE SHOP & CAN	0	16, 478	0	16, 478	0	190. 00
		PHYSICIANS PRIVATE OFFICES	0	0		0		192.00
		MUSCATINE CLINIC CARDIOLOGY CLINIC	0	0	3, 101	3, 101		192. 01 192. 02
		LEASED SPACE		12, 926	7, 489	20, 415		192. 02 192. 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

Provider CCN: 14-1319

					10/24/2023 5:	18 pm_
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
oost conten beschiption	Assigned New	DEDO W TINI	MVDEE EQUIT	Jubrorai	BENEFITS	
	Capi tal				DEPARTMENT	
	•				DEFARIMENT	
	Related Costs	4 00	0.00			
	0	1. 00	2.00	2A	4. 00	
192.06 19206 PORT BYRON CLINIC	0	0	6, 898	6, 898	196	192. 06
192. 07 19207 ORION CLINIC	0	0	12, 296	12, 296	120	192. 07
194. 00 07955 FOUNDATI ON	0	6, 621	0	6, 621	0	194. 00
194. 01 07950 SPORTS MEDICINE	0	0	0	0	296	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	43, 198	0	43, 198	0	194. 06
194. 07 07957 COMMUNI TY HEALTH	0	0	0	0	10	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	1, 801, 157	2, 013, 072	3, 814, 229	28, 830	202. 00

Provider CCN: 14-1319

	Cost Contor Description	DATA	PURCHASI NG	ADMITTING	CASHI ERI NG/AC	10/24/2023 5: ALL OTHER	
	Cost Center Description	PROCESSI NG	RECEIVING AND	ADMITTING	COUNTS	ADMI NI STRATI V	
		5. 01	STORES 5. 02	5. 03	RECEI VABLE 5. 04	E AND GE 5. 05	
+	GENERAL SERVICE COST CENTERS						
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00550 DATA PROCESSING	172, 207					5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES	701	52, 874	00.470			5. 02
5. 03 5. 04	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 963 7, 021	47 34	29, 170 0	38, 702		5. 03 5. 04
5. 05	00590 ALL OTHER ADMINISTRATIVE AND GE	16, 997	455	0	0	114, 711	5.05
	00700 OPERATION OF PLANT	2, 683		0	o	4, 452	7. 00
1	00800 LAUNDRY & LINEN SERVICE	0		0	0	359	8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	355 860		0	0	1, 961 3, 260	9. 00 10. 00
	01100 CAFETERI A	234		0	o	114	11.00
	01300 NURSI NG ADMI NI STRATI ON	0	0	0	Ō	624	13.00
	01400 CENTRAL SERVICES & SUPPLY	0	1, 412	0	0	224	14.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	14, 631 10, 811	155 63		0	2, 292 2, 743	15. 00 16. 00
	01700 SOCIAL SERVICE	10, 811	8	0	0	436	17.00
	01080 I NSERVI CE EDUCATI ON	0	-	0	Ō	8	18.00
	INPATIENT ROUTINE SERVICE COST CENTERS	11.100			4 000	7.050	
1	03000 ADULTS & PEDIATRICS 04300 NURSERY	14, 603 0	2, 102 0	906	1, 002	7, 358 0	30. 00 43. 00
	04400 SKILLED NURSING FACILITY	2, 291	931	0	1, 006	6, 554	44.00
	04600 OTHER LONG TERM CARE	. 0		0	0	0	46. 00
	ANCILLARY SERVICE COST CENTERS		1 250			2 700	
	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	4, 431 0	1, 259 0	4, 424 0	4, 894 0	9, 739 0	50. 00 52. 00
	05300 ANESTHESI OLOGY	0	•	0	o	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	7, 526	6, 443	7, 768		9, 564	54.00
	06000 LABORATORY	6, 124	1	7, 672	8, 488	8, 912	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD 06400 INTRAVENOUS THERAPY	0	0	52 0	57	223 0	62. 00 64. 00
	06600 PHYSI CAL THERAPY	5, 235	479		2, 862	7, 005	•
	06700 OCCUPATI ONAL THERAPY	1, 262			773	1, 636	67.00
	06800 SPEECH PATHOLOGY	701	38		155	573	68.00
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PAT	608		1, 409 112	1, 559 123	1, 677 14	69. 00 71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	9, 996	177	196	1, 692	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	1, 593	1, 762	3, 556	73. 00
	03020 ACUPUNCTURE	0	0	0	0	0	76.00
	03610 SLEEP LAB 03950 IV THERAPY	533 0	133	268	296	597 0	76. 01 76. 02
	OUTPATIENT SERVICE COST CENTERS	0	0	0			70.02
88. 00	08800 KEWANEE RHC	7, 900	1, 310	0	1, 897	7, 871	88. 00
1	08801 WYOMI NG RHC	0				0	88. 01
	08802 GENESEO RHC 08803 ANNAWAN RHC	9, 633 3, 655			1, 574 362	7, 926 1, 798	1
	08804 CAMBRI DGE RHC	2, 178			330	1, 790	88. 04
	09000 CLI NI C	9, 620		0	472	1, 818	
	09001 PAIN CLINIC	1, 917			8	282	90. 01
	09002 SPECIALTY CLINIC 09003 SURGICAL CLINIC	0 2, 571	0 344	0	0 54	0 974	90. 02 90. 03
	09004 GENESEO CLINIC	2,371	0	0	0	0	90.03
	09100 EMERGENCY	17, 325	1, 922	1, 363	1, 508	9, 243	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT						92.00
	OTHER REIMBURSABLE COST CENTERS 09910 CORF	0	0	0	ol	0	99. 10
	10100 HOME HEALTH AGENCY	5, 768			-		101.00
	SPECIAL PURPOSE COST CENTERS					,	
	11300 INTEREST EXPENSE						113.00
118. 00		160, 324	51, 551	29, 170	38, 328	109, 549	118.00
	NONREIMBURSABLE COST CENTERS 19000 GIFT FLOWER COFFEE SHOP & CAN	0	0	0	ol	45	190. 00
	19200 PHYSICIANS PRIVATE OFFICES	ő	o o	0	o	0	192. 00
	19203 MUSCATINE CLINIC	0	0	0	o		192.01
	19201 CARDI OLOGY CLINI C 19202 LEASED SPACE	0	0 329	0	0		192. 02 192. 03
	19204 ANNAWAN CLINIC	0			O O		192. 03
	19205 CAMBRI DGE CLI NI C	ő	Ö	Ö	ő	0	192. 05
	19206 PORT BYRON CLINIC	5, 740			245	1, 522	192.06
	19207 ORION CLINIC 07955 FOUNDATION	5, 376 767			129 0		192. 07 194. 00
174.00	07733 1 00NUATTON	1 /6/	1 0	ı U	·	43	1174.00

Provider CCN: 14-1319

DATA PROCESSING   PURCHASING RECEIVING AND STORES   PURCHASING RECEIVING AND STORES   PROCESSING RECEIVING AND STORES   PROCESSING RECEIVING AND STORES   PROCESSING RECEIVABLE   PROCESSING RECEIVA							10/24/2023 5:	18 pm_
STORES   RECEIVABLE   E AND GE		Cost Center Description	DATA	PURCHASI NG	ADMITTI NG	CASHI ERI NG/AC	ALL OTHER	
194. 01   07950   SPORTS MEDICINE   0   31   0   0   0   194. 01			PROCESSI NG	RECEIVING AND		COUNTS	ADMI NI STRATI V	
194. 01   07950   SPORTS   MEDI CI NE   0   31   0   0   0   194. 01				STORES		RECEI VABLE	E AND GE	
194. 02 07951 KELLY MEDI CAL RENTAL AREA 0 0 0 0 0 194. 02 194. 03 07952 ANESTHESI A BI LLNG 0 0 0 0 0 194. 03 194. 04 07953 SPECI ALTY CLINI C 0 0 0 0 0 194. 04 194. 05 07954 COLONA CLINI C 0 0 0 0 0 0 194. 05 194. 06 07956 TRI NI TY/DI ALYSI S LEASED SPACE 0 0 0 0 0 194. 06 194. 07 07957 COMMUNI TY HEALTH 0 1 0 0 51 194. 07 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			5. 01	5. 02	5. 03	5. 04	5. 05	
194. 03 07952 ANESTHESIA BILLNG 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 0 194. 05 194. 06 07956 TRINITY/DIALYSIS LEASED SPACE 0 0 0 0 0 194. 06 194. 07 07957 COMMUNITY HEALTH 0 1 0 0 51 194. 07 200. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	194. 01 07950	SPORTS MEDICINE	0	31	0	0	716	194. 01
194. 04 07953 SPECIALTY CLINIC 0 0 0 0 0 194. 04 194. 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 1 0 0 51 194. 07 200. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	194. 02 07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194. 02
194. 05 07954 COLONA CLINIC 0 0 0 0 194. 05 194. 06 07956 TRINITY/DIALYSIS LEASED SPACE 0 0 0 0 194. 06 194. 07 07957 COMMUNITY HEALTH 0 1 0 0 0 194. 07 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	194. 03 07952	ANESTHESIA BILLNG	0	0	0	0	0	194. 03
194. 06 07956 TRINITY/DIALYSIS LEASED SPACE 0 0 0 0 194. 06 194. 07 07957 COMMUNITY HEALTH 0 1 0 0 51 194. 07 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 201. 00	194. 04 07953	SPECIALTY CLINIC	0	0	0	0	0	194. 04
194. 07 07957 COMMUNITY HEALTH 0 1 0 0 51 194. 07 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 0 0 0 0 0 0 201. 00	194. 05 07954	COLONA CLINIC	0	0	0	0	0	194. 05
200.00       Cross Foot Adjustments       200.00         201.00       Negative Cost Centers       0       0       0       0       0       0       201.00	194. 06 07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194. 06
201.00 Negative Cost Centers 0 0 0 0 201.00	194. 07 07957	COMMUNITY HEALTH	0	1	0	0	51	194. 07
	200.00	Cross Foot Adjustments						200.00
202.00 TOTAL (sum lines 118 through 201) 172,207 52,874 29,170 38,702 114,711 202.00	201.00	Negative Cost Centers	0	0	0	0	0	201.00
	202. 00	TOTAL (sum lines 118 through 201)	172, 207	52, 874	29, 170	38, 702	114, 711	202.00

Provider CCN: 14-1319

DOST CONTON POSICIFIES   1.00   1.0						) 05/31/2023	10/24/2023 5:	
		Cost Center Description			HOUSEKEEPI NG	DI ETARY	CAFETERI A	
OU 001000 PME COSTS-CHUS B FIXT					0.00	10.00	11 00	
1.00   1.00		CENEDAL SERVICE COST CENTERS	7.00	8.00	9.00	10.00	11.00	
2 00 0000 CAP REL COSTS-AVINEL EQUIP	1 00							1 00
4. 00   000000   000000   000000   000000   000000								
5.01   DOSSO   DATA   PRODESSING								1
0.000   DISCAMENTING ADDRESS		1						1
1.00   0.00   COLAMBITTING		1						1
5.05   0.0500   ALL OTHER ADMINISTRATIVE AND CE   1.166   503   2.00   0.0000   0.0000   0.0000   0.	5.03							5. 03
7.00   00700  DEPEATION OF PLANT   156, 5978   1,800   00800  GUERKETEPINIS   2,131   1,895   31,647   8,000   00900  GUERKETEPINIS   2,131   1,895   31,647   8,000   93,035   1,000	5.04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 04
8.00   0800   LANINDRY & LINEN SERVICE   1.184   14.603   3.1,647   9.00   0.000   01007   010	5.05	00590 ALL OTHER ADMINISTRATIVE AND GE						5. 05
0.000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000000	7.00	00700 OPERATION OF PLANT	156, 593					7. 00
10.00   1000Q   DETARY   5.309   35   1.031   75,890   10.00   13.00	8.00	00800 LAUNDRY & LINEN SERVICE	1, 184	14, 603				8.00
11.00 0 1100 (AFFTERIA ) 3.566 0 184 50,000 93,035 11.00 13.00 1300 (MRS) MRS MAD MISTRATION 929 0 0 0 0 2.21 13.00 13.00 1300 (MRS) MRS MAD MISTRATION 929 0 0 0 0 0 14.00 14	9.00	1			31, 647			9. 00
13.00   01300   MURSH IN CADIMA STRATION   929   0   0   0   3.261   13.00   14.00		1	1	ł	1, 031			1
14.00   01400   PERMIRCY   0   0   0   0   14.00   15.			1	0		50, 009		
15.00 0 10500 PHARMARCY				0	_	0		
16.00   10600   MEDICAL, RECORDS & LIBRARY   2.504   0   77   0   4.895   16.00   18.00   10000   INSERVICE EDUCATION   0   0   0   0   0   0   0   18.00		1	-	0	_	0		1
17.00   01700   SOCIAL SERVICE   0   0   0   0   0   0   0   0   0		1	1	0	1	0		1
18. 00				0	1	0		1
INPATI FAT ROUTH RESERVICE COST CENTERS   2,000   2,000   3,000   30,000				0	1	0		
30.00	18.00		0	0	0	U	0	18.00
43.00   0.4300   NURSERY   0   0   0   0   0   43.00	20 00		20.790	2 052	4 252	4 424	10 141	20 00
44.00   04400   OHLIGAD NIST REPORT   12,001   44.00   0				1		4, 434	· ·	1
46. 00     0    0  0  0  0  0  0  0  0  0					_	21 447		1
## AMCILLARY SERVICE COST CENTERS  50.00   D5000   DEPAIT INS ROM						21, 447		
50.00   05000   0FLIATING ROOM	40.00		0		0		U	40.00
15.2 0.0   05.200   DELLYREY ROOM & LABOR ROOM   0   0   0   0   0   0   0   0   0	50 00		23 264	1 734	5 873	0	7 325	50.00
1.00   0.5300   AIRSTHESI OLOGY   0.0   0.0   0.0   0.53.00				1		0		
54.00   OS-400   RADIOLOGY-DI AGNOSTIC   13, 665   1, 477   1, 408   0   7, 214   54.00   OS-200   OS-200   MEDICAL BLOOD & PACKED RED BLOOD   139   0   0   0   0   0   0   62.00   OS-200   OS-200   MEDICAL SUCRED RED BLOOD   139   0   0   0   0   0   0   64.00   OS-200   OS-200   MEDICAL SUCRED RED BLOOD   139   0   0   0   0   0   0   0   OS-200			-	0	_	0		1
60.00   06.000   LABORATORY   3, 751		1	-	1. 477	_	0		1
Color   Colo		1	1			Ö		1
44-00   0c400   INTRAVENOUS THERAPY   0   0   0   0   0   0   0   0   0		1	1	Ö		Ö		
67: 00   06700   06700   06700   0620PATI ONAL THERAPY   1, 037   0   1777   0   2, 269   67: 00   68: 00   06: 00   06: 00   06: 00   06: 00   06: 00   06: 00   06: 00   06: 00   06: 00   00				0	o	O	0	
67: 00   06700   06700   06700   0620PATI ONAL THERAPY   1, 037   0   1777   0   2, 269   67: 00   68: 00   06: 00   06: 00   06: 00   06: 00   06: 00   06: 00   06: 00   06: 00   06: 00   00	66.00	06600 PHYSI CAL THERAPY	20, 448	1, 207	981	0	10, 270	66.00
68. 00   06800   SPEECH PATHOLOGY   248	67.00	06700 OCCUPATI ONAL THERAPY	1, 037	ľ		О	2, 269	67.00
71.0 0   07100   MEDICAL SUPPLIES CHARGED TO PATI ENTS   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	68.00		248	0	0	o	808	68.00
172, 00   07200   IMPL DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   0   72, 00	69.00	06900 ELECTROCARDI OLOGY	1, 872	0	277	0	1, 536	69.00
173.00   07300   DRICS CHARGED TO PATIENTS   0   0   0   0   0   0   73.00	71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
76. 01 03200 ACUPUNCTURE	72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
76. 01 034510 SLEEP LAB	73.00		0	0	0	0	0	
76. 02   03950   1V THERAPY   0   0   0   0   0   76. 02	76.00	1	0	0	0	0	0	76.00
DUTPATI ENT SERVICE COST CENTERS		1 1	1	ŀ	1	-1		1
88. 00   08801   WYOMI NG RHC   0   0   0   0   0   0   88. 00   88. 01   08802   WYOMI NG RHC   0   0   0   0   0   0   0   88. 02   08802   GENESEO RHC   4,981   39   1,408   0   10,209   88. 02   88. 03   08803   ANNAWAN RHC   0   0   0   0   0   0   0   88. 04   08804   CAMBER DEC RHC   0   0   0   0   0   0   0   90. 01   09000   CLI NI C   0   0   0   0   0   0   0   0   90. 01   09000   CLI NI C   0   0   0   0   0   0   0   90. 01   09000   CLI NI C   0   0   0   0   0   0   0   90. 02   09002   SPECI ALTY CLI NI C   0   0   0   0   0   0   0   90. 03   09003   SURGI CAL   CLI NI C   0   0   0   0   0   0   0   90. 04   09004   GENESEO   CLI NI C   0   0   0   0   0   0   90. 05   09003   SURGI CAL   CLI NI C   0   0   0   0   0   0   90. 06   09100   EMERGENCY   14,109   2,203   2,186   0   6,294   91. 00   09100   DESERVATI ON BEDS (NON-DI STI NCT   14,109   2,203   2,186   0   6,294   91. 01   09910   CORF   0   0   0   0   0   0   91. 01   09100   ORF   0   0   0   0   0   0   91. 01   01010   OMBERSABLE COST CENTERS   1,722   0   92   0   0   91. 02   09100   ORF   0   0   0   0   0   0   91. 02   09100   ORF   0   0   0   0   0   0   91. 02   09100   ORF   0   0   0   0   0   0   91. 02   09100   ORF   0   0   0   0   0   0   91. 02   019200   HYSICIALS (SUM OF LINES 1 through 117)   153,293   14,603   30,039   75,890   90,371   91. 00   192. 00   19200   HYSICIALS (SUM OF LINES 1 through 117)   153,293   14,603   30,039   75,890   90,371   91. 00   192. 01   19203   MUSCATI NE CLI NI C   0   0   0   0   0   0   0   91. 02   19200   HYSICIALS (SUM OF LINES 1 through 117)   153,293   14,603   30,039   75,890   90,371   91. 04   19204   ANNAWAN CLI NI C   0   0   0   0   0   0   0   91. 04   19206   PORT BYRON CLI NI C   0   0   0   0   0   0   91. 04   19206   PORT BYRON CLI NI C   0   0   0   0   0   0   91. 04   19206   PORT BYRON CLI NI C   0   0   0   0   0   91. 04   19206   PORT BYRON CLI NI C   0   0   0   0   0   91. 04   0907955   FOUNDATI ON	76. 02		0	0	0	0	0	76. 02
88. 01   08801   WYOMING RIFC   0 0 0 0 0 0 0 0 88. 01 88. 02   88. 02   08802   GENESEO RIFC   4,981   39   1,408   0 10,209   88. 02   88. 03   08803   ANNAWAN RIFC   0 0 0 0 0 0 0 0 0 0 88. 03   88. 04   08804   CAMBRI DGE RIFC   0 0 0 0 0 0 0 0 0 0 0 88. 03   88. 04   08805   CAMBRI DGE RIFC   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			_	_	T	_1	_	
88. 02   08802   6ENESEO RHC		l l		1	- 1	- 1		1
88. 03   08803   ANNAWAN RRIC		l l				- 1		
88. 04   08804   CAMBRI DGE RHC   0   0   0   0   0   0   0   88. 04   90. 00   09000   CLINI C   0   0   0   0   0   0   0   90. 01   09001   PAIN CLINI C   40   57   0   0   377   90. 01   90. 02   09002   SPECI ALTY CLINI C   0   0   0   0   0   0   90. 03   09003   SURGI CAL CLINI C   400   0   294   0   2,072   90. 03   90. 04   09004   GENESSEO CLINI C   0   0   0   0   0   0   0   91. 00   09100   EMERGENCY   14, 109   2, 203   2, 186   0   6, 294   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT   0   92. 00   99. 10   09100   CORF   0   0   0   0   0   0   0   101. 00   10100   HOME   HEALTH AGENCY   1, 722   0   92   0   0   101. 00   113. 00   1300   INTEREST EXPENSE   1300   INTEREST EXPENSE   1300   1500				l		- 1		
90. 00   09000  CLINIC			0	0	0	0		
90. 01   09001   PAIN CLINIC   40   57   0   0   377   90. 01   90. 02   09002   SPECI ALTY CLINIC   0   0   0   0   0   0   90. 03   09003   SPECI ALTY CLINIC   400   0   0   0   0   90. 04   09004   GENESEO CLINIC   400   0   0   0   0   91. 00   09004   GENESEO CLINIC   14, 109   2, 203   2, 186   0   6, 294   91. 00   09100   EMERGENCY   14, 109   2, 203   2, 186   0   6, 294   91. 00   09200   OBSERVATION BEDS (NON-DISTINCT   92. 00   91. 00   09910   CORF   0   0   0   0   0   0   99. 10   09910   CORF   0   0   0   0   0   99. 10   09910   INTEREST EXPENSE   113. 00   11300   INTEREST EXPENSE   113. 00   11300   INTEREST EXPENSE   113. 00   11300   INTEREST EXPENSE   114. 603   30, 039   75, 890   90, 371   118. 00   190. 00   19000   GIFT FLOWER COFFEE SHOP & CAN   1, 509   0   0   0   0   0   192. 01   192. 01   19203   MUSCATINE CLINIC   0   0   0   0   0   0   192. 01   192. 02   19201   CARDIOLOGY CLINIC   0   0   0   0   0   0   192. 01   192. 03   19202   LEASED SPACE   1, 184   0   951   0   1, 830   192. 03   192. 04   19204   ANAWAYA CLINIC   0   0   0   0   0   192. 03   192. 05   19205   CAMBRI DGE CLINIC   0   0   0   0   0   0   192. 06   19206   PORT BYRON CLINIC   0   0   0   0   0   0   192. 07   19207   ORION CLINIC   0   0   0   0   0   194. 00   07955   FOUNDATION   607   0   0   0   0   0   194. 00   07955   FOUNDATION   607   0   0   0   0   194. 00   07955   FOUNDATION   607   0   0   0   0   194. 00   07955   FOUNDATION   607   0   0   0   0   0   195. 05   0700   0   0   0   0   0   195. 05   0700   0   0   0   0   0   195. 05   0700   0   0   0   0   0   195. 05   0700   0   0   0   0   0   195. 05   0700   0   0   0   0   195. 0700   0700   0   0   0   0   195. 0700   0700   0   0   0   0   195. 0700   0700   0   0   0   0   195. 0700   0700   0   0   0   0   195. 0700   0700   0   0   0   0   195. 0700   0700   0   0   0   0   195. 0700   0700   0   0   0   0   195. 0700   0700   0   0   0   0   195. 0700   0700   0   0   0   0   195. 0700   0700   0   0   0   0   195. 0700			0	0		0		
90. 02   09002   SPECIALTY CLINIC   0   0   0   0   0   0   0   0   0			-	U E7		0		1
90. 03   09003   SURGI CAL CLINI C				57		0		1
90. 04   09004   GENESEO CLINIC   0   0   0   0   0   0   0   0   0			· ·	0	294	0		
91. 00   09100   EMERGENCY   14, 109   2, 203   2, 186   0   6, 294   91. 00   92. 00   09200   O9200   OSERVATI ON BEDS (NON-DI STI NCT					1	0	· ·	
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			_	2 203	_	0		1
99. 10		1	1,,	2,200	2, .00	, i	0,2,.	
99. 10   09910   CORF   0   0   0   0   0   0   0   0   101. 00   101. 00   101. 00   SPECI AL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   113. 00   SUBTOTALS (SUM OF LINES 1 through 117)   153, 293   14, 603   30, 039   75, 890   90, 371   118. 00   NONREI MBURSABLE COST CENTERS   119. 00   19000   GIFT   FLOWER COFFEE SHOP & CAN   1,509   0   0   0   0   0   192. 00   192. 00   19200   PHYSI CI ANS PRI VATE OFFICES   0   0   0   0   0   192. 00   192. 01   19203   MUSCATI NE CLI NI C   0   0   0   0   0   192. 02   19201   CARDI OLOGY CLI NI C   0   0   0   0   0   192. 02   192. 03   19202   LEASED SPACE   1,184   0   951   0   1,830   192. 03   192. 04   19204   ANNAWAN CLI NI C   0   0   0   0   0   192. 05   192.05   CAMBRI DGE CLI NI C   0   0   0   0   0   192. 05   192.06   19206   PORT BYRON CLI NI C   0   0   0   0   0   0   192. 05   192.07   19207   ORI ON CLI NI C   0   0   0   0   0   0   192. 07   19207   ORI ON CLI NI C   0   0   0   0   0   0   0   0   192. 07   19207   ORI ON CLI NI C   0   0   0   0   0   0   0   0   192. 07   194. 00   07955   FOUNDATI ON   607   0   0   0   0   0   786   194. 00				l .	I.			1
101. 00   10100   HOME   HEALTH   AGENCY   1,722   0   92   0   0   101. 0	99. 10		0	0	0	0	0	99. 10
113. 00   11300   INTEREST EXPENSE   113. 00   11300   INTEREST EXPENSE   SUBTOTALS (SUM OF LINES 1 through 117)   153, 293   14, 603   30, 039   75, 890   90, 371   118. 00   NONREI MBURSABLE COST CENTERS	101.00	10100 HOME HEALTH AGENCY	1, 722	0		O	0	
118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   153,293   14,603   30,039   75,890   90,371   118. 00   NONREI MBURSABLE COST CENTERS   190. 00   19200   GIFT FLOWER COFFEE SHOP & CAN   1,509   0   0   0   0   192. 00   192.00   1920								1
NONRE   MBURSABLE COST CENTERS   190. 00   19000   GIFT FLOWER COFFEE SHOP & CAN   1,509   0   0   0   0   190. 00	113.00							113. 00
190. 00   1900	118.00	SUBTOTALS (SUM OF LINES 1 through 117)	153, 293	14, 603	30, 039	75, 890	90, 371	118.00
192. 00   1920		NONREI MBURSABLE COST CENTERS						
192. 01 19203 MUSCATI NE CLI NI C 0 0 0 0 0 192. 01 192. 02 19201 CARDI OLOGY CLI NI C 0 0 0 0 0 0 192. 02 19201 CARDI OLOGY CLI NI C 0 0 0 0 0 192. 02 192. 03 19202 LEASED SPACE 1, 184 0 951 0 1, 830 192. 03 192. 04 19204 ANNAWAN CLI NI C 0 0 0 0 0 0 192. 04 192. 05 19205 CAMBRI DGE CLI NI C 0 0 0 0 0 0 192. 05 192.06 PORT BYRON CLI NI C 0 0 0 0 0 0 192. 05 192. 06 192.06 PORT BYRON CLI NI C 0 0 0 0 0 0 0 192. 07 192. 07 19207 ORI ON CLI NI C 0 0 0 0 0 0 0 192. 07 194. 00 07955 FOUNDATI ON 607 0 0 0 786 194. 00			1, 509	0	0	0		
192. 02 19201 CARDI OLOGY CLINI C 0 0 0 0 192. 02 19202 LEASED SPACE 1, 184 0 951 0 1, 830 192. 03 19202 LEASED SPACE 1, 184 0 951 0 1, 830 192. 03 192. 04 19204 ANNAWAN CLINI C 0 0 0 0 0 192. 04 192. 05 19205 CAMBRI DGE CLINI C 0 0 0 0 0 0 192. 05 192. 06 19206 PORT BYRON CLINI C 0 0 0 0 0 0 192. 06 192. 07 19207 ORI ON CLINI C 0 0 0 0 0 0 192. 07 194. 00 07955 FOUNDATION 607 0 0 0 786 194. 00			0	0	0	o		
192. 03 19202 LEASED SPACE 1, 184 0 951 0 1, 830 192. 03 192. 04 19204 ANNAWAN CLINIC 0 0 0 0 0 192. 04 192. 05 19205 CAMBRI DGE CLINIC 0 0 0 0 0 192. 05 192.06 19206 PORT BYRON CLINIC 0 0 0 0 0 192. 06 192. 07 19207 ORI ON CLINIC 0 0 0 0 0 0 192. 07 194. 00 07955 FOUNDATION 607 0 0 0 0 786 194. 00		1	0	0	_	0		
192. 04 19204 ANNAWAN CLINIC 0 0 0 0 192. 04 192.05 19205 CAMBRI DGE CLINIC 0 0 0 0 0 192. 05 192.06 19206 PORT BYRON CLINIC 0 0 0 0 0 192. 06 192. 07 19207 ORI ON CLINIC 0 0 0 0 0 192. 07 194. 00 07955 FOUNDATION 607 0 0 0 786 194. 00			0	0		0		
192. 05   19205   CAMBRI DGE CLINI C				0	951	0		
192. 06   19206   PORT BYRON CLINIC 0 0 0 0 192. 06   192. 07   19207   ORI ON CLINIC 0 0 0 0 0 192. 07   194. 00   07955   FOUNDATION 607 0 0 0 786   194. 00			-	0	0	0		
192. 07 19207 ORI ON CLI NI C 0 0 0 0 192. 07 194. 00 07955 FOUNDATI ON 607 0 0 0 786 194. 00			0	0	0	0		
194. 00 07955 FOUNDATION 607 0 0 786 194. 00			0	0	0	0		
				0	0	0		
194. UTO 1950 SPUKTS MEDICINE UD UD UD UD 0 0 194. 01				J	_	0		
	194.0	101430  SEOKIS MEDICINE	1 0	1 0	0	0	0	1194.01

In Lieu of Form CMS-2552-10

Period:
From 06/01/2022
To 05/31/2023
Date/Time Prepared:
10/24/2023 5: 18 pm Provider CCN: 14-1319

						10/24/2023 3.	10 PIII
Cost (	Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE				
		7. 00	8. 00	9. 00	10.00	11. 00	
194. 02 07951 KELLY	MEDICAL RENTAL AREA	0	0	0	0	0	194. 02
194. 03 07952 ANESTI	HESIA BILLNG	0	0	0	0	0	194. 03
194. 04 07953 SPECI A	ALTY CLINIC	0	0	0	0	0	194. 04
194. 05 07954 COLONA	A CLINIC	0	0	0	0	0	194. 05
194. 06 07956 TRI NI	TY/DIALYSIS LEASED SPACE	0	0	657	0	0	194. 06
194. 07 07957 COMMUN	NITY HEALTH	0	0	0	0	48	194. 07
200.00 Cross	Foot Adjustments						200.00
201.00 Negati	ve Cost Centers	0	0	0	0	0	201.00
202. 00 TOTAL	(sum lines 118 through 201)	156, 593	14, 603	31, 647	75, 890	93, 035	202.00

Provider CCN: 14-1319

Cost Costor Deceription	NURSI NG	CENTRAL	DHADMACY	MEDI CAL	10/24/2023 5:	
Cost Center Description	ADMI NI STRATI O	CENTRAL SERVICES &	PHARMACY	MEDI CAL RECORDS &	SOCI AL SERVI CE	
	N 13. 00	SUPPLY 14. 00	15. 00	LI BRARY 16. 00	17. 00	
GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	10.00	17.00	
1. 00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00   00200 CAP REL COSTS-MVBLE EQUIP 4.00   00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 01   00550 DATA PROCESSING						5. 01
5. 02 00560 PURCHASING RECEIVING AND STORES						5. 02
5. 03   00570   ADMI TTI NG						5. 03
5. 04   00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.04
5.05   00590 ALL OTHER ADMINISTRATIVE AND GE 7.00   00700 OPERATION OF PLANT						5. 05 7. 00
8. 00   00800   LAUNDRY & LINEN SERVICE						8.00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00   01000   DI ETARY						10.00
11. 00   01100   CAFETERI A	15 140					11.00
13. 00   01300   NURSI NG   ADMI NI STRATI ON 14. 00   01400   CENTRAL   SERVI CES & SUPPLY	15, 160	1, 636				13. 00 14. 00
15. 00 01500 PHARMACY	854	0	61, 032			15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	o	0	52, 541		16.00
17. 00   01700   SOCI AL   SERVI CE	314	0	0	0	3, 776	17.00
18. 00 01080 I NSERVI CE EDUCATION I NPATIENT ROUTINE SERVI CE COST CENTERS	0	0	0	0	0	18. 00
30. 00 03000 ADULTS & PEDIATRICS	3, 582	ol	0	1, 406	2, 666	30.00
43. 00   04300   NURSERY	0	o	0	0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	143	963	44.00
46. 00 O4600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM	2, 583	ol	0	6, 864	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	2, 303	o	0	0, 004	0	52.00
53. 00   05300   ANESTHESI OLOGY	o	o	0	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	2, 544	0	0	12, 084	0	54.00
60. 00   06000   LABORATORY	2, 688	0	0	11, 904	0	60.00
62.00   06200   WHOLE BLOOD & PACKED RED BLOOD 64.00   06400   NTRAVENOUS THERAPY		0	0	80	0	62. 00 64. 00
66. 00   06600   PHYSI CAL THERAPY	Ö	Ö	Ö	4, 014	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	О	0	1, 084	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	218	0	68.00
69. 00   06900   ELECTROCARDI OLOGY 71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PAT	0	0 1, 636	0	2, 187 173	0	69. 00 71. 00
72. 00   07700   MPL. DEV. CHARGED TO PATIENTS		1, 030	0	275	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	o	o	61, 032	2, 471	0	73.00
76. 00   03020   ACUPUNCTURE	0	o	0	0	0	76. 00
76. 01   03610   SLEEP LAB	243	0	0	416	0	76. 01
76. 02 03950 V THERAPY OUTPATIENT SERVICE COST CENTERS	0	0	0	0]	0	76. 02
88. 00 08800 KEWANEE RHC	0	O	0	2, 660	0	88. 00
88. 01   08801   WYOMI NG RHC	o	О	0	0	0	88. 01
88. 02   08802   GENESEO RHC	0	0	0	2, 207	0	88. 02
88. 03   08803   ANNAWAN   RHC 88. 04   08804   CAMBRI DGE   RHC	0	0	0	507	0	88. 03 88. 04
88. 04   08804   CAMBRI DGE RHC 90. 00   09000   CLI NI C		0	0	463 662	0	90.00
90. 01   09001   PAI N   CLI NI C	133	Ö	Ö	11	0	90. 01
90. 02   09002   SPECIALTY CLINIC	0	o	0	0	0	90. 02
90. 03   09003   SURGI CAL CLI NI C	0	0	0	75	0	90.03
90. 04   09004   GENESEO CLI NI C 91. 00   09100   EMERGENCY	2 210	0	0	2 114	0 147	90. 04 91. 00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT	2, 219	U U	U	2, 114	147	91.00
OTHER REIMBURSABLE COST CENTERS			\ 			72.00
99. 10 09910 CORF	0	0	0	0	0	99. 10
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	15, 160	1, 636	61, 032	52, 018	3, 776	118.00
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0		190.00
192. 00 19200  PHYSICIANS PRIVATE OFFICES 192. 01 19203  MUSCATINE CLINIC	0	0	0	0		192. 00 192. 01
192. 01 19203 MUSCATT NE CLINI C 192. 02 19201 CARDI OLOGY CLINI C		0	0	0		192.01
192. 03 19202 LEASED SPACE		o	o	ő		192. 03
192.04 19204 ANNAWAN CLINIC	0	o	0	o	0	192. 04
192. 05 19205 CAMBRI DGE CLI NI C	0	0	0	0		192.05
192. 06 19206 PORT BYRON CLINIC 192. 07 19207 ORION CLINIC		O	0	343 180		192. 06 192. 07
192. 07 19207 ORI ON CLINIC 194. 00 07955 FOUNDATION		0	0	081		192.07
	<u>,                                    </u>	<u> </u>	O <sub>1</sub>	<u> </u>		55

Provi der CCN: 14-1319

In Lieu of Form CMS-2552-10

Period:
From 06/01/2022
To 05/31/2023
Date/Time Prepared:
10/24/2023 5: 18 pm

					10/24/2023 5:	10 PIII
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
	ADMI NI STRATI O	SERVICES &		RECORDS &	SERVI CE	
	N	SUPPLY		LI BRARY		
	13. 00	14. 00	15. 00	16.00	17. 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	o	0	0	0	0	201.00
202.00   TOTAL (sum lines 118 through 201)	15, 160	1, 636	61, 032	52, 541	3, 776	202. 00

eal th Financial Systems STATE HENRY LOCATION PY

Health Financial Systems

In Lieu of Form CMS-2552-10

Provider CCN: 14-1319

From 06/01/2022
To 05/31/2023

Date/Time Prepared:

				To	05/31/2023	Date/Time Prepared: 10/24/2023 5:18 pm
		OTHER GENERAL				1072472023 3. 10 piii
		SERVI CE				
	Cost Center Description	I NSERVI CE	Subtotal	Intern &	Total	
		EDUCATI ON		Residents		
				Cost & Post Stepdown		
				Adjustments		
		18. 00	24. 00	25. 00	26. 00	
	GENERAL SERVICE COST CENTERS	1		1		
1.00	00100 CAP REL COSTS MARIE FOLL D					1.00
2. 00 4. 00	OO200   CAP REL COSTS-MVBLE EQUIP   OO400   EMPLOYEE BENEFITS DEPARTMENT					2.00
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 CASHI ERI NG/ACCOUNTS RECEI VABLE					5. 04
5.05	00590 ALL OTHER ADMINISTRATIVE AND GE					5. 05
7. 00 8. 00	OO7OO   OPERATION OF PLANT   OO8OO   LAUNDRY & LINEN SERVICE					7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG					9.00
10.00	01000 DI ETARY					10.00
11. 00	01100 CAFETERI A					11.00
13.00	01300 NURSING ADMINISTRATION					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY					14.00
15. 00 16. 00	O1500   PHARMACY   O1600   MEDICAL RECORDS & LIBRARY					15. 00 16. 00
17. 00	01700 SOCIAL SERVICE					17.00
18. 00	01080 I NSERVI CE EDUCATI ON	865				18. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS	24	356, 144	0	356, 144	30.00
43.00	04300 NURSERY	0	0		0	43.00
44. 00 46. 00	04400 SKILLED NURSING FACILITY 04600 OTHER LONG TERM CARE	24	86, 796 0	0	86, 796 0	44. 00 46. 00
40.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	<u> </u>	<u> </u>	<u> </u>	40.00
50.00	05000 OPERATING ROOM	118	1, 041, 951	0	1, 041, 951	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	53.00
54. 00 60. 00	05400  RADI OLOGY-DI AGNOSTI C   06000  LABORATORY	150 204	591, 451 213, 267	0	591, 451 213, 267	54. 00 60. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD	1	2, 070		2, 070	62.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	Ō	0	64.00
66. 00	06600 PHYSI CAL THERAPY	69	305, 218	0	305, 218	66.00
67.00	06700 OCCUPATI ONAL THERAPY	19	21, 931	0	21, 931	67.00
68. 00 69. 00	O6800  SPEECH PATHOLOGY   O6900  ELECTROCARDI OLOGY	4 37	5, 811 151, 307	0	5, 811	68. 00 69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PAT	37	2, 061		151, 307 2, 061	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	5	12, 341	Ö	12, 341	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	42	70, 456	0	70, 456	73.00
76. 00	03020 ACUPUNCTURE	0	0	0	0	76.00
76. 01	03610 SLEEP LAB	/	17, 153		17, 153	76.01
76. 02	03950 I V THERAPY OUTPATIENT SERVICE COST CENTERS	0	0	0	0	76. 02
88. 00	08800 KEWANEE RHC	46	87, 737	0	87, 737	88.00
88. 01	08801 WYOMI NG RHC	0	0	0	0	88. 01
	08802 GENESEO RHC	38	115, 718		115, 718	
88. 03	08803 ANNAWAN RHC	9	98, 599 155, 001	0	98, 599	
88. 04 90. 00	O8804   CAMBRI DGE RHC   O9000   CLI NI C	8 11	155, 081 28, 341	0	155, 081 28, 341	88. 04 90. 00
	09001 PAIN CLINIC		3, 929		3, 929	90. 01
		0	0	0	0	90. 02
90. 03	09003 SURGI CAL CLI NI C	1	11, 401	0	11, 401	90. 03
	09004 GENESEO CLINIC	0	0	0	0	90.04
	O9100   EMERGENCY   O9200   OBSERVATION   BEDS   (NON-DISTINCT	36	267, 015	0	267, 015	91. 00 92. 00
92.00	OTHER REIMBURSABLE COST CENTERS			<u> </u>		92.00
99. 10	09910 CORF	0	0	0	0	99. 10
101.00	10100 HOME HEALTH AGENCY	0	31, 333	0	31, 333	101. 00
	SPECIAL PURPOSE COST CENTERS			l I		
	11300 I NTEREST EXPENSE	054	0 (77 111	0	0 /77 111	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	856	3, 677, 111	0	3, 677, 111	118. 00
190. 00	19000 GIFT FLOWER COFFEE SHOP & CAN	0	18, 032	0	18, 032	190.00
192.00	19200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	192. 00
	19203 MUSCATI NE CLI NI C	0	3, 109	0	3, 109	
	19201   CARDI OLOGY CLINI C   19202   LEASED SPACE	0	24 002	0	0 24 002	192. 02 192. 03
	19202  LEASED SPACE   19204  ANNAWAN CLINIC		26, 982 0		26, 982 0	
172.04	120 1	<u> </u>	O <sub>1</sub>	١	U <sub>1</sub>	

Health Financial Systems

In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1319 Worksheet B Peri od:

From 06/01/2022

0

3, 814, 229

201.00

202.00

Part II Date/Time Prepared: 10/24/2023 5:18 pm 05/31/2023 OTHER GENERAL SERVI CE I NSERVI CE Subtotal Intern & Total Cost Center Description EDUCATI ON Resi dents Cost & Post Stepdown Adjustments 18. 00 24. 00 25.00 26.00 192. 05 19205 CAMBRIDGE CLINIC 192.05 0 0 6 3 0 0 0 0 0 0 192.06 19206 PORT BYRON CLINIC 15, 282 15, 282 192.06 192.07 19207 ORION CLINIC 19, 881 0 19, 881 192.07 194. 00 07955 FOUNDATION 8, 824 0 8, 824 194.00 194. 01 07950 SPORTS MEDICINE 194. 01 1, 043 0 0 0 0 0 0 0 0 1, 043 194.02 07951 KELLY MEDICAL RENTAL AREA 194. 02 0 194. 03 07952 ANESTHESIA BILLNG 0 194. 03 194. 04 07953 SPECIALTY CLINIC 0 194. 04 0 194. 05 07954 COLONA CLINIC 194. 05 0 194.06 07956 TRINITY/DIALYSIS LEASED SPACE 43, 855 43, 855 194.06 194. 07 07957 COMMUNITY HEALTH 110 110 194. 07 200.00 Cross Foot Adjustments 200.00 0 C

0

3, 814, 229

865

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118 through 201)

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Health Financial Systems

Handle-HENRY WorlTAL

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1319 | Period: | Worksheet B-1

Health Financial Systems	HHENR	Y YOU I TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CO		eriod: rom 06/01/2022 o 05/31/2023	Worksheet B-1 Date/Time Pre 10/24/2023 5:	pared:
	CAPITAL REL	ATED COSTS			1072172020 01	, p
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	DATA PROCESSING (TIME SPENT)	PURCHASI NG RECEI VI NG AND STORES (SUPPLY COS	
			SALARI ES)		T)	
	1. 00	2. 00	4. 00	5. 01	5. 02	
GENERAL SERVICE COST CENTERS						
1. 00   00100   CAP REL COSTS-BLDG & FLXT	107, 992	4 0// 4/0				1.00
2. 00   00200   CAP REL COSTS-MVBLE EQUIP 4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT	498	1, 966, 463	10 454 000			2.00
5. 01   00550 DATA PROCESSING	2, 049	20, 049 134, 277	19, 456, 090 386, 358			4. 00 5. 01
5. 02 00560 PURCHASING RECEIVING AND STORES	3, 110	134, 277	204, 240	· ·	3, 063, 332	5. 02
5. 03   00570   ADMI TTI NG	1, 349	4, 209				5.03
5. 04   00580   CASHI ERI NG/ACCOUNTS   RECEI VABLE	1, 719	2, 154	519, 975		1, 966	5. 04
5.05 00590 ALL OTHER ADMINISTRATIVE AND GE	3, 971	28, 253	1, 420, 353	9, 090	26, 346	5. 05
7. 00   00700   OPERATION OF PLANT	8, 147	11, 282	286, 725		92, 870	7.00
8. 00   00800   LAUNDRY & LI NEN SERVI CE	775	0	33, 375		4, 910	8.00
9. 00   00900   HOUSEKEEPI NG 10. 00   01000   DI ETARY	1, 395	328 4, 037	442, 032			9.00
10. 00   01000  DI ETARY 11. 00   01100  CAFETERI A	3, 534 2, 334	4,037	658, 199 0		72, 714 0	10.00 11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	608	0	138, 158		0	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	81, 821	14.00
15. 00 01500 PHARMACY	1, 676	9, 259	382, 414	7, 825	8, 971	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	1, 639	3, 280	515, 733		3, 633	16.00
17. 00   01700   SOCIAL SERVICE	0	1, 633	126, 334	100	448	17. 00
18. 00 01080 I NSERVI CE EDUCATI ON	0	806	0	0	1, 826	18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	13, 601	48, 275	1, 653, 343		121, 784	30.00
43.00   04300   NURSERY 44.00   04400   SKILLED   NURSING   FACILITY	0	0	1 522 405	_	0 53, 930	43. 00 44. 00
46. 00   04600 OTHER LONG TERM CARE		0	1, 532, 405	1, 225	0 33, 930	46.00
ANCILLARY SERVICE COST CENTERS	<u> </u>	<u> </u>			0	40.00
50. 00 05000 OPERATING ROOM	15, 227	697, 007	1, 318, 004	2, 370	72, 958	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	o	0	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	o	0	0	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	8, 957	353, 349				54.00
60. 00   06000   LABORATORY	2, 455	94, 248		3, 275	905, 648	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD	91	0	0	0	0	62.00
64. 00   06400   I NTRAVENOUS THERAPY 66. 00   06600   PHYSI CAL THERAPY	13, 384	23, 572	1, 827, 726	2, 800	0 27, 752	64. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	679	23, 372 882	418, 774		7, 309	67.00
68. 00 06800 SPEECH PATHOLOGY	162	0	151, 314		2, 226	ı
69. 00 06900 ELECTROCARDI OLOGY	1, 225	116, 374	260, 586		11, 376	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	o	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	579, 140	
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	106, 776 0		7, 697	76. 01
76. 02 03950 I V THERAPY OUTPATIENT SERVICE COST CENTERS	<u> </u>	U			0	76. 02
88. 00 08800 KEWANEE RHC	O	63, 580	652, 014	4, 225	75, 885	88.00
88. 01   08801   WYOMI NG RHC	o	0	0	0	0	88. 01
88. 02   08802   GENESEO RHC	3, 260	20, 196	772, 944	5, 152	87, 499	88. 02
88. 03   08803   ANNAWAN RHC	o	89, 515	104, 301	1, 955	27, 592	88. 03
88. 04   08804   CAMBRI DGE RHC	0	146, 670	154, 852			•
90. 00   09000   CLI NI C	0	13, 869	269, 476		· ·	
90. 01   09001   PALN CLINIC	26	407	56, 474	1, 025	9, 787	90.01
90. 02   09002   SPECI ALTY   CLI NI C 90. 03   09003   SURGI CAL   CLI NI C	0	0	144 045	1 275	0 19, 957	90. 02 90. 03
90. 04   09004   GENESEO   CLINIC	262	0	166, 065	1, 375	19, 957	90.03
91. 00   09100   EMERGENCY	9, 235	49, 611	1, 033, 506	9, 265	111, 384	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	1,	,	1, 222, 222	.,	,	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	247	598, 233	3, 085	55, 198	101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300   INTEREST EXPENSE	100 040	4 007 0/0	40 (00 00)	05 744	0.00/ /5/	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	103, 242	1, 937, 369	18, 603, 026	85, 744	2, 986, 656	Ji 18. 00
190. 00 19000 GIFT FLOWER COFFEE SHOP & CAN	988	0	0	0	0	190. 00
192. 00 19200 PHYSI CLANS PRI VATE OFFICES	900	0				190.00
192. 01 19203 MUSCATI NE CLI NI C		3, 029				192.01
192. 02 19201 CARDI OLOGY CLINI C		0	Ö	Ö		192.02
192. 03 19202 LEASED SPACE	775	7, 316	434, 055	0	19, 052	192. 03
192. 04 19204 ANNAWAN CLINIC	o	0	0	0	0	192. 04

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

In Lieu of Form CMS-2552-10

Provider CCN: 14-1319

						10/24/2023 5:	18 pm
		CAPI TAL REL	ATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	DATA	PURCHASI NG	
		(SQUARE FEET)	(DOLLAR	BENEFITS		RECEIVING AND	
			VALUE)	DEPARTMENT	(TIME SPENT)	STORES	
				(GROSS		(SUPPLY COS	
				SALARI ES)		T)	
		1. 00	2. 00	4. 00	5. 01	5. 02	
	CAMBRIDGE CLINIC	0	0	ľ	0		192. 05
	PORT BYRON CLINIC	0	6, 738				
	ORION CLINIC	0	12, 011	80, 800			192. 07
194. 00 07955		397	0	0	410		194.00
	SPORTS MEDICINE	0	0	199, 636	0		194. 01
	KELLY MEDICAL RENTAL AREA	0	0	0	0		194. 02
	ANESTHESIA BILLNG	0	0	0	0		194. 03
	SPECIALTY CLINIC	0	0	0	0		194. 04
	COLONA CLINIC	0	0	0	0		194. 05
	TRINITY/DIALYSIS LEASED SPACE	2, 590	0	0	0		194. 06
	COMMUNITY HEALTH	0	0	6, 541	0	85	194. 07
200. 00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers					1	201.00
202. 00	Cost to be allocated (per Wkst. B,	1, 801, 157	2, 013, 072	4, 208, 096	2, 008, 385	164, 663	202.00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	16. 678615	1. 023702		21. 806806		
204.00	Cost to be allocated (per Wkst. B,			28, 830	172, 207	52, 874	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part			0. 001482	1. 869803	0. 017260	205. 00
	[11]						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Health Financial Systems In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 14-1319 Peri od: Worksheet B-1 From 06/01/2022 05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm Cost Center Description ADMI TTI NG CASHIERING/AC Reconciliatio ALL OTHER OPERATION OF ADMI NI STRATI V (GROSS CHAR COUNTS PLANT n GES) RECEI VABLE E AND GE (SQUARE FEET) (GROSS CHAR (ACCUM COST) GES) 5.03 5.04 5A. 05 5.05 7.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00550 DATA PROCESSING 5.01 5.01 00560 PURCHASING RECEIVING AND STORES 5.02 5.02 00570 ADMITTING 5.03 96, 991, 359 5.03 116, 094, 786 5.04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.04 5.05 00590 ALL OTHER ADMINISTRATIVE AND GE -4, 134, 502 41, 935, 416 5.05 0 00700 OPERATION OF PLANT 7 00 1, 627, 799 102, 494 7 00 0 8.00 00800 LAUNDRY & LINEN SERVICE 0 0 131, 330 775 8.00 9.00 00900 HOUSEKEEPI NG 0 717, 044 1, 395 9.00 0 1, 191, 944 01000 DI ETARY 0 3, 534 10.00 10.00 01100 CAFETERI A 0 11.00 41,654 2, 334 11.00 13.00 01300 NURSING ADMINISTRATION 0 228, 262 608 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 81, 828 14.00 0 0 01500 PHARMACY 838, 155 15 00 1.676 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 1,002,932 1,639 16.00 01700 SOCIAL SERVICE 0 17.00 159, 412 0 17.00 01080 INSERVICE EDUCATION 2,749 18.00 18.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 3,010,389 3,010,389 0 2, 690, 302 13,601 30.00 43.00 04300 NURSERY 0 43.00 0 2, 396, 500 44 00 04400 SKILLED NURSING FACILITY 3 020 431 0 17, 935 44 00 0 04600 OTHER LONG TERM CARE 46.00 0 46.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 14, 697, 271 3, 554, 293 15, 227 50.00 14, 697, 271 05200 DELIVERY ROOM & LABOR ROOM 52 00 0 52 00 0 0 53.00 05300 ANESTHESI OLOGY 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 25, 890, 532 25, 890, 532 0 3, 496, 723 8, 957 54.00 54.00 60.00 06000 LABORATORY 25, 489, 520 25, 489, 520 3, 258, 639 2.455 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD 0 62 00 171, 333 171, 333 81, 443 91 62 00 64.00 06400 I NTRAVENOUS THERAPY 0 0 64.00 8, 595, 016 06600 PHYSI CAL THERAPY 8, 595, 016 2, 561, 075 66.00 13, 384 66.00 67.00 06700 OCCUPATI ONAL THERAPY 2, 321, 895 2, 321, 895 598, 310 679 67.00 06800 SPEECH PATHOLOGY 209.418 68.00 466, 123 466, 123 162 68.00 69.00 06900 ELECTROCARDI OLOGY 4, 682, 425 4, 682, 425 613, 078 1, 225 69.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PAT 370, 438 370, 438 0 5, 191 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 587.932 587. 932 0 72.00 618, 510 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 73.00 5, 290, 955 5, 290, 955 1, 300, 095 0 73.00 76.00 03020 ACUPUNCTURE 0 0 76.00 03610 SLEEP LAB 890, 053 76.01 890,053 0 218, 428 747 76.01 03950 IV THERAPY 76.02 O 0 76.02 OUTPATIENT SERVICE COST CENTERS 88 00 08800 KEWANEE RHC 5, 695, 426 2, 877, 853 0 88.00 08801 WYOMI NG RHC 0 88.01 0 88.01 0 0 0 4, 725, 333 88 02 08802 GENESEO RHC 2.898.087 3, 260 88 02 88. 03 08803 ANNAWAN RHC 1,085,886 88.03 657, 321 0 0 88.04 08804 CAMBRI DGE RHC 992, 059 0 544, 863 0 88.04 09000 CLINIC 90.00 1, 416, 506 664.773 0 90.00 90.01 09001 PAIN CLINIC 0 24, 204 103, 254 26 90.01 90.02 09002 SPECIALTY CLINIC 0 90.02 09003 SURGICAL CLINIC 0 356, 257 90.03 90.03 161, 366 262 09004 GENESEO CLINIC 0 90.04 Λ 90.04 91.00 09100 EMERGENCY 4, 527, 477 4, 527, 477 0 3, 379, 395 9, 235 91.00 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99.10 99. 10 09910 CORF 0 Ω 101.00 10100 HOME HEALTH AGENCY 861,058 940, 980 1, 127 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1 through 117) 96, 991, 359 -4, 134, 502 118.00 114, 973, 628 40, 047, 897 100, 334 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CAN 16, 478 988 190. 00 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 0 0 192.00 C 192. 01 19203 MUSCATINE CLINIC 0 0 0 3, 101 0 192.01 192. 02 19201 CARDI OLOGY CLINI C 0 0 0 192.02 192. 03 19202 LEASED SPACE 0 0 595 894 775 192. 03 C 0 0 192. 04 19204 ANNAWAN CLINIC C 0 192.04

0

0

556, 584

735, 133

0 192.05

0 192.06

192. 05 19205 CAMBRIDGE CLINIC

192.06 19206 PORT BYRON CLINIC

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

In Lieu of Form CMS-2552-10

Provider CCN: 14-1319

						10/24/2023 5:	18 pm_
	Cost Center Description	ADMITTI NG	CASHI ERI NG/AC	Reconciliatio	ALL OTHER	OPERATION OF	
		(GROSS CHAR	COUNTS	n	ADMI NI STRATI V	PLANT	
		GES)	RECEI VABLE		E AND GE	(SQUARE FEET)	
			(GROSS CHAR		(ACCUM. COST)		
			GES)				
		5. 03	5. 04	5A. 05	5. 05	7. 00	
192. 07 19207	ORION CLINIC	0	386, 025	0	419, 352	0	192. 07
194. 00 07955	FOUNDATI ON	0	0	0	15, 562	397	194.00
194. 01 07950	SPORTS MEDICINE	0	0	0	261, 856	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	-43, 198	0	0	194. 06
194. 07 07957	COMMUNITY HEALTH	0	0	0	18, 692	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,	385, 886	1, 165, 054		4, 134, 502	1, 788, 287	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 003979	0. 010035		0. 098592	17. 447724	203.00
204.00	Cost to be allocated (per Wkst. B,	29, 170	38, 702		114, 711	156, 593	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000301	0. 000333		0. 002735	1. 527826	205.00
	11)						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

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Health Financial Systems

Health Financial Systems

In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1319 | Period: | Worksheet B-1

From 06/01/2022

05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG LINEN SERVICE ADMI NI STRATI O (HOURS OF (MEALS (FTES) (POUNDS OF SERVICE) SERVED) Ν LAUNDRY) (FTES) 9.00 10.00 11.00 8.00 13.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00550 DATA PROCESSING 5.01 5.01 5.02 00560 PURCHASING RECEIVING AND STORES 5.02 00570 ADMITTING 5.03 5.03 5.04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.04 5.05 00590 ALL OTHER ADMINISTRATIVE AND GE 5 05 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 197 978 8.00 8 00 9.00 00900 HOUSEKEEPI NG 26, 557 411, 960 9.00 10.00 01000 DI ETARY 470 13, 425 137, 136 10.00 01100 CAFETERI A 2, 400 21, 197 11.00 0 90, 368 11.00 01300 NURSING ADMINISTRATION 9, 797 13.00 0 0 743 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 0 15.00 01500 PHARMACY 0 1, 535 0 552 552 15.00 01600 MEDICAL RECORDS & LIBRARY 0 0 16,00 1.000 1, 113 Ω 16,00 17.00 01700 SOCIAL SERVICE 0 1,050 0 203 203 17.00 01080 INSERVICE EDUCATION 18.00 0 0 0 18.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 27,819 82, 700 8,012 2, 315 2, 315 30.00 43.00 04300 NURSERY 0 43.00 44.00 04400 SKILLED NURSING FACILITY 49, 694 104,650 38, 756 2,748 0 44.00 46.00 04600 OTHER LONG TERM CARE 46 00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 23, 503 76, 45C 1, 669 50.00 0 1, 669 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 52.00 05300 ANESTHESI OLOGY 0 53.00  $\cap$ Λ 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 20,018 18, 325 1.644 1,644 54.00 06000 LABORATORY 60.00 18, 525 0 1,737 1,737 60.00 0 62 00 06200 WHOLE BLOOD & PACKED RED BLOOD 0 62 00 0 0 0 0 06400 I NTRAVENOUS THERAPY 64.00 0 0 64.00 06600 PHYSI CAL THERAPY 12, 775 2, 340 66.00 16.364 0 66.00 06700 OCCUPATI ONAL THERAPY 67.00 2,300 517 0 67.00 06800 SPEECH PATHOLOGY 0 68 00 0 184 68 00 0 0 69.00 06900 ELECTROCARDI OLOGY 0 3,600 350 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 0 71.00 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 C 0 ol 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73 00 0 C 0 0 73 00 76.00 03020 ACUPUNCTURE 0 76.00 76.01 03610 SLEEP LAB 2, 378 500 0 157 157 76.01 03950 IV THERAPY 0 76.02 76.02 0 0 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 KEWANEE RHC 0 0 0 88.00 88.01 08801 WYOMI NG RHC 0 88 01 0 08802 GENESEO RHC 88.02 88.02 530 18, 325 0 2, 326 0 88 03 08803 ANNAWAN RHC 0 0 88 03 08804 CAMBRIDGE RHC 0 88.04 88.04 0 90.00 09000 CLI NI C 0 C 0 0 O 90.00 09001 PAIN CLINIC 0 90.01 C 86 86 90.01 90.02 09002 SPECIALTY CLINIC 0 0 0 0 90.02 90 03 09003 SURGICAL CLINIC 0 3, 825 0 472 O 90 03 09004 GENESEO CLINIC 0 90.04 90.04 0 0 91.00 09100 EMERGENCY 29.866 28, 450 O 1, 434 1, 434 91.00 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 OTHER REIMBURSABLE COST CENTERS 99.10 09910 CORF 0 0 0 99.10 101.00 10100 HOME HEALTH AGENCY 1, 200 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 197, 978 391, 035 137, 136 20, 590 9, 797 118. 00 118.00 NONREIMBURSABLE COST CENTERS 0 190. 00 190.00 19000 GIFT FLOWER COFFEE SHOP & CAN C 192. 00 19200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 192.00 192. 01 19203 MUSCATINE CLINIC 0 0 192.01 0 C 192. 02 19201 CARDI OLOGY CLINIC 0 0 0 0 192.02 0 192.03 19202 LEASED SPACE 0 192.03 12, 375 0 192. 04 19204 ANNAWAN CLINIC 0 0 192.04 0 0 0 192. 05 19205 CAMBRI DGE CLINI C C 0 0 192.05 192.06 19206 PORT BYRON CLINIC 0 192.06 192.07 19207 ORION CLINIC 0 0 192.07

Heal th Financial Systems STATE COPY

From 06/01/2022 05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm HOUSEKEEPI NG Cost Center Description LAUNDRY & DI ETARY CAFETERI A NURSI NG LINEN SERVICE (HOURS OF (MEALS (FTES) ADMI NI STRATI O (POUNDS OF SERVICE) SERVED) Ν LAUNDRY) (FTES) 9.00 10.00 11.00 8.00 13.00 194. 00 07955 FOUNDATI ON 179 0 194. 00 0 0 0 0 0 194. 01 07950 SPORTS MEDICINE 0 0 0 194.01 0 194.02 194. 02 07951 KELLY MEDICAL RENTAL AREA 0 0 0 194. 03 07952 ANESTHESIA BILLNG 0 0 0 194. 03 0 194. 04 07953 SPECIALTY CLINIC 0 194.04 194. 05 07954 COLONA CLINIC 0 0 0 194. 05 194. 06 07956 TRINITY/DIALYSIS LEASED SPACE 0 0 194.06 8,550 0 194. 07 07957 COMMUNI TY HEALTH 0 11 0 194. 07 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, 202.00 157, 800 833, 246 1, 398, 649 1, 013, 001 296, 883 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0. 797058 2. 022638 10. 198992 47. 789829 30. 303460 203. 00 204.00 Cost to be allocated (per Wkst. B, 15, 160 204. 00 75,890 93.035 14,603 31, 647 Part II)

0.073761

0.076821

0.553392

4. 389064

1. 547412 205. 00

206.00

207.00

205.00

206.00

207.00

II)

(per Wkst. B-2)

Parts III and IV)

Unit cost multiplier (Wkst. B, Part

NAHE unit cost multiplier (Wkst. D,

NAHE adjustment amount to be allocated

In Lieu of Form CMS-2552-10

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1319 Peri od: From 06/01/2022 To 05/31/2023 Worksheet B-1 Date/Ti me Prepared: 10/24/2023 5:18 pm OTHER GENERAL SERVI CE

(COSTED REQ UIS)         (GROSS PT. CHARGES)         GES)           14.00         15.00         16.00         17.00         18.00	
14.00   15.00   16.00   17.00   18.00   GENERAL SERVICE COST CENTERS	
1. 00	1.00 2.00 4.00 5.01 5.02 5.03 5.04 5.05 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00 18.00
INPATIENT ROUTINE SERVICE COST CENTERS   30.00   03000   ADULTS & PEDIATRICS   0   0   3,010,389   63,325   3,010,389	30. 00
43. 00   04300   NURSERY   0   0   0   0	43.00
44.00   04400   SKI LLED NURSI NG FACI LI TY	44. 00 46. 00
ANCILLARY SERVICE COST CENTERS	40.00
50. 00   05000   OPERATI NG ROOM	50.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	52. 00 53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 25, 890, 532 0 25, 890, 532	54.00
60. 00   06000   LABORATORY   0   0   25, 489, 520   0   25, 489, 520   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD   0   171, 333   0   171, 333	60.00
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD   0   171, 333   0   171, 333   64. 00   06400   I NTRAVENOUS THERAPY   0   0   0   0   0   0	62. 00 64. 00
66. 00   06600   PHYSI CAL THERAPY	
67. 00   06700   0CCUPATI ONAL THERAPY   0   0   2, 321, 895   0   2, 321, 895   0   2, 321, 895	67.00
68. 00   06800   SPEECH PATHOLOGY   0   466, 123   0   466, 123   69. 00   06900   ELECTROCARDI OLOGY   0   0   4, 682, 425   0   4, 682, 425   0   4, 682, 425   0   6, 682,	
71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PAT 100 0 370, 438 0 370, 438	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 587, 932 0 587, 932	72.00
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   100   5, 290, 955   0   5, 290, 955   76. 00   03020   ACUPUNCTURE   0   0   0   0   0   0   0   0   0	73. 00 76. 00
76. 01   03610   SLEEP LAB   0   890, 053   0   890, 053	
76. 02 03950 I V THERAPY 0 0 0 0 0	76. 02
OUTPATIENT SERVICE COST CENTERS   0   08800   KEWANEE RHC   0   5,695,426   0   5,695,426	88 00
88. 01   08801   WYOMI NG RHC   0   0   0   0	88. 01
88. 02   08802   GENESEO RHC   0   4, 725, 333   0   4, 725, 335   0   4, 725, 335   0   4, 725, 335   0   4, 725, 335   0   4, 725, 335   0   4, 725, 335	88. 02
88. 03   08803   ANNAWAN RHC   0   0   1, 085, 886   0   1, 085, 886   88. 04   08804   CAMBRI DGE RHC   0   0   992, 059   0   992, 059	
90. 00   09000   CLI NI C   0   1, 416, 506   0   1, 416, 506	
90. 01   09001   PAI N CLI NI C   0   24, 204   0   24, 204   90. 02   09002   SPECI ALTY CLI NI C   0   0   0   0   0   0   0   0   0	
90. 02   09002   SPECI ALTY CLINI C	90. 02 90. 03
90. 04   09004   GENESEO CLINIC   0   0   0   0	90. 04
91. 00   09100   EMERGENCY   0   0   4, 527, 477   3, 483   4, 527, 477   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT	91. 00 92. 00
OTHER REI MBURSABLE COST CENTERS	72.00
	99. 10
101. 00   10100   HOME   HEALTH AGENCY   0   0   0   0   0   0   0   0   0	101. 00
113. 00 11300   I NTEREST EXPENSE	113. 00
118.00   SUBTOTALS (SUM OF LINES 1 through 117)   100   100   111, 397, 626   89, 665   114, 112, 570	118. 00
NONREI MBURSABLE COST CENTERS   190. 00   19000   GI FT   FLOWER COFFEE SHOP & CAN   O   O   O   O   O   O   O   O   O	190. 00
192.00 PHYSICIANS PRIVATE OFFICES 0 0 0 0	192. 00
	192. 01 192. 02
	192. 02 192. 03
	192. 04

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

In Lieu of Form CMS-2552-10

Peri od: From 06/01/2022 To 05/31/2023 Date/Time Prepared: 10/24/2023 5: 18 pm Provider CCN: 14-1319

						10/24/2023 5:	18 pm
						OTHER GENERAL	
						SERVI CE	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	I NSERVI CE	
		SERVICES &	(COSTED REQ	RECORDS &	SERVI CE	EDUCATI ON	
		SUPPLY	UIS)	LI BRARY	(TIME SPENT)	(GROSS CHAR	
		(COSTED REQ	010)	(GROSS PT.	(TIME SIENT)	GES)	
		UIS)		CHARGES)		UL3)	
		14. 00	15. 00	16. 00	17. 00	18. 00	
192. 05 19205	CAMBRIDGE CLINIC	0	0	0	0	0	192.05
192, 06 19206	PORT BYRON CLINIC	0	0	735, 133	0	735, 133	192.06
192, 07 19207	ORION CLINIC	0	0	386, 025	0	386, 025	192. 07
194. 00 07955	FOUNDATI ON	0	0	0	0	0	194.00
194. 01 07950	SPORTS MEDICINE	0	0	0	0	0	194. 01
	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,	89, 896	996, 245	1, 185, 623	193, 106	3, 020	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	898. 960000	9, 962. 450000	0. 010537	2. 153639	0. 000026	203. 00
204. 00	Cost to be allocated (per Wkst. B,	1, 636	61, 032	52, 541	3, 776	865	204.00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	16. 360000	610. 320000	0. 000467	0. 042112	0. 000008	205. 00
	[11]						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

In Lieu of Form CMS-2552-10

Peri od: Worksheet C From 06/01/2022 To 05/31/2023 Date/Time Prepared: 10/24/2023 5: 18 pm Provi der CCN: 14-1319

						10/24/2023 5:	18 pm
			Title	: XVIII	Hospi tal	Cost	
					Costs	<u> </u>	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	cost center bescription			Total Costs		l lutai custs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	3, 812, 971		3, 812, 971	0	3, 812, 971	30.00
					-		
43.00	04300 NURSERY	0		0	-	0	
44.00	04400 SKILLED NURSING FACILITY	3, 776, 106		3, 776, 106		3, 776, 106	
46.00	04600 OTHER LONG TERM CARE	0		0	0	0	46. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	4, 629, 345		4, 629, 345	0	4, 629, 345	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1,7521,7510		0		0	52.00
53. 00	05300 ANESTHESI OLOGY			0		0	
		4 450 475		1	_		
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 452, 675		4, 452, 675		4, 452, 675	
60.00	06000 LABORATORY	4, 065, 112		4, 065, 112	0	4, 065, 112	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD	92, 870		92, 870	0	92, 870	62.00
64.00	06400 I NTRAVENOUS THERAPY	0		l 0	0	0	64.00
66. 00	06600 PHYSI CAL THERAPY	3, 288, 596	0	3, 288, 596	0	3, 288, 596	
67. 00	06700 OCCUPATI ONAL THERAPY	723, 031			0	723, 031	67.00
68. 00	06800 SPEECH PATHOLOGY	246, 609		246, 609	0	· ·	
						246, 609	
69. 00	06900 ELECTROCARDI OLOGY	768, 364		768, 364		768, 364	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	99, 512		99, 512		99, 512	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	685, 700		685, 700	0	685, 700	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 480, 408		2, 480, 408	0	2, 480, 408	73.00
76.00	03020 ACUPUNCTURE	0		l 0	0	0	76. 00
76. 01	03610 SLEEP LAB	277, 564		277, 564	0	277, 564	
76. 02	03950 I V THERAPY	0		0		0	
70.02	OUTPATIENT SERVICE COST CENTERS						70.02
88. 00		2 221 747		2 221 747		2 221 747	00 00
	08800 KEWANEE RHC	3, 221, 747		3, 221, 747		3, 221, 747	88.00
88. 01	08801 WYOMI NG RHC	0		0	-	0	88. 01
88. 02	08802 GENESEO RHC	3, 439, 255		3, 439, 255		3, 439, 255	
88. 03	08803 ANNAWAN RHC	733, 598		733, 598	0	733, 598	88. 03
88. 04	08804 CAMBRI DGE RHC	609, 061		609, 061	0	609, 061	88. 04
90.00	09000 CLI NI C	745, 277		745, 277	0	745, 277	90.00
90. 01	09001 PAIN CLINIC	121, 481		121, 481	0	121, 481	90. 01
90. 02	09002 SPECIALTY CLINIC	12.7.01		0	0	0	1
90. 02	09003 SURGI CAL CLI NI C	427.050		-	0		
		427, 950		427, 950		427, 950	
90. 04	09004 GENESEO CLINIC	0		0	0	0	90.04
91.00	09100 EMERGENCY	4, 122, 366		4, 122, 366		4, 122, 366	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	1, 175, 224		1, 175, 224		1, 175, 224	92.00
	OTHER REIMBURSABLE COST CENTERS						
99. 10	09910 CORF	0		0		0	99. 10
	10100 HOME HEALTH AGENCY	1, 055, 844		1, 055, 844		1, 055, 844	101 00
101.00	SPECIAL PURPOSE COST CENTERS	1,000,011		1,000,011		1,000,011	101.00
112 00	11300 I NTEREST EXPENSE						113.00
		45 050 ///		45 050 ///		45 050 ///	
200.00		45, 050, 666				45, 050, 666	
201.00		1, 175, 224		1, 175, 224		1, 175, 224	
202.00	Total (see instructions)	43, 875, 442	0	43, 875, 442	0	43, 875, 442	J202. 00

In Lieu of Form CMS-2552-10

Peri od: Worksheet C
From 06/01/2022 Part I
To 05/31/2023 Date/Time Prepared: 10/24/2023 5: 18 pm Provi der CCN: 14-1319

				20011		10/24/2023 5:	18 piii
				e XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Rati o	I npati ent	
						Ratio	
		6. 00	7. 00	8.00	9. 00	10.00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS			•			
	O ADULTS & PEDIATRICS	2, 056, 304		2, 056, 304			30.00
	O NURSERY	0		1 0	1		43.00
	O SKILLED NURSING FACILITY	3, 020, 431		3, 020, 431	1		44.00
	O OTHER LONG TERM CARE	0,020,431		3, 020, 431			46.00
	LLARY SERVICE COST CENTERS	l o					40.00
	O OPERATING ROOM	1, 794, 304	12, 902, 967	14, 697, 271	0. 314980	0. 000000	50.00
	O DELIVERY ROOM & LABOR ROOM	1, 794, 304		1	1		52.00
		0	0	0		0.000000	1
	O ANESTHESI OLOGY	204 044	05 504 504	05 000 500	0.000000	0.000000	53.00
	O RADI OLOGY-DI AGNOSTI C	304, 011	25, 586, 521			0. 000000	54.00
	0 LABORATORY	877, 234	24, 612, 286			0. 000000	60.00
	O WHOLE BLOOD & PACKED RED BLOOD	34, 716	136, 617			0. 000000	62.00
64.00 0640	O I NTRAVENOUS THERAPY	0	0	1		0.000000	64.00
	O PHYSI CAL THERAPY	730, 075	7, 864, 942	8, 595, 017	0. 382617	0.000000	66.00
67.00 0670	O OCCUPATI ONAL THERAPY	486, 743	1, 835, 152	2, 321, 895	0. 311397	0.000000	67.00
68.00 0680	O SPEECH PATHOLOGY	32, 239	433, 884	466, 123	0. 529064	0.000000	68. 00
69.00 0690	O ELECTROCARDI OLOGY	371, 883	4, 310, 542	4, 682, 425	0. 164095	0.000000	69.00
71.00 0710	O MEDICAL SUPPLIES CHARGED TO PAT	231, 627	138, 811			0.000000	71.00
	O IMPL. DEV. CHARGED TO PATIENTS	57, 824	530, 108			0.000000	
•	O DRUGS CHARGED TO PATIENTS	1, 227, 368	4, 063, 587	1		0. 000000	1
	O ACUPUNCTURE	1,22,,000	0	1		0. 000000	1
	O SLEEP LAB	0	890, 053	1		0. 000000	
	O I V THERAPY		0,0,033	1	1	0. 000000	1
	ATIENT SERVICE COST CENTERS	l o		1	0.000000	0.000000	70.02
	O KEWANEE RHC	0	5, 695, 426	5, 695, 426			88. 00
	1 WYOMI NG RHC	0	5, 695, 426	1	1		88. 01
	2 GENESEO RHC	0	-	1			
		0	4, 725, 333				88. 02
	3 ANNAWAN RHC	0	1, 085, 886				88. 03
	4 CAMBRI DGE RHC	0	992, 059	1			88. 04
	O CLI NI C	300	1, 416, 206			0. 000000	1
	1 PAIN CLINIC	0	24, 204	24, 204		0. 000000	
	2 SPECIALTY CLINIC	0	0	0	0.00000	0.000000	90. 02
	3 SURGI CAL CLINI C	0	161, 366	161, 366		0.000000	90. 03
90.04 0900	4 GENESEO CLINIC	0	0	0	0.000000	0.000000	90.04
91.00 0910	O EMERGENCY	3, 000	4, 524, 477	4, 527, 477	0. 910522	0.000000	91.00
92.00 0920	O OBSERVATION BEDS (NON-DISTINCT	113, 254	840, 831		1. 231781	0.000000	92.00
	R REIMBURSABLE COST CENTERS		·		'		İ
	O CORF	0	0	0			99. 10
	O HOME HEALTH AGENCY	o	861, 058		1		101.00
	I AL PURPOSE COST CENTERS	<u> </u>	331, 030	331,000	1		1.51.55
	O INTEREST EXPENSE						113.00
200. 00	Subtotal (see instructions)	11, 341, 313	103, 632, 316	114, 973, 629			200.00
201.00	Less Observation Beds	11, 341, 313	103, 032, 310	114, 9/3, 029			200.00
•	l e	11 241 212	100 (00 01/	114 072 / 20			201.00
202. 00	Total (see instructions)	11, 341, 313	103, 632, 316	114, 973, 629	η		ZUZ. UU

In Lieu of Form CMS-2552-10 Provider CCN: 14-1319

Worksheet C Part I Date/Time Prepared: 10/24/2023 5:18 pm Peri od: From 06/01/2022 To 05/31/2023 Title XVIII Hospi tal Cost

			II LIE AVIII	nospi tai	0031
	Cost Center Description	PPS Inpatient			
	<b>'</b>	Ratio			
		11. 00			
	DATI FUT DOUTLING OFFICE OF COOT OFFITEDO	11.00			
	IPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03	3000 ADULTS & PEDIATRICS				30.
43.00 04	1300 NURSERY				43.
	1400 SKILLED NURSING FACILITY				44.
					•
	600 OTHER LONG TERM CARE				46.
	ICILLARY SERVICE COST CENTERS				
50.00 05	5000 OPERATING ROOM	0. 314980			50.
52. 00   05	5200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.
	5300 ANESTHESI OLOGY	0. 000000			53.
	l e				
	7400 RADI OLOGY-DI AGNOSTI C	0. 171981			54.
60.00 06	5000 LABORATORY	0. 159482			60.
62.00 06	5200 WHOLE BLOOD & PACKED RED BLOOD	0. 542044			62.
1	5400 INTRAVENOUS THERAPY	0. 000000			64.
	6600 PHYSI CAL THERAPY	0. 382617			66.
					•
	5700 OCCUPATI ONAL THERAPY	0. 311397			67.
68.00 06	800 SPEECH PATHOLOGY	0. 529064			68.
69.00 06	5900 ELECTROCARDI OLOGY	0. 164095			69.
	7100 MEDICAL SUPPLIES CHARGED TO PAT	0. 268633			71.
	7200 IMPL. DEV. CHARGED TO PATIENTS				72.
		1. 166291			
	7300 DRUGS CHARGED TO PATIENTS	0. 468802			73.
76. 00   03	3020 ACUPUNCTURE	0. 000000			76.
76. 01 03	3610 SLEEP LAB	0. 311851			76.
	3950 IV THERAPY	0. 000000			76.
		0.000000			70.
	ITPATIENT SERVICE COST CENTERS				
	8800 KEWANEE RHC				88.
88. 01 08	3801 WYOMI NG RHC				88.
88. 02   08	8802 GENESEO RHC				88.
	3803 ANNAWAN RHC				88.
	8804 CAMBRI DGE RHC				88.
	POOO CLINIC	0. 526138			90.
90. 01   09	POO1 PAIN CLINIC	5. 019046			90.
90. 02 09	POO2 SPECIALTY CLINIC	0. 000000			90.
	2003 SURGI CAL CLI NI C	2. 652046			90.
					90.
	2004 GENESEO CLINIC	0. 000000			•
	P100 EMERGENCY	0. 910522			91.
92.00 09	9200 OBSERVATION BEDS (NON-DISTINCT	1. 231781			92.
	THER REIMBURSABLE COST CENTERS	,			
99. 10 09					99.
	0100 HOME HEALTH AGENCY				101.
	PECIAL PURPOSE COST CENTERS				
	300 INTEREST EXPENSE				113.
200.00	Subtotal (see instructions)	1			200.
201.00	Less Observation Beds				201.
	·				
202. 00	Total (see instructions)				202.

In Lieu of Form CMS-2552-10

Worksheet C
Part I
Date/Time Prepared:
10/24/2023 5:18 pm Provider CCN: 14-1319 Peri od: From 06/01/2022 To 05/31/2023

						10/24/2023 3.	то ріп
			l litl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Contor Doscription	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	Cost Center Description			TOTAL COSTS		TOTAL COSTS	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col . 26)					
		1.00	2.00	3.00	4. 00	5. 00	
		1.00	2.00	3.00	4.00	3.00	
	ATIENT ROUTINE SERVICE COST CENTERS						
30.00 0300	00 ADULTS & PEDIATRICS	3, 812, 971		3, 812, 971	0	3, 812, 971	30.00
	00 NURSERY	0		0		0	
		_	l				
	00 SKILLED NURSING FACILITY	3, 776, 106	ľ	3, 776, 106		3, 776, 106	
46.00 0460	OO OTHER LONG TERM CARE	0		0	0	0	46.00
ANCI	ILLARY SERVICE COST CENTERS						1
	OO OPERATING ROOM	4, 629, 345		4, 629, 345	0	4, 629, 345	50.00
		4,027,343		4,027,343	0		
	00 DELIVERY ROOM & LABOR ROOM	0		0	U	0	52.00
53.00 0530	00 ANESTHESI OLOGY	0		0	0	0	53.00
54. 00 0540	00 RADI OLOGY-DI AGNOSTI C	4, 452, 675		4, 452, 675	0	4, 452, 675	54.00
	00 LABORATORY	4, 065, 112		4, 065, 112		4, 065, 112	
			ł				
	00 WHOLE BLOOD & PACKED RED BLOOD	92, 870		92, 870	0	92, 870	
64.00 0640	OO INTRAVENOUS THERAPY	0		0	0	0	64.00
66. 00 0660	00 PHYSI CAL THERAPY	3, 288, 596	0	3, 288, 596	0	3, 288, 596	66.00
	OO OCCUPATI ONAL THERAPY		0		0		
		723, 031	1	. = = , = = .		723, 031	
	00 SPEECH PATHOLOGY	246, 609	0	246, 609	0	246, 609	68. 00
69.00 0690	OO ELECTROCARDI OLOGY	768, 364		768, 364	0	768, 364	69.00
71. 00 0710	00 MEDICAL SUPPLIES CHARGED TO PAT	99, 512		99, 512		99, 512	71.00
	00 IMPL. DEV. CHARGED TO PATIENTS	685, 700					
				685, 700		685, 700	
	00 DRUGS CHARGED TO PATIENTS	2, 480, 408		2, 480, 408	0	2, 480, 408	
76.00 0302	20 ACUPUNCTURE	0		0	0	0	76.00
76. 01 036°	10 SLEEP LAB	277, 564		277, 564	0	277, 564	76. 01
	50 I V THERAPY	277,001		0		0	
					U	U	70.02
	PATIENT SERVICE COST CENTERS						
88.00 0880	OO KEWANEE RHC	3, 221, 747		3, 221, 747	0	3, 221, 747	88. 00
88. 01 0880	01 WYOMI NG RHC	0		0	0	0	88. 01
	02 GENESEO RHC		l		_	_	
		3, 439, 255		3, 439, 255		3, 439, 255	
88. 03   0880	O3 ANNAWAN RHC	733, 598		733, 598	0	733, 598	88. 03
88. 04 0880	04 CAMBRI DGE RHC	609, 061		609, 061	0	609, 061	88. 04
90.00 0900	OO CLI NI C	745, 277		745, 277	0	745, 277	90.00
	01 PAIN CLINIC			121, 481		121, 481	
		121, 481					
	02 SPECIALTY CLINIC	0	l	0	-	0	
90.03 0900	03 SURGI CAL CLINI C	427, 950		427, 950	0	427, 950	90. 03
90. 04 0900	04 GENESEO CLINIC	1 0		l o	0	0	90.04
	OO EMERGENCY	4, 122, 366		4, 122, 366	0	4, 122, 366	
	OO OBSERVATION BEDS (NON-DISTINCT	1, 175, 224		1, 175, 224		1, 175, 224	92.00
OTHE	ER REIMBURSABLE COST CENTERS						
99. 10 099°	10 CORF	0		0		0	99. 10
101 00 1010	OO HOME HEALTH AGENCY	1, 055, 844	l .	1, 055, 844		1, 055, 844	
		1,000,644		1,000,844		1, 000, 644	1101.00
	CLAL PURPOSE COST CENTERS						1
113. 00 1130	00 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	45, 050, 666	0	45, 050, 666	0	45, 050, 666	200.00
201.00	Less Observation Beds	1, 175, 224	l e	1, 175, 224		1, 175, 224	
202.00	Total (see instructions)	43, 875, 442	0	43, 875, 442	0	43, 875, 442	1202.00

In Lieu of Form CMS-2552-10

Peri od: | Worksheet C From 06/01/2022 | Part I To 05/31/2023 | Date/Time Prepared: | 10/24/2023 5: 18 pm | Hospi tal | Cost Provider CCN: 14-1319 Title XIX

			Ti tl	e XIX	Hospi tal	Cost	
	Charges						
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	•	'	•	+ col . 7)	Ratio	I npati ent	
				,		Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
30.00	03000 ADULTS & PEDI ATRI CS	2, 056, 304		2, 056, 304			30.00
43.00	04300 NURSERY	2,000,001		0			43.00
44. 00	04400 SKILLED NURSING FACILITY	3, 020, 431		3, 020, 431			44.00
46. 00	04600 OTHER LONG TERM CARE	0,020,101		0,020,101			46.00
40.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>			l l		40.00
50.00	05000 OPERATING ROOM	1, 794, 304	12, 902, 967	14, 697, 271	0. 314980	0. 000000	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 7,4, 304	12, 702, 707			0. 000000	
53. 00	05300 ANESTHESI OLOGY		0			0.000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	304, 011	25, 586, 521	-		0.000000	
	06000 LABORATORY	1					
60.00		877, 234	24, 612, 286			0.000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD	34, 716	136, 617			0. 000000	
64. 00	06400 I NTRAVENOUS THERAPY	0	0	_		0. 000000	64.00
66.00	06600 PHYSI CAL THERAPY	730, 075	7, 864, 942			0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	486, 743	1, 835, 152			0.000000	
68.00	06800 SPEECH PATHOLOGY	32, 239	433, 884			0.000000	
69. 00	06900 ELECTROCARDI OLOGY	371, 883	4, 310, 542			0.000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	231, 627	138, 811	370, 438		0.000000	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	57, 824	530, 108	587, 932	1. 166291	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 227, 368	4, 063, 587	5, 290, 955		0.000000	73.00
76.00	03020 ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76. 01	03610 SLEEP LAB	0	890, 053	890, 053	0. 311851	0.000000	76. 01
76.02	03950 I V THERAPY	o	0		0. 000000	0.000000	76. 02
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 KEWANEE RHC	0	5, 695, 426	5, 695, 426	0. 565673	0.000000	88. 00
88. 01	08801 WYOMI NG RHC	o	0	0	0. 000000	0.000000	88. 01
88. 02	08802 GENESEO RHC	l ol	4, 725, 333	4, 725, 333	0. 727833	0.000000	88. 02
88. 03	08803 ANNAWAN RHC	l ol	1, 085, 886			0.000000	88. 03
88. 04	08804 CAMBRI DGE RHC	0	992, 059			0.000000	
90.00	09000 CLI NI C	300	1, 416, 206			0. 000000	90.00
90. 01	09001 PAIN CLINIC	0	24, 204			0. 000000	
90. 02	09002 SPECIALTY CLINIC		2.,20.			0. 000000	90. 02
90. 03	09003 SURGI CAL CLI NI C		161, 366	1		0. 000000	
90. 04	09004 GENESEO CLINIC		101, 000	0 101,000		0. 000000	90.04
91. 00	09100 EMERGENCY	3,000	4, 524, 477			0.000000	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT	113, 254	840, 831	954, 085		0. 000000	92.00
72.00	OTHER REIMBURSABLE COST CENTERS	113, 234	040, 031	754,005	1. 231701	0.000000	92.00
99. 10	09910 CORF			0			00 10
		0	0(1.050				99. 10
101.00	10100 HOME HEALTH AGENCY	0	861, 058	861, 058			101. 00
110 00	SPECIAL PURPOSE COST CENTERS						112 00
	11300 INTEREST EXPENSE	44 044 040	400 (00 01)	444 070 100			113.00
200.00		11, 341, 313	103, 632, 316	114, 973, 629			200.00
201.00			400				201.00
202.00	Total (see instructions)	11, 341, 313	103, 632, 316	114, 973, 629			202. 00

In Lieu of Form CMS-2552-10

Provider CCN: 14-1319

Peri od: Worksheet C
From 06/01/2022 Part I
To 05/31/2023 Date/Time Prepared: 10/24/2023 5: 18 pm

				10/24/2023 5: 18 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000 ADULTS & PEDIATRICS				30. (
43. 00   04300 NURSERY				43.0
44.00 04400 SKILLED NURSING FACILITY				44.0
46.00   04600 OTHER LONG TERM CARE				46.0
ANCI LLARY SERVI CE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 000000			50.0
52. 00   05200   DELIVERY ROOM & LABOR ROOM	0. 000000			52.0
53. 00   05300   ANESTHESI OLOGY	0. 000000			53.0
1	1			
54. 00   05400   RADI OLOGY - DI AGNOSTI C	0. 000000			54. (
60. 00   06000   LABORATORY	0. 000000			60.0
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD	0. 000000			62.0
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64.0
66. 00  06600 PHYSI CAL THERAPY	0. 000000			66.0
67. 00  06700 OCCUPATI ONAL THERAPY	0. 000000			67.0
68. 00   06800   SPEECH PATHOLOGY	0. 000000			68.0
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. (
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 000000			71. (
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.0
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. (
76. 00   03020   ACUPUNCTURE	0. 000000			76.0
76. 01   03610   SLEEP LAB	0. 000000			76.0
76. 02 03950 I V THERAPY	0. 000000			76.0
OUTPATIENT SERVICE COST CENTERS	0: 000000			70.0
88. 00   08800   KEWANEE RHC	0. 000000			88.0
88. 01   08801   WYOMI NG RHC	1			•
	0. 000000			88. (
88. 02   08802   GENESEO   RHC	0. 000000			88. (
88. 03   08803   ANNAWAN RHC	0. 000000			88.0
88. 04   08804   CAMBRI DGE RHC	0. 000000			88.0
90. 00   09000   CLI NI C	0. 000000			90.0
90. 01  09001  PAIN CLINIC	0. 000000			90.0
90. 02  09002   SPECIALTY CLINIC	0. 000000			90.0
90. 03   09003   SURGI CAL CLI NI C	0. 000000			90.0
90. 04   09004   GENESEO CLI NI C	0. 000000			90.0
91. 00 09100 EMERGENCY	0. 000000			91.0
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	0. 000000			92.0
OTHER REIMBURSABLE COST CENTERS				
99. 10 09910 CORF				99
101.00 10100 HOME HEALTH AGENCY				101.0
SPECIAL PURPOSE COST CENTERS				101.0
113. 00 11300 INTEREST EXPENSE	1			113. (
				200.0
200.00 Subtotal (see instructions)				
201.00 Less Observation Beds				201. (
202.00 Total (see instructions)	I I			202.0

Health Financial Systems

In Lieu of Form CMS-2552-10 APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provi der CCN: 14-1319 Peri od: Worksheet D

From 06/01/2022

92.00

366

85, 186 200. 00

Part II Date/Time Prepared: 05/31/2023 10/24/2023 5:18 pm Title XVIII Hospi tal Cost Total Charges Capital Costs Cost Center Description Capi tal Ratio of Cost Inpati ent to Charges (column 3 x Related Cost (from Wkst. Program (from Wkst. C, Part I, (col. 1 ÷ Charges column 4) B, Part II, col. 8) col. 2) col. 26) 1. 00 2.00 4.00 5. 00 3.00 ANCILLARY SERVICE COST CENTERS 50 00 1, 041, 951 0.070894 54, 294 50 00 05000 OPERATING ROOM 14, 697, 271 765.841 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 05300 ANESTHESI OLOGY 0.000000 53.00 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 5, 902 591, 451 25, 890, 532 0.022844 258, 381 54.00 54.00 25, 489, 520 60.00 06000 LABORATORY 213, 267 0.008367 497, 965 4, 166 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD 2,070 171, 333 0.012082 15, 478 187 62.00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 64.00 0 8, 595, 017 06600 PHYSI CAL THERAPY 66.00 305, 218 0.035511 125, 675 66.00 4.463 67.00 06700 OCCUPATI ONAL THERAPY 21, 931 2, 321, 895 0.009445 88, 764 838 67.00 68.00 06800 SPEECH PATHOLOGY 5, 811 466, 123 0.012467 10, 969 137 68.00 69.00 06900 ELECTROCARDI OLOGY 151, 307 4, 682, 425 0.032314 201, 304 6,505 69.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 2, 061 370, 438 0.005564 137, 037 71.00 762 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 12, 341 587, 932 0.020991 6, 132 129 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 70, 456 5, 290, 955 0.013316 546, 309 7, 275 73.00 03020 ACUPUNCTURE 76.00 0.000000 76.00 0 0 76.01 03610 SLEEP LAB 17, 153 890,053 0.019272 0 0 76.01 03950 IV THERAPY 0.000000 76.02 0 0 76.02 OUTPATIENT SERVICE COST CENTERS 08800 KEWANEE RHC 88.00 87, 737 5, 695, 426 0.015405 0 0 88.00 88.01 08801 WYOMI NG RHC 0.000000 0 0 88.01 08802 GENESEO RHC 115, 718 0.024489 88.02 4, 725, 333 0 0 0 88.02 88 03 08803 ANNAWAN RHC 98.599 1,085,886 0.090801 Ω 88 03 08804 CAMBRI DGE RHC 88.04 155, 081 992, 059 0.156322 0 88.04 0 90.00 09000 CLI NI C 28, 341 1, 416, 506 0.020008 0 90.00 09001 PAIN CLINIC 0 90.01 3, 929 24, 204 0.162329 0 90.01 o 09002 SPECIALTY CLINIC 90 02 0.000000 90 02 0 90. 03 09003 SURGI CAL CLINI C 0 11, 401 161, 366 0.070653 0 90.03 09004 GENESEO CLINIC 0.000000 0 0 90.04 90.04 91. 00 09100 EMERGENCY 267, 015 4, 527, 477 0.058977 2.742 162 91.00 92.00 |09200 OBSERVATION BEDS (NON-DISTINCT

109, 769

3, 312, 607

954, 085

109, 035, 836

0.115052

3.184

2, 659, 781

200.00

Total (lines 50 through 199)

THROUGH COSTS

In Lieu of Form CMS-2552-10

Period: Worksheet D
From 06/01/2022 Part IV
To 05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm

						10/24/2023 5:	18 pm_
			Ti tl e	: XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	·	Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		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	Ö		0 0	0	
53. 00	05300 ANESTHESI OLOGY	0	Ö		0 0	l o	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	Ö		0 0	l o	1
60.00	06000 LABORATORY	0	Ô		0	l o	1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD	0	Ö		0 0	Ö	
64. 00	06400 I NTRAVENOUS THERAPY	0				0	64.00
66. 00	06600 PHYSI CAL THERAPY	0				0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0				0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0			0	68.00
69.00	06900 ELECTROCARDI OLOGY	0				0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT					0	71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS					0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS				0	0	1
76.00	03020 ACUPUNCTURE	0			0	0	1
	03610 SLEEP LAB	0			0	•	
76. 01 76. 02		0			0	0	
76. 02	03950 I V THERAPY	0	0		0 0	0	76. 02
00 00	OUTPATIENT SERVICE COST CENTERS			I			00.00
88.00	08800 KEWANEE RHC	0	0		0	0	
88. 01	08801 WYOMI NG RHC	0	0		0	0	88. 01
88. 02	08802 GENESEO RHC	0	0		0	0	88. 02
88. 03	08803 ANNAWAN RHC	0	0		0	0	88. 03
88. 04	08804 CAMBRI DGE RHC	0	0		0	0	88. 04
90.00	09000 CLI NI C	0	0		0	0	90.00
90. 01	09001 PAIN CLINIC	0	0		0	0	90. 01
90. 02	09002 SPECIALTY CLINIC	0	0		0	0	90. 02
90. 03	09003 SURGI CAL CLI NI C	0	0		0	0	90. 03
90. 04	09004 GENESEO CLINIC	0	0		0	0	
91. 00	09100 EMERGENCY	0	0		0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0			0	0	
200.00	Total (lines 50 through 199)	0	0	1	0	0	200.00

In Lieu of Form CMS-2552-10

Peri od: Worksheet D
From 06/01/2022 Part IV
To 05/31/2023 Date/Time Prepared: 10/24/2023 5: 18 pm THROUGH COSTS

						10/24/2023 3.	то ріп
				XVIII	Hospi tal	Cost	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	LLARY SERVICE COST CENTERS						1
	O OPERATING ROOM	0	0	(	14, 697, 271	0. 000000	1
	ODELIVERY ROOM & LABOR ROOM	0	0	(	0	0. 000000	1
	O ANESTHESI OLOGY	0	0	(	0	0. 000000	
	O RADI OLOGY-DI AGNOSTI C	0	0	(	25, 890, 532		
60.00 0600	O LABORATORY	0	0	(	25, 489, 520	0.000000	60.00
	O WHOLE BLOOD & PACKED RED BLOOD	0	0	(	171, 333	0.000000	62.00
64.00 0640	O INTRAVENOUS THERAPY	0	0	(	0	0.000000	64.00
66.00 0660	O PHYSI CAL THERAPY	0	0	(	8, 595, 017	0.000000	66.00
67. 00 0670	O OCCUPATIONAL THERAPY	0	0	(	2, 321, 895	0.000000	67.00
68. 00 0680	O SPEECH PATHOLOGY	0	0	(	466, 123	0.000000	68.00
69. 00 0690	O ELECTROCARDI OLOGY	0	0	(	4, 682, 425	0.000000	69.00
71.00 0710	O MEDICAL SUPPLIES CHARGED TO PAT	0	0	(	370, 438	0.000000	71.00
72. 00 0720	OIMPL. DEV. CHARGED TO PATIENTS	0	0	(	587, 932	0.000000	72.00
73. 00 0730	O DRUGS CHARGED TO PATIENTS	0	0	(	5, 290, 955	0.000000	73.00
76. 00 0302	O ACUPUNCTURE	0	0	(	0	0.000000	76.00
76. 01   0361	O SLEEP LAB	0	0	(	890, 053	0.000000	76. 01
76. 02 0395	O I V THERAPY	0	0	(	0	0.000000	76. 02
OUTP	ATIENT SERVICE COST CENTERS						1
88. 00 0880	O KEWANEE RHC	0	0	(	5, 695, 426	0.000000	88. 00
88. 01 0880	1 WYOMI NG RHC	0	0	(	0	0.000000	88. 01
88. 02 0880	2 GENESEO RHC	0	0	(	4, 725, 333	0.000000	88. 02
88. 03 0880	3 ANNAWAN RHC	0	0		1, 085, 886	0.000000	88. 03
88. 04 0880	4 CAMBRI DGE RHC	0	0		992, 059	0.000000	88. 04
90.00 0900	O CLI NI C	0	0		1, 416, 506	0. 000000	90.00
90. 01 0900	1 PAIN CLINIC	0	0		24, 204		90. 01
90. 02 0900	SPECIALTY CLINIC	0	0		0	0. 000000	90. 02
	3 SURGI CAL CLINIC	0	0		161, 366		
	4 GENESEO CLINIC	0	0		0		1
	O EMERGENCY	0	0	1	4, 527, 477		
	O OBSERVATION BEDS (NON-DISTINCT	0	0		954, 085		
200.00	Total (lines 50 through 199)	l 0	1 0				200.00
	(			,	.,,,	I	1-11.00

In Lieu of Form CMS-2552-10

Peri od: Worksheet D
From 06/01/2022 Part IV
To 05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm THROUGH COSTS

						10/24/2023 5:	18 pm_
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷	Ŭ	Costs (col. 8	:	Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS				<u>'</u>		
50.00	05000 OPERATI NG ROOM	0. 000000	765, 841		0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0	l o	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	258, 381		0	0	54.00
60.00	06000 LABORATORY	0. 000000	497, 965		0	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD	0. 000000	15, 478		0	l o	1
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0	i e	0	0	64.00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	125, 675		0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	88, 764		0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	10, 969		0	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	201, 304		0	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 000000	137, 037		0	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	6, 132		0	0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	546, 309		0	0	1
76. 00	03020 ACUPUNCTURE	0. 000000	340, 307 0		0	0	1
76. 01	03610 SLEEP LAB	0. 000000	0			0	76. 01
76. 02	03950 I V THERAPY	0. 000000	0			-	
70.02	OUTPATIENT SERVICE COST CENTERS	0.000000		<u>'</u>	51 0		70.02
88. 00	08800 KEWANEE RHC	0. 000000	0		0	0	88. 00
88. 01	08801 WYOMI NG RHC	0. 000000	0			0	88. 01
88. 02	08802 GENESEO RHC	0. 000000	0		0	Ö	1
88. 03	08803 ANNAWAN RHC	0. 000000	0		0	0	1
88. 04	08804 CAMBRI DGE RHC	0. 000000	0		0	0	88. 04
90.00	09000 CLINIC	0. 000000	0		0	0	90.00
90. 01	09001 PALN CLINIC	0. 000000	0		0	0	90.01
90. 02	09002 SPECIALTY CLINIC	0. 000000	0		) 0	0	90.02
90. 03	09003 SURGI CAL CLI NI C	0. 000000	0			0	90.02
90. 04	09004 GENESEO CLINIC	0. 000000	0		) 0	0	1
91. 00	09100 EMERGENCY	0. 000000	2, 742			0	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0. 000000	3, 184			0	1
200.00		0.000000	2, 659, 781			_	200.00
200.00	1 Total (Titles 30 till ough 177)	1	2,037,701	'	٥	1	1200.00

In Lieu of Form CMS-2552-10

Worksheet D Part V Date/Time Prepared: 10/24/2023 5:18 pm Provi der CCN: 14-1319 Peri od: From 06/01/2022 To 05/31/2023

			Title	: XVIII	Hospi tal	Cost	<u> </u>
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not	(000 111011)	
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.	11130.7		Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
50.00	05000 OPERATING ROOM	0. 314980	0	3, 699, 250	0	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000			0	0	
54. 00		0. 171981		6, 928, 429	0	0	54.00
	05400 RADI OLOGY-DI AGNOSTI C					-	
60.00	06000 LABORATORY	0. 159482		6, 318, 933		0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD	0. 542044		51, 039	0	0	
64.00	06400 I NTRAVENOUS THERAPY	0. 000000		0	0	0	64.00
66.00	06600 PHYSI CAL THERAPY	0. 382617		2, 506, 797		0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 311397		552, 696		0	
68.00	06800 SPEECH PATHOLOGY	0. 529064		104, 794		0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 164095		1, 498, 390	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 268633	0	43, 501	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	1. 166291	0	161, 967	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 468802	0	1, 692, 012	7, 624	0	73.00
76.00	03020 ACUPUNCTURE	0. 000000	0	0	0	0	76.00
76. 01	03610 SLEEP LAB	0. 311851		135, 896	0	0	76. 01
76. 02	03950 I V THERAPY	0. 000000				0	76. 02
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 KEWANEE RHC						88. 00
88. 01	08801 WYOMI NG RHC						88. 01
88. 02	08802 GENESEO RHC						88. 02
88. 03	08803 ANNAWAN RHC						88. 03
88. 04	08804 CAMBRI DGE RHC						88. 04
90.00	09000 CLINIC	0. 526138	0	122, 985	1, 856	0	1
90. 00	09001 PAIN CLINIC	5. 019046		12, 473		0	90.00
90. 01	09002 SPECIALTY CLINIC	0. 000000		12, 4/3		0	90.01
	l l			1	_	_	
90. 03	09003 SURGI CAL CLINI C	2. 652046		31, 159	0	0	90.03
90.04	09004 GENESEO CLINIC	0. 000000		1 275 244	0	0	90.04
91.00	09100 EMERGENCY	0. 910522		1, 075, 966		0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	1. 231781	0	000,200		0	
200.00			0	25, 269, 493	9, 480	0	200.00
201.00				0	0		201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		0	25, 269, 493	9, 480	0	202. 00

In Lieu of Form CMS-2552-10

Provi der CCN: 14-1319

Peri od: From 06/01/2022 To 05/31/2023

Worksheet D Part V Date/Time Prepared: 10/24/2023 5: 18 pm

			Title	: XVIII	Hospi tal	Cost	то р
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Servi ces Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
	ANCILLARY SERVICE COST CENTERS	6. 00	7. 00				
	05000 OPERATING ROOM	1, 165, 190	0				50.00
	05200 DELIVERY ROOM & LABOR ROOM	1, 100, 190	0				52. 00
	05300 ANESTHESI OLOGY	0	0				53.00
	05400 RADI OLOGY-DI AGNOSTI C	1, 191, 558	-				54.00
	06000 LABORATORY	1, 191, 338					60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD	27, 665	0				62.00
	06400 I NTRAVENOUS THERAPY	27,000	0				64.00
	06600 PHYSI CAL THERAPY	959, 143	0				66.00
	06700 OCCUPATI ONAL THERAPY	172, 108	0				67.00
	06800 SPEECH PATHOLOGY	55, 443					68.00
	06900 ELECTROCARDI OLOGY	245, 878					69.00
4	07100 MEDICAL SUPPLIES CHARGED TO PAT	11, 686					71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	188, 901	0				72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	793, 219	3, 574				73.00
76. 00	03020 ACUPUNCTURE	0	0				76.00
76. 01	03610 SLEEP LAB	42, 379	0				76. 01
76. 02	03950 IV THERAPY	0	0				76. 02
	OUTPATIENT SERVICE COST CENTERS						
	08800 KEWANEE RHC						88. 00
	08801 WYOMI NG RHC						88. 01
	08802 GENESEO RHC						88. 02
	08803 ANNAWAN RHC						88. 03
	08804 CAMBRI DGE RHC						88. 04
	09000 CLINIC	64, 707	977				90.00
	09001 PAIN CLINIC	62, 603					90. 01
	09002 SPECIALTY CLINIC	00 (05	0	ł			90. 02
	09003 SURGI CAL CLI NI C	82, 635	0				90. 03
	09004 GENESEO CLINIC 09100 EMERGENCY	979, 691	0				90. 04 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT	410, 437	0				91.00
200.00	Subtotal (see instructions)	7, 460, 999		1			200.00
200.00	Less PBP Clinic Lab. Services-Program	7,400,777 A	4, 551				201.00
201.00	Only Charges						201.00
202. 00	Net Charges (line 200 - line 201)	7, 460, 999	4, 551				202.00
50	,		.,	1			

In Lieu of Form CMS-2552-10

Provider CCN: 14-1319 Component CCN: 14-Z319

Worksheet D Part V Date/Time Prepared: 10/24/2023 5:18 pm Peri od: From 06/01/2022 To 05/31/2023

			Title	XVIII S	wing Beds - SNF	Cost	. с р
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2. 00	3.00	4.00	5. 00	
ANG	CILLARY SERVICE COST CENTERS				<u> </u>		
50.00 050	000 OPERATING ROOM	0. 314980	0	(	0	0	50.00
52. 00 05	200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52.00
	300 ANESTHESI OLOGY	0. 000000	l o		0	0	53.00
	400 RADI OLOGY-DI AGNOSTI C	0. 171981			0	0	54.00
	000 LABORATORY	0. 159482			0	0	60.00
	200 WHOLE BLOOD & PACKED RED BLOOD	0. 542044			0	0	62.00
	400 INTRAVENOUS THERAPY	0. 000000			0	0	64.00
	600 PHYSI CAL THERAPY	0. 382617			0	0	66.00
	700 OCCUPATI ONAL THERAPY	0. 311397			0	0	67.00
	800 SPEECH PATHOLOGY	0. 529064			0	o o	
	900 ELECTROCARDI OLOGY	0. 164095			0	0	69.00
	100 MEDICAL SUPPLIES CHARGED TO PAT	0. 268633		)		o o	71.00
1	200 IMPL. DEV. CHARGED TO PATIENTS	1. 166291	0	)		Ö	1
	300 DRUGS CHARGED TO PATIENTS	0. 468802	0	)		o o	73.00
	020 ACUPUNCTURE	0. 000000		)		o o	76.00
	610 SLEEP LAB	0. 311851		)		Ö	1
	950 I V THERAPY	0. 000000				0	76. 02
	TPATIENT SERVICE COST CENTERS	0.00000		`	<u> </u>		70.02
	800 KEWANEE RHC			I			88. 00
	801 WYOMI NG RHC						88. 01
	802 GENESEO RHC						88. 02
	803 ANNAWAN RHC						88. 03
	804 CAMBRI DGE RHC						88. 04
	000 CLINIC	0. 526138	1		0	0	1
	001 PAIN CLINIC	5. 019046		)		Ö	90. 01
	002 SPECIALTY CLINIC	0. 000000				Ö	90. 02
	003 SURGI CAL CLI NI C	2. 652046		)		0	90.03
	004 GENESEO CLINIC	0. 000000				0	90.03
	100 EMERGENCY	0. 910522		)		0	1
	200 OBSERVATION BEDS (NON-DISTINCT	1. 231781		)		0	1
200.00	Subtotal (see instructions)	1. 231/01		)			200.00
200.00	Less PBP Clinic Lab. Services-Program			)			200.00
201.00	Only Charges						201.00
202. 00	Net Charges (line 200 - line 201)		0	,	o	_	202. 00
202.00	The Charges (Title 200 - Title 201)	I	ı	1	ار	ı	1202.00

Health Financial Systems

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST In Lieu of Form CMS-2552-10 Provider CCN: 14-1319

Component CCN: 14-Z319

Peri od: Worksheet D From 06/01/2022 Part V To 05/31/2023 Date/Time Prepared: 10/24/2023 5: 18 pm Swing Beds - SNF Cost

		· ·			10/24/2023 5:	18 pm
		Title	XVIII	Swing Beds - SNF	Cost	
	Cost	ts		<del>-</del>		
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7. 00				
ANCILLARY SERVICE COST CENTERS	0.00	71.00				
50. 00 05000 OPERATING ROOM	0	0				50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0				52.00
53. 00   05300   ANESTHESI OLOGY	Ŏ	0				53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0				54.00
		0				
60. 00   06000   LABORATORY		0				60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD	0	0				62.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0				64.00
66. 00 06600 PHYSI CAL THERAPY	O	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	O	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00  06900 ELECTROCARDI OLOGY	0	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	O	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	O	0				73.00
76. 00 03020 ACUPUNCTURE	O	0				76. 00
76. 01   03610   SLEEP LAB	o	0				76. 01
76. 02 03950 I V THERAPY	o	0				76. 02
OUTPATIENT SERVICE COST CENTERS	-1	-				
88. 00 08800 KEWANEE RHC						88. 00
88. 01   08801   WYOMI NG RHC	1					88. 01
88. 02   08802   GENESEO RHC						88. 02
88. 03   08803   ANNAWAN RHC	1					88. 03
88. 04   08804   CAMBRI DGE   RHC	1					88. 04
90. 00   09000   CLI NI C		0				90.00
90. 01   09001   PAIN CLINIC		0				90.00
		0				
90. 02   09002   SPECIALTY CLINIC	0	0				90.02
90. 03   09003   SURGI CAL   CLI NI C	0	0				90. 03
90. 04   09004   GENESEO   CLI NI C	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-Progra	m   O					201. 00
Only Charges						
202.00   Net Charges (line 200 - line 201)	0	0				202. 00

Health Financial Systems

In Lieu of Form CMS-2552-10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provi der CCN: 14-1319 Component CCN: 14-5464

Peri od: Worksheet D From 06/01/2022 Part IV 05/31/2023

Date/Time Prepared: 10/24/2023 5:18 pm

0 200.00

Title XVIII Skilled Nursing

Facility Cost Center Description Non Physician Nursi ng Nursi ng Allied Health Allied Health Anestheti st Program Post-Stepdown Program Post-Stepdown Adjustments Cost Adjustments 1.00 2.00 ЗА 3.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0 50.00 0 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 C 0 52.00 05300 ANESTHESI OLOGY 0 0 0 53.00 53.00 000000000000000 0 0 0 0 0 0 0 0 0 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 0 54.00 06000 LABORATORY 0 60.00 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD 0 0 0 62.00 64.00 06400 I NTRAVENOUS THERAPY 0 0 64.00 06600 PHYSI CAL THERAPY 0 0 66.00 0 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 68.00 0 0 69.00 06900 ELECTROCARDI OLOGY 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 0 0 71.00 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00 73.00 03020 ACUPUNCTURE 0 76.00 0 76.00 0 03610 SLEEP LAB 0 76.01 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 88.00 0000000000000 0 0 0 0 0 0 0 0 0 0 08801 WYOMING RHC 88.01 0 0 88.01 88.02 08802 GENESEO RHC 0 0 88.02 08803 ANNAWAN RHC 0 0 88.03 0 88.03 0 88.04 08804 CAMBRI DGE RHC 0 0 88.04 90.00 09000 CLI NI C 0 0 90.00 90.01 09001 PAIN CLINIC 0 0 0 90.01 09002 SPECIALTY CLINIC 0 0 90.02 90.02 0 90.03 09003 SURGI CAL CLINIC 90. 03 0 0 0 90.04 09004 GENESEO CLINIC 0 0 90.04 91. 00 09100 EMERGENCY 0 0 0 0 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 Ω

200.00

Total (lines 50 through 199)

Health Financial Systems

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS

In Lieu of Form CMS-2552-10

THROUGH COSTS

Provider CCN: 14-1319 Component CCN: 14-5464 Peri od: Worksheet D
From 06/01/2022 Part IV
To 05/31/2023 Date/Time Prepared: 10/24/2023 5: 18 pm

Title XVIII

Skilled Nursing

PPS

		litie	XVIII :	skilled Nursing	PPS	
Cook Cooks Doors at a	All Others	T-+-1 C+	Tatal	Facility	D-+:6 C+	
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	Medi cal	(sum of cols.	Outpatient	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col . 7)	
			and 4)		(see	
	4.00	F 00	/ 00	7. 00	instructions)	
ANOLLI ADV. CEDVI CE. COCT. CENTEDO	4. 00	5. 00	6. 00	7.00	8. 00	
ANCILLARY SERVICE COST CENTERS 50.00 O5000 OPERATING ROOM			ı ,	14 (07 071	0.000000	F0 00
	0	1		14, 697, 271	0.000000	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0.000000	52.00
53. 00   05300   ANESTHESI OLOGY	0	0		0	0. 000000	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	1	25, 890, 532	0. 000000	
60. 00   06000   LABORATORY	0	0	(	25, 489, 520		
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD	0	0	(	171, 333		
64.00 06400 I NTRAVENOUS THERAPY	0	0	(	0	0.000000	64.00
66. 00   06600 PHYSI CAL THERAPY	0	0	(	8, 595, 017	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(	2, 321, 895	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		466, 123	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(	4, 682, 425	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	(	370, 438	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	587, 932	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		5, 290, 955	0.000000	73.00
76. 00 03020 ACUPUNCTURE	0	0		0	0.000000	76.00
76. 01 03610 SLEEP LAB	0	0		890, 053	0.000000	76. 01
76. 02   03950   V THERAPY	0	0		0	0.000000	76. 02
OUTPATIENT SERVICE COST CENTERS			'			
88. 00 08800 KEWANEE RHC	0	0		5, 695, 426	0.000000	88.00
88. 01 08801 WYOMI NG RHC	0	0		0	0.000000	88. 01
88. 02   08802   GENESEO RHC	0	0		4, 725, 333		
88. 03   08803   ANNAWAN RHC	0	0		1, 085, 886		
88. 04   08804   CAMBRI DGE   RHC	0	0		992, 059		
90. 00   09000   CLINIC	0	l o		1, 416, 506		90.00
90. 01   09001   PAIN CLINIC	0	l o		24, 204	0. 000000	90.01
90. 02 09002 SPECIALTY CLINIC	0	0		24, 204	0. 000000	90.02
90. 03   09003   SURGI CAL CLI NI C	0	0		161, 366		90.03
90. 04   09004   GENESEO   CLI NI C	0			101, 300	0.000000	
91. 00   09100   EMERGENCY	0		]	4, 527, 477	0.000000	
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT	0		]	954, 085		
	0		]	·		
200.00   Total (lines 50 through 199)	0	0	ıl (	109, 035, 836		200. 00

In Lieu of Form CMS-2552-10

THROUGH COSTS

Component CCN: 14-5464

Peri od: Worksheet D
From 06/01/2022 Part IV
To 05/31/2023 Date/Time Prepared: 10/24/2023 5: 18 pm

Title XVIII Skilled Nursing

					Facility		
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷		Costs (col. 8		Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12. 00	13.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	15, 252	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	4, 145	0	0	0	54.00
60.00	06000 LABORATORY	0. 000000	13, 373	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD	0. 000000	0	0	0	0	62.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0	0	0	0	64.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	196, 711	0	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	131, 743	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	4, 539	0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	0	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	l o	0	l o	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	76, 725	l o	0	l o	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 I V 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 WYOMI NG RHC	0. 000000	0	0	0	0	88. 01
88. 02	08802 GENESEO RHC	0. 000000	0	0	0	0	88. 02
88. 03	08803 ANNAWAN RHC	0. 000000	0	0	0	0	88. 03
88. 04	08804 CAMBRI DGE RHC	0. 000000	0	0	0	0	88. 04
90.00	09000 CLI NI C	0. 000000	272	0	0	0	90.00
90. 01	09001 PAIN CLINIC	0. 000000	0	0	0	0	90. 01
90. 02	09002 SPECIALTY CLINIC	0. 000000	0	0	0	0	90.02
90. 03	09003 SURGI CAL CLI NI C	0. 000000	0	ا	0	0	90. 03
90. 04	09004 GENESEO CLINIC	0. 000000	0	0	0	0	90.04
91. 00	09100 EMERGENCY	0. 000000	0	l	n	l ő	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0. 000000	0	l	n	l ő	
200.00	,	3. 333000	442, 760	Ö	0		200.00
200.00	1.2.2. (	1	, 700	'	1	,	

Heal th Fi nanci al Systems STATE HENRY 100 TA

Health Financial Systems Haware-HENRY COST TAL IN Lieu of Form CMS-2552-10

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 14-1319 Period: Worksheet D

Component CCN: 14-5464

Period: W From 06/01/2022 Po To 05/31/2023 Do

Worksheet D Part V Date/Time Prepared: 10/24/2023 5:18 pm PPS

0 202.00

Title XVIII

Skilled Nursing

0

Facility Charges Costs Cost Center Description PPS Cost to Cost Cost PPS Services Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Part I, col. Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 3.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 314980 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52.00 52 00 0 0 0 0 0 0 05300 ANESTHESI OLOGY 0.000000 53.00 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 171981 0 0 54.00 0 60.00 06000 LABORATORY 0.159482 0 0 0 0 0 0 0 0 0 0 0 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD 0 0.542044 0 62.00 0 62.00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0 64.00 06600 PHYSI CAL THERAPY 0 66.00 0.382617 0 0 66.00 06700 OCCUPATIONAL THERAPY 0 0.311397 0 67.00 67 00 0 68.00 06800 SPEECH PATHOLOGY 0.529064 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.164095 0 0 0 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 0.268633 0 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 72 00 1.166291 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.468802 0 0 0 73.00 76.00 03020 ACUPUNCTURE 0.000000 0 0 76.00 03610 SLEEP LAB 03950 IV THERAPY 76. 01 0. 311851 0 0 0 0 76.01 0.000000 0 76.02 0 76.02 OUTPATIENT SERVICE COST CENTERS 88.00 88.00 08800 KEWANEE RHC 08801 WYOMING RHC 88.01 88.01 08802 GENESEO RHC 88.02 88 02 88.03 08803 ANNAWAN RHC 88.03 08804 CAMBRI DGE RHC 88.04 88.04 90.00 09000 CLI NI C 90.00 0. 526138 0 0 0 0 0 0 0 0 0 0 09001 PAIN CLINIC 5. 019046 0 90.01 90.01 0 90.02 09002 SPECIALTY CLINIC 0.000000 0 90.02 0 0 90. 03 09003 SURGICAL CLINIC 2.652046 0 90.03 0 90.04 90 04 09004 GENESEO CLINIC 0.000000 0 0 91.00 09100 EMERGENCY 0. 910522 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT 0 92.00 92.00 1. 231781 0 0 0 0 200. 00 200.00 Subtotal (see instructions) C Less PBP Clinic Lab. Services-Program 201.00 201.00

Only Charges

Net Charges (line 200 - line 201)

202.00

In Lieu of Form CMS-2552-10

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

Peri od: From 06/01/2022 To 05/31/2023

Worksheet D Part V Date/Time Prepared: 10/24/2023 5:18 pm PPS

Title XVIII

Skilled Nursing Facility

		Cos	sts		
	Cost Center Description	Cost	Cost		
	0031 0011101 203011 011	Rei mbursed	Rei mbursed		
		Servi ces	Servi ces Not		
		Subject To	Subject To		
			Ded. & Coins.		
		(see inst.)	(see inst.)		
		6. 00	7.00		
	ANCILLARY SERVICE COST CENTERS	0.00	7.00		
50.00	05000 OPERATI NG ROOM	0	0		50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300 ANESTHESI OLOGY	0	١		53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		J 0		54.00
60.00	06000 LABORATORY				60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD				62.00
	06400 I NTRAVENOUS THERAPY	0			64.00
64.00		0	0		
66.00	06600 PHYSI CAL THERAPY	0	0		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		67.00
68. 00	06800 SPEECH PATHOLOGY	0	0		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0		71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		72.00
	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 I V THERAPY	0	0		76. 02
	OUTPATIENT SERVICE COST CENTERS	_			
88. 00	08800 KEWANEE RHC				88. 00
88. 01	08801 WYOMI NG RHC				88. 01
88. 02	08802 GENESEO RHC				88. 02
88. 03	08803 ANNAWAN RHC				88. 03
88.04	08804 CAMBRI DGE RHC				88. 04
90.00	09000 CLI NI C	0	0		90.00
90. 01	09001 PAIN CLINIC	0	0		90. 01
90.02	09002 SPECIALTY CLINIC	0	0		90. 02
90. 03	09003 SURGI CAL CLI NI C	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		l o		92.00
200.00			1		200.00
201.00	, , , , , , , , , , , , , , , , , , , ,				201.00
201.00	Only Charges				201.00
202.00		0	0		202. 00
202.00	inst sharges (Trile 200 Trile 201)	1	1	I	1202.00

In Lieu of Form CMS-2552-10
Worksheet D-1 Peri od:
From 06/01/2022
To 05/31/2023 Date/Ti me Prepared:
10/24/2023 5: 18 pm
Cost Provider CCN: 14-1319 Title XVIII

		Title XVIII Hospital	Cost	
	Cost Center Description		1.00	
	PART I - ALL PROVIDER COMPONENTS		1. 00	
	I NPATI ENT DAYS			
1.00	Inpatient days (including private room days and swing-bed day	ys, excluding newborn)	2, 495	1.00
2.00	Inpatient days (including private room days, excluding swing-		1, 989	2. 00
3. 00	Private room days (excluding swing-bed and observation bed days	ays). If you have only private room days	5, 0	3.00
4. 00	do not complete this line.  Semi-private room days (excluding swing-bed and observation between the complete this line.	and days)	1, 220	4.00
5. 00	Total swing-bed SNF type inpatient days (including private ro		· ·	1
	reporting period			
6.00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December 31 of the cost	243	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)			7
7. 00	Total swing-bed NF type inpatient days (including private roof reporting period	om days) through December 31 of the cost	37	7. 00
8. 00	Total swing-bed NF type inpatient days (including private roo	om days) after December 31 of the cost	-37	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	siii daye) arter becomber or er the eest		0.00
9. 00	Total inpatient days including private room days applicable t	to the Program (excluding swing-bed and	654	9. 00
10.00	newborn days) (see instructions)	only (including private room days)	140	10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc		149	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		253	11.00
	December 31 of the cost reporting period (if calendar year, e			
12.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including private room days)	0	12. 00
12 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	V anly (including private room days)	0	13.00
13. 00	after December 31 of the cost reporting period (if calendar y			13.00
14. 00	Medically necessary private room days applicable to the Progr		0	14.00
15.00	Total nursery days (title V or XIX only)		0	
16. 00	Nursery days (title V or XIX only)		0	16. 00
17 00	SWING BED ADJUSTMENT	and through December 21 of the cost		17.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	ces through becember 31 of the cost		17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of the cost		18. 00
	reporting period			
19. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of the cost	133. 47	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	os after December 21 of the cost	133. 47	20.00
20.00	reporting period	es after beceiiber 31 of the cost	155.47	20.00
21.00	Total general inpatient routine service cost (see instruction	ns)	3, 812, 971	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decemb	per 31 of the cost reporting period (lir	n <b>e</b> 0	22. 00
22.00	5 x line 17) Swing had east applicable to SNE type convices after December	s 21 of the east reporting period (line	0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting period (ine	٥	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	er 31 of the cost reporting period (line	4, 938	24.00
	7 x line 19)			
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting period (line 8	-4, 938	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)		773, 289	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)	3, 039, 682	
27.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	(Trile 21 million 1711 20)	0,007,002	27.00
28. 00	General inpatient routine service charges (excluding swing-be	ed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		0	1
30.00	Semi-private room charges (excluding swing-bed charges)	. Line 20)	0 000000	1
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ 11fle 28)	0.000000	1
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	1
34.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instructions)	0.00	1
35. 00	Average per diem private room cost differential (line 34 x li	ne 31)	0.00	1
36.00	Private room cost differential adjustment (line 3 x line 35)	and private part and discountry and	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost differential (lir	ne 3, 039, 682	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	JUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see		1, 528. 24	•
39.00	Program general inpatient routine service cost (line 9 x line	,	999, 469	1
40. 00 41. 00	Medically necessary private room cost applicable to the Program general inpatient routine service cost (line 39)	,	999, 469	
41.00	Trotal Trogram general impatrent routine service cost (IIIIe 35	, i i i ii <del>ii  ii  i</del> ii  ii  ii  ii  i	1 777, 409	1 41.00

Heal th Financial Systems

COMPUTATION OF INPATIENT OPERATING COST

HEALTH FOR THE PROPERTY OF TABLE O

In Lieu of Form CMS-2552-10

Worksheet D-1

From 06/01/2022 05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm Title XVIII Hospi tal Cost Cost Center Description Total Total Average Per Program Days Program Cost (col. 3 x Inpati ent Inpati ent Diem (col. Cost Days ÷ col. 2) col. 4) 1.00 2.00 3.00 4.00 5.00 42.00 NURSERY (title V & XIX only) 0 0.00 0 42.00 Intensive Care Type Inpatient Hospital Units 43 00 INTENSIVE CARE UNIT 43 00 44.00 CORONARY CARE UNIT 44.00 BURN INTENSIVE CARE UNIT 45.00 45.00 46.00 SURGICAL INTENSIVE CARE UNIT 46.00 OTHER SPECIAL CARE (SPECIFY) 47.00 47.00 Cost Center Description 1 00 48.00 48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) 794, 525 48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1) 48 01 Total Program inpatient costs (sum of lines 41 through 48.01) (see instructions) 1, 793, 994 49.00 PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and 50.00 50.00 0  $\Pi\Pi$ 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II 0 51.00 and IV) Total Program excludable cost (sum of lines 50 and 51) 52.00 52.00 0 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 53.00 0 53.00 medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION 54.00 Program di scharges 54.00 55.00 Target amount per discharge 0.00 55.00 55.01 Permanent adjustment amount per discharge 0.00 55.01 0.00 Adjustment amount per discharge (contractor use only) 55.02 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 56.00 56, 00 0 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 57 00 Bonus payment (see instructions) 58.00 0 58.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, 0.00 59.00 59.00 updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the 0.00 60.00 60.00 market basket) Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 0 61.00 61.00 55.01, or line 59, or line 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) 62.00 Relief payment (see instructions) 0 62.00 Allowable Inpatient cost plus incentive payment (see instructions) 0 63.00 PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See 227, 708 64.00 64.00 instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See 386, 645 65.00 65.00 instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for 614, 353 66.00 66.00 CAH, see instructions Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period 67.00 0 67.00 (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period 68.00 68.00 0 (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 69.00 69.00 0 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 Program routine service cost (line 9 x line 71) 72.00 72.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 73.00 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 74.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 75.00 75.00 26, line 45) Per diem capital-related costs (line 75 ÷ line 2) 76.00 76.00 77.00 Program capital -related costs (line 9 x line 76) 77.00 Inpatient routine service cost (line 74 minus line 77) 78.00 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79 00 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 Inpatient routine service cost limitation (line 9 x line 81) 82 00 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 Total Program inpatient operating costs (sum of lines 83 through 85) 86.00 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 769 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1, 528. 25 88. 00 Health Financial Systems

In Lieu of Form CMS-2552-10 COMPUTATION OF INPATIENT OPERATING COST Provi der CCN: 14-1319 Worksheet D-1 Peri od: From 06/01/2022 To 05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm Title XVIII Hospi tal Cost Cost Center Description 1. 00 1, 175, 224 89.00 Observation bed cost (line 87 x line 88) (see instructions) 89.00 Cost Center Description Routine Cost column 1 ÷ Total Observati on (from line column 2 Observati on Bed Pass Bed Cost Through Cost 21) (col. 3 x col. 4) (see (from line 89) instructions) 1. 00 2.00 3.00 4. 00 5.00 COMPUTATION OF OBSERVATION BED PASS THROUGH COST 3, 812, 971 3, 812, 971 3, 812, 971 3, 812, 971 90.00 0. 093403 109, 769 90.00 Capital-related cost 356, 144 1, 175, 224 1, 175, 224 1, 175, 224 91.00 Nursing Program cost 0 0.000000 0 91.00 0 92.00 Allied health cost 0.000000 0 92.00

0.000000

1, 175, 224

0 93.00

93.00 All other Medical Education

In Lieu of Form CMS-2552-10 Worksheet D-1

Provider CCN: 14-1319 Peri od: From 06/01/2022 To 05/31/2023 Component CCN: 14-5464

Date/Time Prepared: 10/24/2023 5:18 pm PPS

Skilled Nursing Facility Title XVIII

	Cost Center Description		
		1. 00	
	PART I - ALL PROVIDER COMPONENTS		
1 00	INPATIENT DAYS	12.044	1 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed days, excluding newborn) Inpatient days (including private room days, excluding swing-bed and newborn days)	12, 864 12, 864	1. 00 2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	12, 864	3.00
3.00	do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	12, 864	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost		5.00
	reporting period		
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)		
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	U	8.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	441	9.00
	newborn days) (see instructions)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
10.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	10.00
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)	0	13.00
13.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	J	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		17. 00
10 00	reporting period		10.00
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	0.00	19.00
	reporting period		
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	3, 776, 106	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
23. 00	5 x line 17)   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	o	23. 00
23.00	x line 18)	, o	23.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
	7 x line 19)		
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
	x line 20)		
26.00	Total swing-bed cost (see instructions)	0	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3, 776, 106	27.00
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
	Pri vate room charges (excluding swing-bed charges)	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)	0	27.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	
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	
35.00	Average per diem private room cost differential (line 34 x line 31)	0. 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	3, 776, 106	37. 00
	27 minus line 36) 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

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		Titl∈	e XVIII	Skilled Nursing	PPS	
Cost Center Description	Total	Total	Average Per	Facility Program Days	Program Cost	
	Inpatient	I npati ent	Diem (col. 1		(col. 3 x	
	Cost	Days	÷ col . 2)		col. 4)	
42.00 NUDCEDY (+; +l c \ / 8 \ Yl \ c ccl v)	1. 00	2. 00	3. 00	4. 00	5. 00	42.00
42.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Unit	<u> </u>					42.00
43. 00 INTENSIVE CARE UNIT						43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46. 00 SURGI CAL INTENSI VE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00
cost center bescription					1. 00	
48.00 Program inpatient ancillary service cost (V	/kst. D-3, col.	3, line 200)				48. 00
48.01 Program inpatient cellular therapy acquisit				column 1)		48. 01
49.00 Total Program inpatient costs (sum of lines	41 through 48.	01)(see instru	ctions)			49. 00
PASS THROUGH COST ADJUSTMENTS  50.00 Pass through costs applicable to Program in	natient routine	services (fro	m Wkst D sur	n of Parts I and		50.00
	patront routino	301 11 003 (11 0	iii wast. b, sai	" Or runts i und		00.00
51.00 Pass through costs applicable to Program in	patient ancilla	ry services (f	rom Wkst. D, s	sum of Parts II		51.00
and IV)	E0   E1)					F0 00
52.00 Total Program excludable cost (sum of lines 53.00 Total Program inpatient operating cost excl		alatad nan nh	vei ei an aneeti	actict and		52. 00 53. 00
53.00 Total Program inpatient operating cost excl		erated, non-pn	ysician anesti	letist, and		53.00
TARGET AMOUNT AND LIMIT COMPUTATION	. 02)					
54.00 Program discharges						54.00
55.00 Target amount per discharge						55.00
55.01 Permanent adjustment amount per discharge 55.02 Adjustment amount per discharge (contractor	uco only)					55. 01 55. 02
56.00 Target amount (line 54 x sum of lines 55, 5	J,	)				56.00
57.00 Difference between adjusted inpatient opera			line 56 minus	line 53)		57.00
58.00 Bonus payment (see instructions)	3	,		,		58. 00
59.00 Trended costs (lesser of line 53 ÷ line 54,		m the cost rep	orting period	endi ng 1996,		59.00
updated and compounded by the market basket 60.00 Expected costs (lesser of line 53 ÷ line 54		om prior year	cost roport	indated by the		60.00
market basket)	, or time 55 fr	olii pi i oi yeai	cost report, i	updated by the		00.00
61.00 Continuous improvement bonus payment (if li	ne 53 ÷ line 54	is less than	the lowest of	lines 55 plus		61.00
55.01, or line 59, or line 60, enter the le						
53) are less than expected costs (lines 54	x 60), or 1 % o	f the target a	mount (line 5	6), otherwise		
enter zero. (see instructions) 62.00 Relief payment (see instructions)						62. 00
63.00 Allowable Inpatient cost plus incentive pay	ment (see instr	uctions)				63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine co	sts through Dec	ember 31 of th	e cost reporti	ng period (See		64.00
instructions)(title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine co	sts after Decem	her 31 of the	cost renortin	neriod (See		65. 00
instructions)(title XVIII only)	ists after becein	bei 31 of the	cost reporting	g perrou (see		03.00
66.00 Total Medicare swing-bed SNF inpatient rout	ine costs (line	64 plus line	65)(title XVI	I only); for		66.00
CAH, see instructions						
67.00 Title V or XIX swing-bed NF inpatient routi (line 12 x line 19)	ne costs throug	h December 31	of the cost re	eporting period		67. 00
68.00 Title V or XIX swing-bed NF inpatient routi	ne costs after	December 31 of	the cost rep	ortina period		68. 00
(line 13 x line 20)						
69.00 Total title V or XIX swing-bed NF inpatient		•				69. 00
70.00 PART III - SKILLED NURSING FACILITY, OTHER 70.00 Skilled nursing facility/other nursing faci				\	3, 776, 106	70. 00
71.00 Adjusted general inpatient routine service				,	293. 54	70.00
72.00 Program routine service cost (line 9 x line			_,		129, 451	72.00
73.00 Medically necessary private room cost appli					0	73.00
74.00 Total Program general inpatient routine ser	•		•		129, 451	74.00
75.00 Capital-related cost allocated to inpatient 26, line 45)	routine servic	e costs (from	Worksheet B, I	Part II, column	0	75. 00
76.00 Per diem capital-related costs (line 75 ÷ l	ine 2)				0. 00	76. 00
77.00 Program capital-related costs (line 9 x lin					0	77. 00
78.00 Inpatient routine service cost (line 74 mir					0	78. 00
79.00 Aggregate charges to beneficiaries for exce				1: 70)	0	79.00
80.00 Total Program routine service costs for con	•	cost limitatio	n (IINe 78 mii	nus iine 79)	0 0. 00	80. 00 81. 00
81.00   Inpatient routine service cost per diem lin 82.00   Inpatient routine service cost limitation (		1)			0.00 n	81.00
83.00 Reasonable inpatient routine service costs					129, 451	83.00
84.00 Program inpatient ancillary services (see i		•			162, 452	84. 00
85.00 Utilization review - physician compensation	•				0	85.00
86.00 Total Program inpatient operating costs (su		nrough 85)			291, 903	86. 00
PART IV - COMPUTATION OF OBSERVATION BED PA 87.00 Total observation bed days (see instruction					0	87. 00
	*			ı		

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COMPUTATION OF INPATIENT OPERATING COST Provider CCN: 14-1319 Worksheet D-1 Peri od: From 06/01/2022 To 05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm Component CCN: 14-5464 Title XVIII Skilled Nursing PPS Facili ty Cost Center Description 1. 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)

Cost Center Description Cost 0 89.00 Routine Cost Total column 1 ÷ Observati on column 2 (from line Observation Bed Pass 21) Bed Cost Through Cost (col. 3 x col. 4) (see instructions) (from line 89) 1. 00 2.00 3.00 4. 00 COMPUTATION OF OBSERVATION BED PASS THROUGH COST 90.00 Capital-related cost 0 0.000000 0 90.00 91.00 Nursing Program cost 0.000000 ol 91.00 0 0 0 0 92.00 Allied health cost 0.000000 92.00 0 0 93.00 All other Medical Education 0 0.000000 0 93.00

In Lieu of Form CMS-2552-10

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In Lieu of Form CMS-2552-10

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1319

Period:
From 06/01/2022
To 05/31/2023 5: 18 pm

					10/24/2023 5:	18 pm
		Title	XVIII	Hospi tal	Cost	
Cost Center Des	cri pti on	F	Ratio of Cost	Inpati ent	I npati ent	
	·		To Charges	Program	Program Costs	
			ŭ	Charges	(col . 1 x	
				3	col . 2)	
			1. 00	2.00	3. 00	
INPATIENT ROUTINE SER	RVICE COST CENTERS					
30.00 03000 ADULTS & PEDIAT	RICS			946, 390		30.00
43. 00 04300 NURSERY						43.00
ANCILLARY SERVICE COS	ST CENTERS					
50.00   05000   OPERATING ROOM			0. 314980	765, 841	241, 225	50.00
52.00  05200   DELIVERY ROOM &	LABOR ROOM		0.000000	0	0	52.00
53. 00   05300   ANESTHESI OLOGY			0.000000	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGN	OSTI C		0. 171981	258, 381	44, 437	54.00
60. 00   06000   LABORATORY			0. 159482	497, 965	79, 416	60.00
62.00 06200 WHOLE BLOOD & P.	ACKED RED BLOOD		0. 542044	15, 478	8, 390	62.00
64. 00 06400 I NTRAVENOUS THE	RAPY		0.000000	0	0	64.00
66.00 06600 PHYSI CAL THERAP	Υ		0. 382617	125, 675	48, 085	66.00
67. 00 06700 OCCUPATI ONAL TH	ERAPY		0. 311397	88, 764	27, 641	67.00
68.00 06800 SPEECH PATHOLOG	Υ		0. 529064	10, 969	5, 803	68.00
69. 00 06900 ELECTROCARDI OLO	GY		0. 164095	201, 304	33, 033	69.00
71.00 07100 MEDICAL SUPPLIE	S CHARGED TO PAT		0. 268633	137, 037	36, 813	71.00
72.00 07200 I MPL. DEV. CHAR	GED TO PATIENTS		1. 166291	6, 132	7, 152	72.00
73.00 07300 DRUGS CHARGED T	O PATIENTS		0. 468802	546, 309	256, 111	73.00
76. 00 03020 ACUPUNCTURE			0.000000	0	0	76.00
76. 01   03610   SLEEP   LAB			0. 311851	0	0	76. 01
76. 02 03950 I V THERAPY			0.000000	0	0	76.02
OUTPATIENT SERVICE CO	OST CENTERS					
88.00 08800 KEWANEE RHC			0.000000		0	88.00
88. 01   08801   WYOMI NG RHC			0.000000		0	88. 01
88. 02   08802   GENESEO RHC			0.000000		0	88. 02
88. 03   08803   ANNAWAN RHC			0.000000		0	88. 03
88. 04   08804   CAMBRI DGE RHC			0.000000		0	88. 04
90. 00 09000 CLINIC			0. 526138	0	0	90.00
90. 01   09001   PAIN CLINIC			5. 019046	0	0	90. 01
90. 02 09002 SPECIALTY CLINI	C		0.000000	0	0	90.02
90. 03 09003 SURGICAL CLINIC			2. 652046	0	0	90. 03
90.04 09004 GENESEO CLINIC		j	0.000000	o	0	90. 04
91. 00 09100 EMERGENCY			0. 910522	2, 742	2, 497	91.00
92.00 09200 OBSERVATION BED	S (NON-DISTINCT	j	1. 231781	3, 184	3, 922	92.00
200.00 Total (sum of I	ines 50 through 94 and 96 through 98)	j		2, 659, 781	794, 525	200. 00
201.00 Less PBP Clinic	Laboratory Services-Program only charges	s (line 61)		0		201. 00
202.00 Net charges (li	ne 200 minus line 201)			2, 659, 781		202. 00

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HOWEVE-HENRY VOC/LTAL
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1319 | Period: | Worksheet D-3

					10/24/2023 3.	το μιιι
		Title XV		ing Beds - SNF	Cost	
	Cost Center Description	Rat	tio of Cost	I npati ent	I npati ent	
		T	o Charges	Program	Program Costs	
				Charges	(col. 1 x	
				ŭ	col . 2)	
			1. 00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		0. 314980	59, 539	18, 754	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0.000000	0	0	52.00
53.00	05300 ANESTHESI OLOGY		0.000000	o	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 171981	8, 891	1, 529	54.00
60.00	06000 LABORATORY		0. 159482	54, 570	8, 703	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD		0. 542044	ol	0	62.00
	06400 I NTRAVENOUS THERAPY		0.000000	ol	0	64.00
66.00	06600 PHYSI CAL THERAPY		0. 382617	151, 081	57, 806	66.00
67. 00	06700 OCCUPATI ONAL THERAPY		0. 311397	113, 017	35, 193	
	06800 SPEECH PATHOLOGY		0. 529064	5, 049	2, 671	
	06900 ELECTROCARDI OLOGY		0. 164095	21, 861	3, 587	
	07100 MEDICAL SUPPLIES CHARGED TO PAT		0. 268633	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS		1. 166291	ol	0	72.00
	07300 DRUGS CHARGED TO PATIENTS		0. 468802	114, 231	53, 552	73.00
	03020 ACUPUNCTURE		0. 000000	0	0	76.00
	03610 SLEEP LAB		0. 311851	ő	0	76.01
	03950 IV THERAPY		0. 000000	ő	0	76. 02
70.02	OUTPATIENT SERVICE COST CENTERS		0.00000	٥,	5	70.02
88. 00	08800 KEWANEE RHC		0. 000000		0	88. 00
	08801 WYOMI NG RHC		0. 000000		0	88. 01
88. 02	08802 GENESEO RHC		0. 000000		0	88. 02
88. 03	08803 ANNAWAN RHC		0.000000		0	88. 03
88. 04	08804 CAMBRI DGE RHC		0. 000000		0	88. 04
	09000 CLI NI C		0. 526138	ol	0	90.00
90. 01	09001 PALN CLINIC		5. 019046	0	0	90. 01
90. 02	09002 SPECIALTY CLINIC		0. 000000	o o	0	90.02
	09003 SURGI CAL CLI NI C		2. 652046	ol O	0	90.03
	09004 GENESEO CLINIC		0. 000000	ol Ol	0	90.04
	09100 EMERGENCY		0. 910522	ol Ol	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT		1. 231781	٥	0	92.00
200.00			1. 231701	528, 239	181, 795	
200.00		s (line 61)		J20, 237		200.00
201.00		3 (1116 01)		528, 239		201.00
202.00	I liver charges (Title 200 IIII lius Title 201)	I		520, 239	ļ	202.00

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

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

Title XVIII

Skilled Nursing Facility

Provider CN: 14-5464

From 06/01/2022
To 05/31/2023
Date/Time Prepared: 10/24/2023 5: 18 pm
Provider CN: 14-5464

					10/24/2023 5:	18 pm
		Title	: XVIII	Skilled Nursing	PPS	· ·
				Facility		
	Cost Center Description		Ratio of Cos		Inpatient	
	cost denter bescription		To Charges	Program	Program Costs	
			10 Charges			
				Charges	(col . 1 x	
					col . 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS					30.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM		0. 31498	30 15, 252	4, 804	50.00
	05200 DELIVERY ROOM & LABOR ROOM		0. 00000		4,804	1
	05300 ANESTHESI OLOGY		0. 00000		0	
	05400 RADI OLOGY-DI AGNOSTI C		0. 17198			
60.00	06000 LABORATORY		0. 15948	13, 373	2, 133	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD		0. 54204	14 0	0	62.00
64.00	06400 INTRAVENOUS THERAPY		0. 00000	00	0	64.00
66.00	06600 PHYSI CAL THERAPY		0. 3826	7 196, 711	75, 265	66.00
	06700 OCCUPATI ONAL THERAPY		0. 31139			
	06800 SPEECH PATHOLOGY		0. 52906			68.00
	06900 ELECTROCARDI OLOGY		0. 32400		l	
					0	
	07100 MEDICAL SUPPLIES CHARGED TO PAT		0. 26863		0	
	07200 IMPL. DEV. CHARGED TO PATIENTS		1. 16629		0	
	07300 DRUGS CHARGED TO PATIENTS		0. 46880	76, 725	35, 969	
76.00	03020 ACUPUNCTURE		0.00000	00	0	76.00
76. 01	03610 SLEEP LAB		0. 31185	51 0	0	76. 01
	03950 IV THERAPY		0. 00000		0	76. 02
<b>+</b>	OUTPATIENT SERVICE COST CENTERS					1
	08800 KEWANEE RHC		0.00000	nol	0	88. 00
	08801 WYOMI NG RHC		0. 00000		0	88. 01
					1	
	08802 GENESEO RHC		0.00000		0	
	08803 ANNAWAN RHC		0. 00000		0	88. 03
	08804 CAMBRI DGE RHC		0. 00000		0	88. 04
	09000 CLI NI C		0. 52613	38 272	143	90.00
90. 01	09001 PAIN CLINIC		5. 01904	16 0	0	90. 01
90. 02	09002 SPECIALTY CLINIC		0. 00000	00	0	90. 02
	09003 SURGI CAL CLI NI C		2. 65204		Ō	1
	09004 GENESEO CLINIC		0. 00000		0	90.04
	09100 EMERGENCY		0. 91052		0	1
			l .			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT		1. 23178		0	
200.00	Total (sum of lines 50 through 94 and 96 through 98)			442, 760	162, 452	
201. 00	Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0		201. 00
202.00	Net charges (line 200 minus line 201)			442, 760		202. 00

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In Lieu of Form CMS-2552-10

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-1319

From 06/01/2022

To 05/31/2023

Propared:

10/24/2023 5:18 pm

Title XVIII Hospi tal Cost 1.00 PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions) 7, 465, 550 Medical and other services reimbursed under OPPS (see instructions) 2.00 0 2.00 OPPS or REH payments 3.00 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 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 9 00 9 00 0 10.00 Organ acquisitions Λ 10.00 7, 465, 550 Total cost (sum of lines 1 and 10) (see instructions) 11.00 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 16.00 had such payment been made in accordance with 42 CFR §413.13(e) 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 0 19.00 instructions) 20 00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 20 00 0 instructions) 21.00 Lesser of cost or charges (see instructions) 7, 540, 206 21.00 22.00 Interns and residents (see instructions) 0 22.00 Cost of physicians' services in a teaching hospital (see instructions) 23.00 0 23.00 Total prospective payment (sum of lines 3, 24.00 4. 4.01. 8 and 9) 0 24.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions) 25.00 61.684 25.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 3, 749, 211 26.00 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 3, 729, 311 27.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28.00 REH facility payment amount 28.50 28.50 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) Λ 29.00 3, 729, 311 30.00 Subtotal (sum of lines 27, 28, 28.50 and 29) 30.00 Primary payer payments 31.00 403 31.00 Subtotal (line 30 minus line 31) 3, 728, 908 32.00 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11) 33.00 44, 763 34.00 Allowable bad debts (see instructions) 34.00 Adjusted reimbursable bad debts (see instructions) 29, 096 35.00 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 19, 195 36.00 37.00 Subtotal (see instructions) 3, 758, 004 37.00 38 00 MSP-LCC reconciliation amount from PS&R 38 00 0 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 39.50 39. 75 N95 respirator payment adjustment amount (see instructions) 39.75 39 97 39 97 Demonstration payment adjustment amount before sequestration 0 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 RECOVERY OF ACCELERATED DEPRECIATION 39.99 0 39.99 40.00 Subtotal (see instructions) 3, 758, 004 40.00 Sequestration adjustment (see instructions) 72, 153 40 01 40 01 40.02 Demonstration payment adjustment amount after sequestration 40.02 40.03 Sequestration adjustment-PARHM pass-throughs 40.03 41.00 Interim payments 3, 643, 642 41.00 Interim payments-PARHM 41.01 41.01 Tentative settlement (for contractors use only) 42.00 42.00 0 Tentative settlement-PARHM (for contractor use only) 42.01 42.01 42, 209 43.00 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 44.00 0 44.00 §115. 2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 90.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 92.00 The rate used to calculate the Time Value of Money 0.00 Time Value of Money (see instructions) 93.00 93 00 0 94.00 Total (sum of lines 91 and 93) 0 94.00

Health Financial Systems

CALCULATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 14-1319

In Lieu of Form CMS-2552-10 Worksheet E
Part B
Date/Time Prepared:
10/24/2023 5: 18 pm Peri od: From 06/01/2022 To 05/31/2023 Title XVIII Hospi tal Cost 1. 00 MEDICARE PART B ANCILLARY COSTS 200.00 Part B Combined Billed Days

0 200. 00

Health Financial Systems

CALCULATION OF REIMBURSEMENT SETTLEMENT

In Lieu of Form CMS-2552-10 Provider CCN: 14-1319 Peri od: From 06/01/2022 To 05/31/2023

Component CCN: 14-5464

Worksheet E
Part B
Date/Time Prepared:
10/24/2023 5:18 pm
PPS

Skilled Nursing Facility Title XVIII

	Fac	CILITY		
			1.00	
	DADT D. MEDICAL AND OTHER HEALTH SERVICES		1.00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES  Medical and other services (see instructions)		0	1.00
2. 00	Medical and other services reimbursed under OPPS (see instructions)		0	
3. 00	OPPS or REH 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	
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	1
8.00	Transitional corridor payment (see instructions)		0	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	
10. 00 11. 00	Organ acquisitions  Total cost (sum of lines 1 and 10) (see instructions)		0 0	
11.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES		0	111.00
	Reasonable charges			1
12.00	Anci I lary service charges		0	12.00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	ı
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	je basis	0	15. 00
16.00	Amounts that would have been realized from patients liable for payment for services on a cha	argebasi s	0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e)			
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	1
18.00	Total customary charges (see instructions)	(000	0	
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) instructions)	(See	0	19. 00
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18)	(500	0	20.00
20.00	instructions)	(300		20.00
21.00			0	21.00
22.00	Interns and residents (see instructions)		0	22. 00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions	*		26.00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23 linstructions)	3] (See	0	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28. 00
28. 50				28. 50
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	1
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)		0	1
31.00	Primary payer payments		0	31.00
32.00	· · ·		0	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
	Composite rate ESRD (from Wkst. I-5, line 11)		0	
	Allowable bad debts (see instructions)		0	
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions)		0	
	Subtotal (see instructions)		0	1
	MSP-LCC reconciliation amount from PS&R			38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	1
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)		0	39. 75
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. 99	RECOVERY OF ACCELERATED DEPRECIATION		0	
40.00	Subtotal (see instructions)		0	
40. 01 40. 02	Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration		0 0	1
40. 02	Sequestration adjustment-PARHM pass-throughs			40. 02
41. 00	Interim payments		0	1
41. 01	Interim payments-PARHM			41. 01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42. 01
43.00	Balance due provider/program (see instructions)		0	
43. 01	Balance due provider/program-PARHM (see instructions)		1	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter	- 1,	0	44.00
	§115. 2			1
00.00	TO BE COMPLETED BY CONTRACTOR			00.00
90.00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			90. 00 91. 00
91.00	The rate used to calculate the Time Value of Money			92.00
	Time Value of Money (see instructions)			93.00
	1		I .	

Heal th Financial Systems STATE	COP'	In Lie	ı of Form CMS-	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1319	Peri od:	Worksheet E	
	Component CCN: 14-5464	From 06/01/2022 To 05/31/2023	Part B Date/Time Pro 10/24/2023 5	epared: : 18 pm
	Title XVIII	Skilled Nursing	PPS	
		Facility		
			1. 00	
94.00 Total (sum of lines 91 and 93)			1.00	94.00
			1. 00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days				200.00

Health Financial Systems

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1319

In Lieu of Form CMS-2552-10

Peri od:
From 06/01/2022 Part I
To 05/31/2023 Date/Time Prepared:
10/24/2023 5:18 pm

		Title XVIII		Hospi tal	Cost	то рп
			t Part A		-t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
. 00	Total interim payments paid to provider		1, 563, 171	2. 22	3, 641, 891	1. (
. 00	Interim payments payable on individual bills, either		0		0	2. (
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3.
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
01	ADJUSTMENTS TO PROVIDER	02/23/2023	440, 453	02/23/2023	249, 906	3.
02	THE TO THE TELL	02, 20, 2020	0	02, 20, 2020	0	3.
03			0		0	3.
04			0		0	3.
05			0		0	3.
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM	01/04/2023	78, 916	01/04/2023	248, 155	3.
51			0		0	3.
52			0		0	3.
53 54			0		0 0	3. 3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		361, 537		1, 751	3.
,,	3. 50-3. 98)		301, 337		1, 751	٥.
00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 924, 708		3, 643, 642	4.
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR	T	Т		T	_
00	List separately each tentative settlement payment after					5.
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
01	TENTATI VE TO PROVI DER		0		0	5.
02			Ö		l ol	5
03			0		0	5
	Provider to Program					
50	TENTATI VE TO PROGRAM		0		0	5.
51			0		0	5
52	0.11.1.1.4.4.4.4.5.04.5.40.11.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4		0		0	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5
00	5.50-5.98) Determined net settlement amount (balance due) based on					6.
50	the cost report. (1)					0.
01	SETTLEMENT TO PROVIDER		0		42, 209	6.
02	SETTLEMENT TO PROGRAM		382, 299		0	6.
00	Total Medicare program liability (see instructions)		1, 542, 409		3, 685, 851	7.
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		(	NMENT SERVICES	1. 00 06101	2. 00	
00	Name of Contractor					8.

Health Financial Systems

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

In Lieu of Form CMS-2552-10 Provider CCN: 14-1319

Component CCN: 14-Z319

Peri od: Worksheet E-1
From 06/01/2022 Part I
To 05/31/2023 Date/Time Prepared: 10/24/2023 5: 18 pm

Swing Beds - SNF Cost Title XVIII

		Title	XVIII Sv	ving Beds - SNF	Cost	
		Inpatien	t Part A	Par	-t 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		871, 946		0	1.00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					1
3. 01	ADJUSTMENTS TO PROVIDER	02/23/2023	106, 228		0	3.01
3. 02			0		0	
3. 03			l o		0	3. 03
3. 04			0		0	3.04
3. 05			0		0	
3.03	Provider to Program				0	3.03
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3. 51	ADJUSTIVENTS TO PROGRAW				0	3.50
			0			
3. 52					0	
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		106, 228		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		978, 174		0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR	T	Г		1	
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	
5. 02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		0		0	
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					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		0		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		208, 140		0	6. 02
7. 00	Total Medicare program liability (see instructions)		770, 034		0	
7.00	Trotal mode ode o program redorrety (oco restructions)		,,,,,,,,,	Contractor	NPR Date	7.50
				Number	(Mo/Day/Yr)	
		(	)	1, 00	2.00	
8. 00	Name of Contractor		NMENT SERVICES		2.00	8.00
5. 50	33,111,40101	I NC.		33101		5.50
	1	į		l	I	1

Health Financial Systems

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

In Lieu of Form CMS-2552-10 Provider CCN: 14-1319

Component CCN: 14-5464

Peri od: Worksheet E-1
From 06/01/2022 Part I
To 05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm

Skilled Nursing PPS

Skilled Nursing Facility Title XVIII

				Facility		
		Inpatien	it Part A	Par	t 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	1.00	166, 053	3.00	4.00	1.00
2. 00	Interim payments payable on individual bills, either		0			2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3.02			0		0	3. 02
3. 03			l 0		1 0	3.03
3. 04			0			3.04
3. 05			l ő			
0.00	Provider to Program					0.00
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3. 50	ADJUSTIVILINTS TO FROGRAM		0			1
			0			
3. 52			_			
3. 53			0		0	
3. 54			0		0	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		166, 053		0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5.01
5. 02			0		1 0	5.02
5. 03			0			
0.00	Provider to Program					0.00
5. 50	TENTATI VE TO PROGRAM		0		0	5.50
5. 51	TENTATI VE TO TROGIVIM		0			
5. 52			0			
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0			
5. 99	5. 50-5. 98)		l o			5. 99
/ 00						/ 00
6. 00	Determined net settlement amount (balance due) based on					6. 00
,	the cost report. (1)		_		_	
6. 01	SETTLEMENT TO PROVIDER		0		0	
6. 02	SETTLEMENT TO PROGRAM		0		0	
7. 00	Total Medicare program liability (see instructions)		166, 053		0	7.00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
			)	1. 00	2. 00	
8.00	Name of Contractor	NATI ONAL GOVER	NMENT SERVICES	06101		8. 00
		I NC.				
	•	•			•	•

Health Financial Systems
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

In Lieu of Form CMS-2552-10
Period: Worksheet E-1
From 06/01/2022 Part II
Date/Time Prepared: 10/24/2023 5:18 pm
Hospital Cost Provider CCN: 14-1319 Title XVIII

	THE XVIII HOSPITAL	0031	
		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 (see instructions)		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4. 00	Total inpatient days (see instructions)		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.	1	7.00
	line 168		
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

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Health Financial Systems

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1319
Component CCN: 14-Z319

Title XVIII Swing Beds - SNF Cost

Part A Part B

		omponent con. 14 2517	03/31/2023	10/24/2023 5:	
		Title XVIII	wing Beds - SNF	•	
			Part A	Part B	
	COMPUTATION OF NET COST OF COVERED SERVICES		1. 00	2. 00	
1.00	Inpatient routine services - swing bed-SNF (see instructions)		620, 497	0	1. 00
2. 00	Inpatient routine services - swing bed-NF (see instructions)		020, 177	· ·	2. 00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A	A, and sum of Wkst. D,	183, 613	0	3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing				
	instructions)				0.04
3. 01	Nursing and allied health payment-PARHM (see instructions)	(		0.00	3. 01
4. 00	Per diem cost for interns and residents not in approved teaching instructions)	g program (see		0. 00	4. 00
5. 00	Program days		402	0	5. 00
6.00	Interns and residents not in approved teaching program (see ins	tructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method	od only	0		7.00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		804, 110	0	8. 00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)	blo to physician	804, 110	0	10. 00 11. 00
11. 00	Deductibles billed to program patients (exclude amounts applical professional services)	bre to physician	١	U	11.00
12. 00	Subtotal (line 10 minus line 11)		804, 110	0	12. 00
13.00	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	19, 002	0	13.00
	for physician professional services)				
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		785, 108	0	15.00
16. 00 16. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)		١	U	16. 00 16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstration	tion) payment	0		16. 55
10.00	adjustment (see instructions)	eron, paymont			10.00
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 instruc	ctions)	705 100	0	18.00
19. 00 19. 01	Total (see instructions) Sequestration adjustment (see instructions)		785, 108 15, 074	0	19. 00 19. 01
19. 01	Demonstration adjustment (see mistractions)  Demonstration payment adjustment amount after sequestration)		13, 074	0	19. 01
19. 03	Sequestration adjustment-PARHM pass-throughs			· ·	19. 03
19. 25	Sequestration for non-claims based amounts (see instructions)		0	0	19. 25
20.00	Interim payments		978, 174	0	20.00
20. 01	Interim payments-PARHM			_	20. 01
21. 00	Tentative settlement (for contractor use only)		0	0	21.00
21. 01 22. 00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (line 19 minus lines 19.01, 19.02,	10 25 20 and 21)	-208, 140	0	21. 01 22. 00
22. 00	Balance due provider/program-PARHM (see instructions)	19. 25, 20, and 21)	-200, 140	U	22. 00
23. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2.	o	0	23. 00
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonstrat		1		
200.00	Is this the first year of the current 5-year demonstration perio	od under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement				
201 00	Medicare swing-bed SNF inpatient routine service costs (from Wks	st D-1 Pt II line			201. 00
	66 (title XVIII hospital))				
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from N	Wkst. D-3, col. 3, line			202. 00
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fi	ret year of the currer	t 5 year demons		204. 00
	period)	rist year or the currer	it 5-year deliloris	tration	
205.00	Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 time	es line 204)			206. 00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursen				
	Program reimbursement under the §410A Demonstration (see instruc				207. 00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2,	col. 1, sum of lines 1			208. 00
200 00	and 3)  Adjustment to Medicare swing-bed SNF PPS payments (see instructi	ions)			209. 00
	Reserved for future use	1 0113)			210. 00
2.0.00	Comparision of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 20	9 plus line 210) (see			215. 00
	instructions)				

In Lieu of Form CMS-2552-10
Worksheet E-3
D1/2022 Part V
B1/2023 Date/Time Prepared:
10/24/2023 5:18 pm
tal Cost Provider CCN: 14-1319 Peri od: From 06/01/2022 To 05/31/2023 Title XVIII Hospi tal

		Ittle XVIII   nospital	COST	
PART Y - CALCULATION OF REINBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REINBURSEMENT				
Impatient services   1,793,994   1,00   2,00   0,			1.00	
2.00   Nursing and Allied Health Managed Care payment (see instructions)				
0				
Cell ular 'therapy acquisition cost (see instructions)				
4.00   Subtotal (sum of lines 1 through 3.01)   1,793,994   4.00   0.500   Primary payer payments   0   5.00   5.00   Computation of Lessen Dr Cost R CHARGES   1,811,934   6.00   Computation of Lessen Dr Cost R CHARGES   1,811,934   6.00   Cost Charges   0   7.00   Routine service charges   0   0   7.00   Routine Services   0   0   7.00   Routine Service (some acquisition charges, net of revenue   0   9.00   0   0   0   0   0   0   0   0   0				1
Primary payer payments				
Total Cost (Line 4 less line 5). For CAH (see instructions)   1,811,934   6.00		, ,		1
			_	•
Reasonable charges   0	6. 00		1, 811, 934	6.00
Routine service charges				
Ancillary service charges   0   8.00   0.0				
0,00				
10.00   Customary charges   0   0   0.00				
Customary charges	9.00			
11.00   Aggregate amount actually collected from patients liable for payment for services on a charge basis   0   1.00	10.00		0	10.00
12.00   Amounts that would have been real ized from patients   Iable for payment for services on a charge basis   had such payment been made in accordance with 42 CFR 413. 13(e)		Customary charges		
had such payment been made in accordance with 42 CFR 413.13(e)    13. 00 Ratio of line 11 to line 12 (not to exceed 1.000000)    14. 00 Total customary charges (see instructions)				1
13.00   Ratio of line 11 to line 12 (not to exceed 1.000000)   13.00	12.00		0	12.00
14.00		had such payment been made in accordance with 42 CFR 413.13(e)		
15.00   Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)   16.00   Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)   16.00   17.00   17.00   17.00   17.00   18.00   18.00   18.00   19.0		Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
Instructions   16.00   Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see Instructions)   17.00	14.00		0	14.00
16.00   Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see Instructions)   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   18.00   18.00   18.00   18.00   19.0	15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see	0	15.00
Instructions   Cost of physicians' services in a teaching hospital (see instructions)   0   17.00				
17.00	16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see	0	16.00
COMPUTATION OF RELIMBURSEMENT SETTLEMENT   18.00   18.00   19.00   1		instructions)		
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)   1, 811, 931   19.00   19.00   Excess reasonable cost (from line 16)   257, 196   20.00   21.00   Excess reasonable cost (from line 16)   0   21.00   22.00   Subtotal (line 19 minus line 20 and 21)   1,554, 738   22.00   23.00   Coinsurance   0   23.00   23.00   24.00   Subtotal (line 22 minus line 23)   22.00   24.00   Subtotal (line 22 minus line 23)   27.48   25.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   17,564, 738   24.00   27.00   Adjusted reimbursable bad debts (see instructions)   17,865   26.00   27.00   Allowable bad debts (for dual eligible beneficiaries (see instructions)   17,865   26.00   27.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   22,157   27.00   29.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   29.00   29.50   Pioneer ACO demonstration payment adjustment (see instructions)   0   29.50   29.90	17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
19.00   Cost of covered services (sum of lines 6, 17 and 18)				
20. 00   Deductibles (exclude professional component)   257,196   20. 00	18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
21.00   Excess reasonable cost (from line 16)   0   21.00   22.00   Subtotal (line 19 minus line 20 and 21)   1,554,738   22.00   23.00   24.00   Subtotal (line 22 minus line 23)   1,554,738   24.00   25.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   27,484   25.00   27.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   22,157   27.00   28.00   Subtotal (sum of lines 24 and 25, or line 26)   29.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   29.00   29.50   29.50   29.98   Recovery of accelerated depreciation.   0   29.98   29.99   Demonstration payment adjustment (see instructions)   29.99   29.90   29.00   29.00   29.90   29.90   29.90   29.00   29.90   29	19.00	Cost of covered services (sum of lines 6, 17 and 18)		
22. 00       Subtotal (line 19 minus line 20 and 21)       1,554,738       22. 00         23. 00       Coinsurance       0       23. 00         24. 00       Subtotal (line 22 minus line 23)       1,554,738       24. 00         25. 00       Allowable bad debts (exclude bad debts for professional services) (see instructions)       27, 484       25. 00         26. 00       Adjusted reimbursable bad debts (see instructions)       17, 865       26. 00         27. 00       Allowable bad debts for dual eligible beneficiaries (see instructions)       22, 157       27. 00         28. 00       Subtotal (sum of lines 24 and 25, or line 26)       1, 572, 603       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. 98       Recovery of accelerated depreciation.       0       29. 99         30. 00       Subtotal (see instructions)       0       29. 98         30. 01       Sequestration payment adjustment amount before sequestration       0       29. 99         30. 02       Demonstration payment adjustment amount after sequestration       0       29. 99         30. 02       Demonstration payment adjustment amount after sequestration       0 </td <td>20.00</td> <td>Deductibles (exclude professional component)</td> <td>257, 196</td> <td>20.00</td>	20.00	Deductibles (exclude professional component)	257, 196	20.00
23. 00 Coinsurance	21.00	Excess reasonable cost (from line 16)	0	21.00
24.00       Subtotal (line 22 minus line 23)       1,554,738       24.00         25.00       Allowable bad debts (exclude bad debts for professional services) (see instructions)       27,484       25.00         26.00       Adjusted reimbursable bad debts (see instructions)       17,865       26.00         27.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       22,157       27.00         28.00       Subtotal (sum of lines 24 and 25, or line 26)       1,572,603       28.00         29.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0 29.00         29.50       Pioneer ACO demonstration payment adjustment (see instructions)       0 29.50         29.99       Recovery of accelerated depreciation.       0 29.99         30.01       Sequestration payment adjustment amount before sequestration       0 29.99         30.01       Sequestration adjustment (see instructions)       30.00         30.02       Sequestration adjustment amount after sequestration       0 30.02         30.03       Sequestration adjustment-PARHM       30.03         31.01       Interim payments       1,924,708         31.01       Tentative settlement (for contractor use only)       32.01         32.01       Bal ance due provi der/program (line 30 minus lines 30.01, 30.02, 31, and 32)       33.01	22.00	Subtotal (line 19 minus line 20 and 21)	1, 554, 738	22.00
25. 00       Allowable bad debts (exclude bad debts for professional services) (see instructions)       27, 484       25. 00         26. 00       Adjusted reimbursable bad debts (see instructions)       17, 865       26. 00         27. 00       Allowable bad debts for dual eligible beneficiaries (see instructions)       22, 157       27. 00         28. 00       Subtotal (sum of lines 24 and 25, or line 26)       1, 572, 603       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. 98       Recovery of accelerated depreciation.       0 29. 99         30. 00       Subtotal (see instructions)       0 29. 99         30. 01       Sequestration adjustment (see instructions)       30. 00         30. 02       Sequestration adjustment amount after sequestration       30. 02         30. 03       Sequestration adjustment amount after sequestration       0 30. 02         31. 01       Interim payments       1, 924, 708       31. 00         31. 01       Interim payments-PARHM       31. 01         32. 01       Tentative settlement (for contractor use only)       32. 01         33. 01       Bal ance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32)       32. 01 <td>23.00</td> <td>Coi nsurance</td> <td>0</td> <td>23.00</td>	23.00	Coi nsurance	0	23.00
26. 00 Adjusted reimbursable bad debts (see instructions) 27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 50 Pioneer ACO demonstration payment adjustment (see instructions) 29. 98 Recovery of accelerated depreciation. 29. 99 Demonstration payment adjustment amount before sequestration 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 02 Demonstration payment adjustment (see instructions) 31. 00 Interim payments 31. 01 Interim payments 31. 01 Interim payments 31. 01 Tentative settlement (for contractor use only) 32. 01 Tentative settlement (for contractor use only) 33. 00 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	24.00	Subtotal (line 22 minus line 23)	1, 554, 738	24.00
27. 00 All owable bad debts for dual eligible beneficiaries (see instructions)  28. 00 Subtotal (sum of lines 24 and 25, or line 26)  29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  29. 50 Pi oneer ACO demonstration payment adjustment (see instructions)  29. 98 Recovery of accelerated depreciation.  29. 99 Demonstration payment adjustment amount before sequestration  30. 00 Subtotal (see instructions)  30. 01 Sequestration adjustment (see instructions)  30. 02 Demonstration payment adjustment amount after sequestration  30. 03 Sequestration adjustment (see instructions)  30. 01 Interim payments  31. 01 Interim payments  31. 01 Interim payments  32. 00 Tentative settlement (for contractor use only)  33. 01 Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32)  34. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  22. 157 27. 00  1, 572, 603 28. 00  1, 572, 603 28. 00  29. 90  29. 90  29. 50  29. 99  30. 02  29. 99  30. 03  30. 03  30. 04  30. 05  30. 07  30.	25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	27, 484	25.00
28. 00 Subtotal (sum of lines 24 and 25, or line 26) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 29. 98 Recovery of accelerated depreciation. 29. 99 Demonstration payment adjustment amount before sequestration 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment-PARHM 31. 00 Interim payments 31. 01 Interim payments 32. 00 Tentative settlement (for contractor use only) 33. 01 Tentative settlement (for contractor use only) 33. 01 Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 32. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 32. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 32. 01 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 32. 02. 03. 03. 03. 03. 03. 03. 03. 03. 03. 03	26.00	Adjusted reimbursable bad debts (see instructions)	17, 865	26.00
29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 29.98 Recovery of accelerated depreciation. 29.99 Demonstration payment adjustment amount before sequestration 30.00 Subtotal (see instructions) 30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment amount after sequestration 31.00 Interim payments 31.01 Interim payments 32.00 Tentative settlement (for contractor use only) 32.01 Tentative settlement (For contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	22, 157	27.00
29.50 Pioneer ACO demonstration payment adjustment (see instructions)  29.98 Recovery of accelerated depreciation.  29.99 Demonstration payment adjustment amount before sequestration  30.00 Subtotal (see instructions)  30.01 Sequestration adjustment (see instructions)  30.02 Demonstration payment adjustment amount after sequestration  30.03 Sequestration adjustment amount after sequestration  30.03 Sequestration adjustment-PARHM  31.00 Interim payments  Interim payments-PARHM  Tentative settlement (for contractor use only)  32.01 Tentative settlement (for contractor use only)  33.01 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)  34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  0 29.98  29.99  1,572,603  30.00  30.00  30.01  30.02  30.02  30.03  31.01  32.05  33.01	28.00	Subtotal (sum of lines 24 and 25, or line 26)	1, 572, 603	28.00
29. 98 29. 99 29. 99 30. 00 30. 01 30. 02 30. 02 30. 02 30. 03 30. 03 30. 03 30. 03 31. 00 31. 01 32. 00 31. 01 32. 00 33. 01 32. 00 33. 01 34. 00 35. 02 36. 02 37. 02 38. 02 38. 02 39. 02 39. 03 30. 00 30. 01 30. 02 30. 02 30. 03 30. 01 30. 02 30. 03 30. 04 30. 05 30. 05 30. 07 30. 07 30. 08 30. 08 30. 09 30. 08 30. 08 30. 09 30. 08 30. 09 30. 09 30. 09 30. 09 30. 09 30. 09 30. 09 30. 09 30. 09 30. 09 30. 09 30. 09 30. 09 31. 01 32. 00 33. 01 34. 00 34. 00 35. 02 36. 03 37. 04 38. 06 38. 07 38. 07 38. 08 38	29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ol	29.00
29. 99 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment (see instructions) 30. 03 Sequestration adjustment-PARHM 31. 00 Interim payments 31. 01 Interim payments 31. 01 Interim payments-PARHM 32. 00 Tentative settlement (for contractor use only) 32. 01 Tentative settlement (For contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30. 03, 31. 01, and 32. 01) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	29.50	Pioneer ACO demonstration payment adjustment (see instructions)	ol	29. 50
30.00 Subtotal (see instructions) 30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment-PARHM 31.00 Interim payments Interim payments-PARHM 32.00 Tentative settlement (for contractor use only) 32.01 Tentative settlement -PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  1, 572, 603 30.00 30.01 30.02 30.03 31.00 31.00 31.00 32.01 31.00 31.00 31.01 32.01 33.00 33.01 34.00	29. 98	Recovery of accelerated depreciation.	ol	29. 98
30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment-PARHM 31.00 Interim payments Interim payments Interim payments-PARHM 31.01 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 30.01 30.02 30.03 31.00 31.00 31.01 32.01 32.01 33.01 34.00	29. 99	Demonstration payment adjustment amount before sequestration	ol	29. 99
30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment-PARHM 31.00 Interim payments Interim payments-PARHM 32.00 Tentative settlement (for contractor use only) 32.01 Tentative settlement -PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  30.01 30.02 30.03 1, 924, 708 31.00 31.01 31.01 32.01 32.01 33.01 34.00	30.00		1, 572, 603	30.00
30.02 Demonstration payment adjustment amount after sequestration  30.03 Sequestration adjustment-PARHM  31.00 Interim payments  Interim payments-PARHM  31.01 Tentative settlement (for contractor use only)  32.00 Tentative settlement-PARHM (for contractor use only)  33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)  33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)  34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  0 30.02 30.03  1, 924, 708 31.00  31.01 32.00  32.00 32.00  32.00 33.01 32.00  33.01 33.01 33.01 30.02, 31, and 32)  33.01 30.02 31.01 32.00  33.02 30.02 31.01 32.00  33.03 31.01 32.00  33.03 31.01 32.00  33.03 33.01 33.01	30. 01	Sequestration adjustment (see instructions)		
30.03 Sequestration adjustment-PARHM 30.03 31.00 Interim payments 1,924,708 31.00 31.01 Interim payments-PARHM 1,924,708 31.00 31.01 Tentative settlement (for contractor use only) 0 32.00 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 32.00 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 33.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00				
31.00 Interim payments 31.01 Interim payments 31.01 Interim payments-PARHM 31.01 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00		, , , , , , , , , , , , , , , , , , , ,		30. 03
31.01 Interim payments-PARHM 32.00 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00			1, 924, 708	1
32.00 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00			,, . 00	
32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00			n	
33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)  33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)  34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  0 34.00			ĭ	
33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00		· • • • • • • • • • • • • • • • • • • •	-382 299	
34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00			002, 277	
				•
	2 30			

Health Financial Systems

CALCULATION OF REIMBURSEMENT SETTLEMENT In Lieu of Form CMS-2552-10 Provider CCN: 14-1319

Worksheet E-3
Part VI
Date/Time Prepared:
10/24/2023 5:18 pm
PPS Peri od: From 06/01/2022 To 05/31/2023 Component CCN: 14-5464 Skilled Nursing Facility Title XVIII

		1. 00				
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART	A PPS SNF				
	SERVI CES					
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)					
1.00	Resource Utilization Group Payment (RUGS)	210, 674	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)	210, 674	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,		5.00			
	Part B. This line is now shaded.)					
6. 00	Deducti bl e	0	6. 00			
7. 00	Coi nsurance	41, 404	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			
	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)	169, 270				
13. 00	Inpatient primary payer payments	0	13.00			
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00			
	Pioneer ACO demonstration payment adjustment (see instructions)	0	14. 50			
14. 98	Recovery of accelerated depreciation.	0	14. 98			
14. 99	Demonstration payment adjustment amount before sequestration	0	14. 99			
	Subtotal (see instructions	169, 270				
15. 01	Sequestration adjustment (see instructions)	3, 217	15. 01			
15. 02	Demonstration payment adjustment amount after sequestration	0	15. 02			
15. 75	Sequestration for non-claims based amounts (see instructions)	0	15. 75			
16. 00		166, 053				
	Tentative settlement (for contractor use only)	0				
	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)	0	18. 00			
19. 00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19. 00			

Heal th Fi nanci al Systems STATE HENRY (1971 TAL)

Health Financial Systems

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column

onl y)

Provider CCN: 14-1319

Peri od: Worksheet G From 06/01/2022 To 05/31/2023 Date/Time Pr

Date/Time Prepared: 10/24/2023 5:18 pm

In Lieu of Form CMS-2552-10

		General Fund	Speci fi c	Endowment	10/24/2023 5: Plant Fund	18 pm
		General Tuna	Purpose Fund	Fund	Traire runu	
		1. 00	2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	17, 448, 993		0	0	
2. 00 3. 00	Temporary investments Notes receivable	45, 695, 441		0	0	2. 00 3. 00
4. 00	Accounts receivable	32, 628, 632		0	0	4.00
5. 00	Other receivable	1, 164, 718	1	0	Ö	
6.00	Allowances for uncollectible notes and accounts receivable			0	0	6.00
7. 00	Inventory	823, 342	0	0	0	
8.00	Prepai d expenses	0	0	0	0	8. 00
9.00	Other current assets	1, 805, 728	1	0	0	9.00
10.00	Due from other funds	0	0	0		10.00
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	69, 367, 148	0	0	0	11.00
12. 00	Land	1, 358, 669	O	0	0	12.00
13. 00	Land improvements	1, 658, 717	1	0		
14. 00	Accumulated depreciation	-1, 360, 671	l o	0	Ō	14.00
15.00		46, 560, 826	O	0	0	15.00
16.00	Accumulated depreciation	-30, 644, 480	0	0	0	16.00
17.00	· •	0	0	0	0	17. 00
18. 00		0	0	0	0	18. 00
	Fi xed equipment	21, 335, 163	1	0	0	19.00
20.00		-14, 228, 902	1	0	0	
21. 00 22. 00		0	0	0	0	21. 00 22. 00
23. 00		1, 844, 531		0	)   	23.00
24. 00		-1, 224, 209	_	0	0	24.00
25. 00	Mi nor equi pment depreci abl e	1,221,207	ő	0	Ő	25. 00
	Accumul ated depreciation	Ō	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	Mi nor equi pment-nondepreci abl e	881, 117		0		
30. 00	, ,	26, 180, 761	0	0	0	30.00
21 00	OTHER ASSETS	0		0	0	21 00
31. 00 32. 00	Investments Deposits on Leases	0	0	0	0	
33. 00	Due from owners/officers	0		0	0	
34. 00	1	14, 697, 631		0	0	
35. 00	Total other assets (sum of lines 31-34)	14, 697, 631	1	0	_	
36.00	Total assets (sum of lines 11, 30, and 35)	110, 245, 540	1	0		36.00
	CURRENT LIABILITIES					
37.00		0	0	0		
38. 00	Salaries, wages, and fees payable	3, 628, 578	1	0		
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	, , , , , , , , , , , , , , , , , , , ,	661, 508	0	0	0	
41. 00 42. 00	Deferred income Accelerated payments	001, 508		U	U	41. 00 42. 00
43. 00	Due to other funds	0	o	0	0	1
44. 00		5, 292, 510		0	ő	
	Total current liabilities (sum of lines 37 thru 44)	9, 582, 596		0	0	
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46. 00
47.00	Notes payable	3, 294, 149	1	0	0	
48. 00	Unsecured Loans	0	0	0	0	
49.00	Other long term liabilities	25, 135, 459	1	0		
	Total long term liabilities (sum of lines 46 thru 49)	28, 429, 608	1	0		
51. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	38, 012, 204	0	0	0	51.00
52. 00	General fund balance	72, 233, 336				52.00
53. 00	Specific purpose fund	72,200,000	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	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
EO 00	replacement, and expansion	70 000 001		_	_	F0 00
59.00	Total fund balances (sum of lines 52 thru 58)	72, 233, 336	1	0	0	
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	110, 245, 540	1	0		00.00
	1=:/	1	1		1	ı

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

In Lieu of Form CMS-2552-10
Worksheet G-1

Provider CCN: 14-1319

Peri od: Worksheet G-1 From 06/01/2022 To 05/31/2023 Date/Time Prepared:

						10/24/2023 5:	18 pm
		General	Fund	Speci al	Purpose Fund	Endowment	
						Fund	
		1. 00	2. 00	3.00	4. 00	5. 00	
1.00	Fund balances at beginning of period		64, 225, 421		C	)	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		8, 105, 799				2.00
3.00	Total (sum of line 1 and line 2)		72, 331, 220		C	)	3.00
4.00	NET INCOME FROM FOUNDATION	0			0	0	4. 00
5.00		0			0	0	
6.00		0			0	0	
7.00		0			0	0	
8.00		0			0	0	
9.00		0			0	0	1 7.00
10.00	Total additions (sum of line 4-9)		0		C	)	10.00
11. 00	Subtotal (line 3 plus line 10)		72, 331, 220		C	)	11.00
12.00	NET LOSS FROM FOUNDATION	108, 288			0	0	
13.00		0			0	0	
14. 00		0			0	0	1
15. 00		0			0	0	
16.00		0			0	0	
17. 00		0			0	0	
18. 00	Total deductions (sum of lines 12-17)		108, 288		C	)	18.00
19. 00	Fund balance at end of period per balance		72, 222, 932		C	)	19. 00
	sheet (line 11 minus line 18)	E . I I	DI I				
		Endowment	Prant	Fund			
		Fund					
		6. 00	7. 00	8.00			
1. 00	Fund balances at beginning of period	0.00	71.00	0.00	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)	o			0		10.00
11.00	Subtotal (line 3 plus line 10)	O			0		11.00
12.00	NET LOSS FROM FOUNDATION		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	0			0		19.00
	sheet (line 11 minus line 18)			l			

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provi der CCN: 14-1319

In Lieu of Form CMS-2552-10

Period: Worksheet G-2
From 06/01/2022 Parts I & II
To 05/31/2023 Date/Time Prepared: 10/24/2023 5: 18 pm

			'	0 03/31/2023	10/24/2023 5:	
	Cost Center Description		I npati ent	Outpati ent	Total	
			1.00	2. 00	3. 00	
PART I - PATIENT REVENUES						
	General Inpatient Routine Services					
1. 00	Hospi tal		2, 056, 304		2, 056, 304	1.00
2.00	SUBPROVIDER - I PF					2.00
3.00	SUBPROVI DER - I RF					3.00
4. 00	SUBPROVI DER				0	4.00
5. 00	Swing bed - SNF		0		0	5. 00 6. 00
6. 00 7. 00	Swing bed - NF   SKILLED NURSING FACILITY		3, 020, 431		3, 020, 431	7.00
8. 00	NURSI NG FACI LI TY		3,020,431		3, 020, 431	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, 076, 735		5, 076, 735	10.00
10.00	Intensive Care Type Inpatient Hospital Services		0,070,700		0,070,700	10.00
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	0		0	16. 00
	11-15)					
17. 00	Total inpatient routine care services (sum of lines 10 and 16	)	5, 076, 735		5, 076, 735	17. 00
18. 00	Ancillary services		6, 264, 576	88, 670, 777	94, 935, 353	18. 00
19.00	Outpati ent servi ces		0	0	0	19.00
20.00	KEWANEE RHC		0	5, 695, 426	5, 695, 426	20.00
20. 01	WYOMI NG RHC		0	4 725 222	4 725 222	20. 01
20. 02	GENESEO RHC		0	., . = - ,	4, 725, 333	20. 02
20. 03 20. 04	ANNAWAN RHC		0	1, 085, 886 992, 059	1, 085, 886 992, 059	
21. 00	CAMBRIDGE RHC   FEDERALLY QUALIFIED HEALTH CENTER			992, 039	992,039	20.04
22. 00	HOME HEALTH AGENCY		0	861, 058	861, 058	22.00
23. 00	AMBULANCE SERVICES			001, 030	001, 000	23. 00
24. 00	CMHC					24.00
24. 10	CORF		0	o	0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P. )					25.00
26.00	HOSPI CE					26.00
27.00	COLONA CLINIC		0	1, 416, 506	1, 416, 506	27.00
27. 01	PAIN CLINIC		0	24, 204	24, 204	27. 01
27. 02	SURGI CAL CLI NI C		0	441, 920	441, 920	27. 02
27. 03	PROFESSI ONAL FEES		597, 876		7, 358, 320	27. 03
27. 04	CAMBRI DGE CLI NI C		0	992, 059	992, 059	27. 04
27. 05	ANNAWAN CLINIC		0	0	0	27. 05
27. 06	PORT BYRON CLINIC		0	735, 133	735, 133	27.06
27. 07	MUSCATINE CLINIC	to Wkot	11 020 107	112 400 005	124 220 002	27. 07
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 G-3. line 1)	to WKSt.	11, 939, 187	112, 400, 805	124, 339, 992	28. 00
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			50, 614, 456		29. 00
30.00	PROVISION FOR BAD DEBT		2, 355, 103			30.00
31. 00	THOUSE OF THE BLEST		2,000,100	l I		31.00
32. 00			l o	1		32.00
33. 00			0			33.00
34.00			0			34.00
35.00			0			35.00
36.00	Total additions (sum of lines 30-35)			2, 355, 103		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)	2) (+====================================		0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 4 to Wkst. G-3, line 4)	z) (transter		52, 969, 559		43. 00
	ILU WASE. U-S, TITIE 4)		I	ı l		l

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Health Financial Systems

Harmon-HENRY Goo'l TAL

In Lieu of Form CMS-2552-10

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1319
Period:
From 06/01/2022
To 05/31/2023
Date/Time Prepared:
10/24/2023 Ft 10 202

			lo 05/31/2023	Date/lime Pre	
				10/24/2023 5:	18 piii
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)			124, 339, 992	1.00
2. 00	Less contractual allowances and discounts on patients' accounts			69, 841, 523	1
3. 00	Net patient revenues (line 1 minus line 2)			54, 498, 469	
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			52, 969, 559	4.00
5. 00	Net income from service to patients (line 3 minus line 4)			1, 528, 910	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			56, 890	6.00
7.00	Income from investments			815, 674	7.00
8.00	Revenues from telephone and other miscellaneous communication services			110	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			157, 140	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			191, 531	14.00
15.00	Revenue from rental of living quarters			0	15. 00
16.00					
17.00	3				17.00
18. 00					18. 00
19.00	00 Tuition (fees, sale of textbooks, uniforms, etc.)				19.00
20.00				0	20. 00
21. 00				0	21.00
22. 00				0	22.00
23.00				0	23. 00
24.00				-320, 505	1
24. 01	RENTAL INCOME			195, 907	•
24. 02	PROPERTY I NCOME			1, 078, 512	
24. 03	340B PHARMACY REVENUE			1, 248, 806	ł
24. 04	OTHER (SPECIFY)			0	24. 04
24. 05	OTHER OPERATING REVENUE			280, 233	ł
24. 06				0	24.06
24. 50	1			3, 920, 725	1
25.00	· · · · · · · · · · · · · · · · · · ·			7, 628, 383	
26.00				9, 157, 293	
27. 00				1, 014, 285	1
27. 02				37, 209	
28. 00				1, 051, 494	
29.00	Net income (or loss) for the period (line 26 minus line 28)			8, 105, 799	29.00

In Lieu of Form CMS-2552-10

Health Financial Systems

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS Provider CCN: 14-1319 Peri od: From 06/01/2022 To 05/31/2023 Worksheet H Date/Time Prepared: 10/24/2023 5:18 pm HHA CCN: 14-7450

						Home Health	10/24/2023 5: PPS	18 pm
		Salarias	Empl oyee	Transportatio	Contracted/Pu	Agency I Other Costs	Total (sum of	
		Sal ari es	Benefits	n (see	rchased	other costs	cols. 1 thru	
				instructions)	Servi ces		5)	
	I	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
1. 00	GENERAL SERVICE COST CENTERS  Capital Related - Bldg. &	1				٥	0	1.00
1.00	Fixtures			0		U	0	1.00
2.00	Capital Related - Movable			О		0	0	2.00
	Equi pment							
3. 00 4. 00	Plant Operation & Maintenance Transportation	0	0	0	0	0	0	3. 00 4. 00
5. 00	Administrative and General	139, 050	0	223	7, 312	14, 672	161, 257	5.00
	HHA REIMBURSABLE SERVICES				,			
6. 00	Skilled Nursing Care	429, 762	0	45, 801	0	0	475, 563	1
7. 00 8. 00	Physical Therapy Occupational Therapy	0	0	0	0	0	0	7. 00 8. 00
9. 00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	o	0	Ö	0	0	0	10.00
11. 00	Home Health Aide	29, 420	0	47	0	0	29, 467	11.00
12.00	Supplies (see instructions)	0	0	0	0	52, 621	52, 621	12.00
13. 00 14. 00	Drugs DME	0	0		0	0	0   0	13. 00 14. 00
14.00	HHA NONREI MBURSABLE SERVI CES				J	<u> </u>		14.00
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 18. 00	Private Duty Nursing	0	0	0	0	0	0	17. 00 18. 00
19. 00	Health Promotion Activities		0	0	0	0	0	19.00
20. 00	Day Care Program	Ö	0	Ö	ő	Ö	Ö	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 23. 50	All Others (specify) Telemedicine	0	0	0	0	0	0	23. 00 23. 50
24. 00	Total (sum of lines 1-23)	598, 232	0	46, 071	7, 312	67, 293	718, 908	•
		Recl assi fi cat	Recl assi fi ed	Adjustments	Net Expenses			
		i on	Trial Balance		for			
			(col. 6 + col.7)		Allocation (col. 8 +			
			COI . 1)		col. 9)			
		7. 00	8. 00	9. 00	10.00			
1 00	GENERAL SERVICE COST CENTERS							1 00
1. 00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2. 00	Capital Related - Movable	0	0	0	0			2.00
	Equi pment							
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4. 00 5. 00	Transportation Administrative and General		161, 257	-5, 250	156, 007			4. 00 5. 00
5.00	HHA REIMBURSABLE SERVICES	<u> </u>	101, 237	-5, 250	130,007			3.00
6. 00	Skilled Nursing Care	0	475, 563	0	475, 563			6.00
7. 00	Physi cal Therapy	0	0	0	0			7.00
8.00	Occupational Therapy	0	0	0	0			8.00
9. 00 10. 00	Speech Pathology Medical Social Services	0	0	0	0			9. 00 10. 00
11. 00	Home Heal th Ai de	l ő	29, 467	ĺ	29, 467			11.00
12.00	Supplies (see instructions)	0	52, 621	0	52, 621			12.00
13. 00	Drugs	0	0		_			13.00
14. 00	DME	0	0	0	0			14.00
15. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	0	0			15. 00
16. 00	Respiratory Therapy		0	l	0			16.00
17. 00	Pri vate 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 21. 00	Day Care Program Home Delivered Meals Program	0	0	0	0			20. 00 21. 00
22. 00	Homemaker Service		0	0	0			22.00
23. 00	All Others (specify)		0	0	0			23. 00
23. 50		0	0	0	0			23.50
24. 00	Total (sum of lines 1-23)	0	718, 908	-5, 250	713, 658			24.00

Health Financial Systems
COST ALLOCATION - HHA GENERAL SERVICE COST In Lieu of Form CMS-2552-10 Peri od: Worksheet H-1
From 06/01/2022 Part I
To 05/31/2023 Date/Time Prepared: 10/24/2023 5: 18 pm Provider CCN: 14-1319 HHA CCN: 14-7450

						Home Health	PPS	то рііі
			Capital Rela	ated Costs		Agency I		
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	BI dgs & Fixtures	Movabl e Equi pment	Plant Operation & Maintenance	Transportati o n	Subtotal (col s. 0-4)	
		0	1. 00	2.00	3. 00	4.00	4A. 00	
1 00	GENERAL SERVICE COST CENTERS	0	0		ı			1 00
1. 00	Capital Related - Bldg. & Fixtures		٩				0	1.00
2. 00	Capital Related - Movable Equipment	0		0			0	
3. 00 4. 00	Plant Operation & Maintenance Transportation	0	0	0			0	3. 00 4. 00
5. 00	Administrative and General	156, 007	Ö	Ö	•		156, 007	1
	HHA REIMBURSABLE SERVICES	475 5/0	ما				475 5/0	, ,,
6. 00 7. 00	Skilled Nursing Care Physical Therapy	475, 563 0	0	0	•		475, 563 0	1
8. 00	Occupational Therapy	Ö	Ö	0			0	1
9. 00	Speech Pathology	0	0	0	(	_	0	9.00
10. 00 11. 00	Medical Social Services Home Health Aide	0 29, 467	0	0		_	0 29, 467	
12. 00	Supplies (see instructions)	52, 621	0	0			52, 621	•
13.00	Drugs	0	О	0			0	13.00
14. 00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0	(	0	0	14. 00
15. 00	Home Dialysis Aide Services	0	ol	0		0	0	15. 00
16.00	Respiratory Therapy	0	O	0	•		0	16. 00
17. 00	Private Duty Nursing	0	0	0	(	0	0	17.00
18. 00 19. 00	Clinic Health Promotion Activities	0	0	0		0	0	18. 00 19. 00
20. 00	Day Care Program		Ö	0			0	20.00
21. 00	Home Delivered Meals Program	O	0	0			0	
22. 00	Homemaker Service	0	0	0			0	
23. 00 23. 50	All Others (specify) Telemedicine	0	0	0			0	23. 00 23. 50
	Total (sum of lines 1-23)	713, 658	Ō	0			713, 658	
		Administrativ e & General 5.00	Total (cols. 4A + 5) 6.00					
	GENERAL SERVICE COST CENTERS							
1. 00	Capital Related - Bldg. & Fixtures							1.00
2. 00	Capital Related - Movable							2. 00
	Equi pment							
3. 00 4. 00	Plant Operation & Maintenance Transportation							3. 00 4. 00
5. 00	Administrative and General	156, 007						5.00
	HHA REIMBURSABLE SERVICES							
6. 00 7. 00	Skilled Nursing Care Physical Therapy	133, 042	608, 605					6. 00 7. 00
8. 00	Occupational Therapy		o					8.00
9. 00	Speech Pathology	O	О					9. 00
10.00	Medical Social Services	0	0					10. 00 11. 00
11. 00 12. 00	Home Health Aide Supplies (see instructions)	8, 244 14, 721	37, 711 67, 342					12.00
13. 00	Drugs	0	0					13. 00
14. 00	DME	0	0					14.00
15. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0					15. 00
16. 00	Respiratory Therapy	Ö	o					16.00
17. 00	Private Duty Nursing	0	0					17. 00
18. 00 19. 00	Clinic Health Promotion Activities	0	0					18. 00 19. 00
20. 00	Day Care Program		o					20.00
21.00	Home Delivered Meals Program	0	O					21.00
22. 00	Homemaker Service	0	0					22.00
23. 00 23. 50	All Others (specify) Telemedicine		0					23. 00 23. 50
	Total (sum of lines 1-23)		713, 658					24. 00

Health Financial Systems

COST ALLOCATION - HHA STATISTICAL BASIS

In Lieu of Form CMS-2552-10

Peri od: Worksheet H-1
From 06/01/2022 Part II
To 05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm Provider CCN: 14-1319 HHA CCN: 14-7450 Home Health PPS

						Agency I	FF3	
		Capital Rel	atad Costs			Agency		
		Capi tai Kei	ateu costs					
		BI dgs &	Movabl e	Plant	Transportation	Reconciliatio	Administrativ	-
		Fi xtures	Equi pment	Operation &	n (MI LEAGE)	n	e & General	
		(SQUARE FEET)	(DOLLAR	Maintenance	II (WILLAGE)	11	(ACCUM. COST)	
		(SQUARE LELT)	VALUE)	(SQUARE FEET)			(ACCOM. COST)	
		1. 00	2.00	3. 00	4. 00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	JA. 00	3.00	
1. 00	Capital Related - Bldg. &	0				0		1.00
1.00	Fixtures	J				J		1.00
2. 00	Capital Related - Movable		0			0		2.00
2.00	Equi pment		O			J		2.00
3. 00	Plant Operation & Maintenance	n	0	ر ا		0		3.00
4. 00	Transportation (see		0					4.00
4.00	instructions)	J	O		,			4.00
5. 00	Administrative and General	0	0			-156, 007	557, 651	5.00
5. 00	HHA REIMBURSABLE SERVICES	0			,	130,007	337,031	3.00
6. 00	Skilled Nursing Care	0	0		) (	0	475, 563	6.00
7. 00	Physical Therapy		0		1		473,303 n	7.00
8. 00	Occupational Therapy		0				n	8.00
9. 00	Speech Pathology	0	0				0	9.00
10.00	Medical Social Services	0	0				0	10.00
11. 00	Home Heal th Aide	0	0				29, 467	
12.00	Supplies (see instructions)	0	0					12.00
13. 00	Drugs	0	0			0	0 0 0 0	1
14. 00	DME	0	0				0	
14.00	HHA NONREI MBURSABLE SERVI CES	<u> </u>				0		14.00
15. 00	Home Dialysis Aide Services	0	0	C		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	18.00
19.00	Health Promotion Activities	0	0				0	19.00
20.00		0	0				0	20.00
	Day Care Program	0	0			0	0	
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	23.00
23. 50	Tel emedicine	0	0			15/ 207	J 557 /54	23.50
24. 00	Total (sum of lines 1-23)	0	0			-156, 007	557, 651	
25. 00	Cost To Be Allocated (per		0		ן כי	1	156, 007	25. 00
27 00	Worksheet H-1, Part I)	0.000000	0.000000	0 000000	0.00000		0 070757	2/ 00
26.00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0.000000	1	0. 279757	J 26. UU

Health Financial Systems

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

In Lieu of Form CMS-2552-10 Provider CCN: 14-1319

> HHA CCN: 14-7450

Peri od: Worksheet H-2
From 06/01/2022 Part I
To 05/31/2023 Date/Time Prepared: 10/24/2023 5: 18 pm Peri od:

Н

ome Health	PPS
Agonov I	

						Agency I	PPS	
			CAPI TAL REI	ATED COSTS		Agency		
	Cost Center Description	HHA Trial	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	DATA	PURCHASI NG	
		Bal ance (1)			BENEFITS	PROCESSI NG	RECEIVING AND	
			1.00	0.00	DEPARTMENT	F 04	STORES	
1 00	Administrative and General	0 0	1.00	2.00	4. 00 129, 390	5. 01 67, 274	5. 02	1 00
1. 00 2. 00	Skilled Nursing Care	608, 605	18, 797	253		07, 274	2, 967 0	1. 00 2. 00
3. 00	Physical Therapy	000,000	0	0		0		3. 00
4. 00	Occupational Therapy	0	0	0	0	0	ol ol	4. 00
5. 00	Speech Pathology	Ō	0	Ō	Ō	0	o	5. 00
6.00	Medical Social Services	0	0	0	0	0	o	6.00
7.00	Home Health Aide	37, 711	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	67, 342	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 12. 00	Home Dialysis Aide Services Respiratory Therapy	0	0	0		0	0	11. 00 12. 00
13. 00	Pri vate Duty Nursing	0	0	0			0	13. 00
14. 00	Clinic	0	0	0	· ·	_	Ö	14. 00
15. 00	Health Promotion Activities	0	0	Ō	0	0	o	15. 00
16.00	Day Care Program	0	0	0	0	0	o	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	Tel emedi ci ne	0	0	0	0	0	0	19.50
20. 00 21. 00	Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	713, 658	18, 797	253	129, 390	67, 274	2, 967	20. 00 21. 00
21.00	26, line 1 divided by the sum							21.00
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
	Cost Center Description	ADMITTING	CASHI ERI NG/AC	Subtotal	ALL OTHER	OPERATION OF	LAUNDRY &	
			COUNTS RECEI VABLE		ADMINISTRATIV E AND GE	PLANT	LINEN SERVICE	
		5. 03	5. 04	5A. 04	5. 05	7. 00	8. 00	
1. 00	Administrative and General	0	8, 641	227, 322			0	1. 00
2.00	Skilled Nursing Care	0	0	608, 605	60, 004	0	0	2.00
3.00	Physi cal 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 7. 00	Medical Social Services Home Health Aide	0	0	U 27 711	3, 718	0	0	6. 00 7. 00
8. 00	Supplies (see instructions)	0	0	37, 711 67, 342			0	8. 00
9. 00	Drugs	0	0	07,342	0,037	0	Ö	9. 00
10.00	DME	Ö	o o	Ö	Ö	0	o	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	o	11.00
12.00	Respi ratory 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	14.00
	Health Promotion Activities	0	0	0	0	0	0	15.00
16. 00 17. 00	Day Care Program Home Delivered Meals Program	)   	0	0	0	0	0	16. 00 17. 00
18. 00	Homemaker Service	0	0	0	0	0		18.00
19. 00	All Others (specify)	l ő	0	Ö	l ő	0	Ö	19. 00
19. 50		1	1	ا آ	l o	0	ol	19. 50
	Tel emedi ci ne	0	0			0	l ol	. ,
20.00	Total (sum of lines 1-19) (2)	0	8, 641	940, 980		19, 664	o	20.00
20.00	Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	0	8, 641	940, 980 0. 000000		19, 664	_	
	Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	0	8, 641			19, 664	_	20.00
	Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	0	8, 641			19, 664	_	20.00
	Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	0	8, 641			19, 664	_	20.00

<sup>(1)</sup> Column O, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

In Lieu of Form CMS-2552-10

Health Financial Systems

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Worksheet H-2 Part I Date/Time Prepared: 10/24/2023 5:18 pm Provider CCN: 14-1319 Peri od: From 06/01/2022 To 05/31/2023 HHA CCN: 14-7450 Home Health

						Agency I	113	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
					ADMI NI STRATI O	SERVICES &		
		2.00	10.00	44.00	N	SUPPLY	15.00	
1. 00	Administrative and General	9. 00 2, 427	10. 00	11. 00	13.00	14. 00	15. 00 0	1. 00
2.00	Skilled Nursing Care	2,427	0			0	0	2.00
3.00	Physical Therapy		0		· -	0	0	3.00
4. 00	Occupational Therapy		0		· -	0	0	4. 00
5. 00	Speech Pathology		0		· -	0	0	5. 00
6. 00	Medical Social Services	Ö	0	d	o	Ö	0	6. 00
7.00	Home Heal th Aide	О	0	C	0	О	0	7. 00
8.00	Supplies (see instructions)	0	0	C	0	0	0	8.00
9.00	Drugs	0	0	C	0	0	0	9.00
10.00	DME	0	0	C	_	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	C	_	0	0	11.00
12.00	Respiratory Therapy	0	0	C		0	0	12. 00 13. 00
13. 00 14. 00	Private Duty Nursing	0	0		· -	0	0	14.00
15. 00	Health Promotion Activities		0			0	0	15. 00
16. 00	Day Care Program	0	0		o o	0	0	16. 00
17. 00	Home Delivered Meals Program	Ö	0	d		Ö	0	17. 00
18.00	Homemaker Service	О	0	C	0	0	0	18. 00
19. 00	All Others (specify)	0	0	C	0	0	0	19.00
19. 50	Tel emedi ci ne	0	0	C	0	0	0	19. 50
20.00	Total (sum of lines 1-19) (2)	2, 427	0	C	0	0	0	20.00
21. 00	Unit Cost Multiplier: column 26, line 1 divided by the sum							21. 00
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
				OTHER GENERAL				
	Octob Octob December 1	MEDIONI	6001.41	SERVI CE		1 . 1	0 1 1 1 1	
	Cost Center Description	MEDI CAL RECORDS &	SOCI AL SERVI CE	I NSERVI CE EDUCATI ON	Subtotal	Intern & Residents	Subtotal	
		LI BRARY	SERVICE	EDUCATION		Cost & Post		
						Stepdown		
						Adjustments		
1 00		16. 00	17. 00	18. 00	24.00	25. 00	26.00	1 00
1. 00 2. 00	Administrative and General	0	0	C		0	271, 825 668, 609	1. 00 2. 00
3.00	Skilled Nursing Care Physical Therapy	0	0		000,009	0	000, 009	3.00
4. 00	Occupational Therapy		0			0	0	4. 00
5. 00	Speech Pathology	l o	0		o o	o	0	5. 00
6.00	Medi cal Soci al Servi ces	О	0	C	0	0	0	6. 00
7.00	Home Health Aide	0	0	C	41, 429	0	41, 429	7.00
8.00	Supplies (see instructions)	0	0	C	73, 981	0	73, 981	8. 00
9.00	Drugs	0	0	C	0	0	0	9. 00
10.00	DME	0	0		0	0	0	10.00
11. 00 12. 00	Home Dialysis Aide Services Respiratory Therapy	0	0			0	0	11. 00 12. 00
13. 00	Private Duty Nursing	0	0		o o	ő	0	
14. 00	Clinic	Ö	0		1	Ö	0	
15.00	Health Promotion Activities	o	0	C	0	0	0	15.00
16.00	Day Care Program	0	0	C	0	0	0	16.00
17. 00	Home Delivered Meals Program	0	0	C	0	0	0	17. 00
18.00	Homemaker Service	0	0		0	0	0	18.00
19. 00 19. 50	All Others (specify) Telemedicine	0	0			0	0	19. 00 19. 50
20. 00	Total (sum of lines 1-19) (2)		0		· -	0	1, 055, 844	
21. 00	Unit Cost Multiplier: column		O		1,000,044	Ĭ	., 555, 544	21.00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.	l l		I	1			

<sup>(1)</sup> Column O, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

STATE COPY

In Lieu of Form CMS-2552-10

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS	Provi der		Peri od: From 06/01/2022	Worksheet H-2 Part I
	HHA CCN:	14-7450		Date/Time Prepared:
				10/24/2023 5:18 pm
			Home Health	PPS
			Agency I	

				Agency I	
	Cost Center Description		Total HHA		
		A&G (see Part	Costs		
		11)			
		27. 00	28. 00		
1.00	Administrative and General				1.00
2.00	Skilled Nursing Care	231, 811	900, 420		2.00
3.00	Physi cal Therapy	0	0		3.00
4.00	Occupational Therapy	0	0		4.00
5.00	Speech Pathology	0	0		5.00
6.00	Medical Social Services	0	0		6.00
7.00	Home Health Aide	14, 364	55, 793		7.00
8.00	Supplies (see instructions)	25, 650	99, 631		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	o		19.00
19. 50	Tel emedi ci ne	0	0		19. 50
20.00	Total (sum of lines 1-19) (2)	271, 825	1, 055, 844		20.00
21.00	Unit Cost Multiplier: column	0. 346707			21.00
	26, line 1 divided by the sum				
	of column 26, line 20 minus				
	column 26, line 1, rounded to				
	6 decimal places.				

<sup>(1)</sup> Column O, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Health Financial Systems

In Lieu of Form CMS-2552-10 ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL Provider CCN: 14-1319 Peri od: Worksheet H-2

HHA CCN:

From 06/01/2022

05/31/2023

14-7450

Part II

Date/Time Prepared:

17.00

18.00

19.00

19.50

20.00

21.00

22 00

1, 200

2, 427

2. 022500

10/24/2023 5: 18 pm Home Health PPS Agency I CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE PURCHASI NG** ADMITTI NG DATA Cost Center Description (SQUARE FEET) (DOLLAR **BENEFITS** PROCESSI NG RECEIVING AND (GROSS CHAR VALUE) DEPARTMENT (TIME SPENT) **STORES** GES) (GROSS (SUPPLY COS SALARIES) T) 2.00 5.03 1.00 4.00 5. 01 5.02 1.00 Administrative and General 1, 127 247 598, 233 3, 085 55, 198 1.00 2.00 Skilled Nursing Care 0 2.00 0 0 0 0 3 00 3 00 Physical Therapy 0 0 0 4.00 Occupational Therapy 0 4.00 Speech Pathology 0 5.00 0 0 5.00 0 0 6.00 Medical Social Services 000000000000 0 0 0 6.00 0 0 0 7 00 Home Health Aide Ω 7 00 0 8.00 Supplies (see instructions) C 8.00 9.00 0 0 9.00 Drugs 0 0 0 0 DME. 0 0 10.00 10.00 000 0 0 11.00 Home Dialysis Aide Services Ω 0 11.00 12.00 Respiratory Therapy 0 0 12.00 Private Duty Nursing 13.00 13.00 0 0 0 14.00 Clinic 0 14.00 0 15.00 Health Promotion Activities C 0 15.00 o 16.00 Day Care Program 16.00 17.00 Home Delivered Meals Program 0 0 0 0 17.00 0 0 0 0 Homemaker Service 18.00 C 0 18.00 0 0 0 19.00 All Others (specify) C 19.00 0 0 19.50 19.50 Tel emedi ci ne 0 0 55, 198 20.00 Total (sum of lines 1-19) 1.127 247 598, 233 3.085 20.00 21.00 Total cost to be allocated 18, 797 253 129, 390 67.274 2.967 21.00 22.00 Unit cost multiplier 16.678793 1.024291 0.216287 21.806807 0.053752 0.000000 22.00 CASHIERING/AC Reconciliatio ALL OTHER OPERATION OF LAUNDRY & HOUSEKEEPI NG Cost Center Description COUNTS ADMI NI STRATI V PLANT LINEN SERVICE (HOURS OF n (POUNDS OF RECEI VABLE E AND GE (SQUARE FEET) SERVICE) (ACCUM. COST) (GROSS CHAR LAUNDRY) GES) 5.04 5A. 05 5. 05 7.00 8.00 9.00 Administrative and General 1, 200 1.00 861, 058 00 1, 127 0 1.00 227. 322 2.00 Skilled Nursing Care 0 608, 605 0 2 00 o 3.00 Physical Therapy 0 000000000000000000 0 3.00 4.00 Occupational Therapy 0 0 4.00 0 0 Speech Pathology 0 0 5.00 5.00 C 0 0 6.00 Medical Social Services r 6.00 7.00 Home Heal th Aide 0 37, 711 0 0 0 0 7.00 0 8.00 Supplies (see instructions) 0 0 0 67, 342 8.00 Drugs 0 9.00 C 0 9.00 10.00 DMF C 10.00 Home Dialysis Aide Services 11.00 0 0 11.00 0 Respiratory Therapy 0 12.00 12.00 0 0 13.00 Private Duty Nursing C 13.00 0 14.00 14.00 Clinic 0 15.00 Health Promotion Activities 0 0 0 0 0 0 15.00 0 16,00 Day Care Program C 16,00

0

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861,058

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940, 980

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92, 773

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17.00

18.00

19.00 19.50

20.00

21.00

Home Delivered Meals Program

Total (sum of lines 1-19)

Total cost to be allocated

Homemaker Service

Tel emedi ci ne

22.00 Unit cost multiplier

All Others (specify)

BASIS

Health Financial Systems

HENRY LOCALTAL

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL Provider CCN: 14-1319 In Lieu of Form CMS-2552-10 Peri od: | Worksheet H-2 From 06/01/2022 | Part II To 05/31/2023 | Date/Ti me Prepared: 10/24/2023 5: 18 pm | BASIS

HHA CCN:

14-7450

						Home Health	PPS	•
	Cost Contan Decement on	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	Agency I PHARMACY	MEDI CAL	
	Cost Center Description	(MEALS	(FTES)	ADMI NI STRATI O	SERVICES &	(COSTED REQ	RECORDS &	
		SERVED)	(FIES)	N N	SUPPLY	UIS)	LI BRARY	
		JERVED)		(FTES)	(COSTED REQ	013)	(GROSS PT.	
				(1123)	UIS)		CHARGES)	
		10.00	11. 00	13. 00	14. 00	15. 00	16. 00	
1. 00	Administrative and General	0					0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physi cal 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	
8. 00	Supplies (see instructions)	0	0	0		-	0	1
9. 00	Drugs	0	0	0		-	0	
10.00	DME	0	0	0			0	1
11.00	Home Dialysis Aide Services	0	0	0	_	-	0	
12.00	Respiratory Therapy	0	0	0	0	-	0	
13. 00 14. 00	Private Duty Nursing Clinic	0	0	0		-	0	
15. 00	Health Promotion Activities	0	0	0		-	0	1
16. 00	Day Care Program		0	0	_	-	0	
17. 00	Home Delivered Meals Program		0	0	_	-	0	
18. 00	Homemaker Service	0	0		٥		0	1
19. 00	All Others (specify)	0	0			_	0	ı
19. 50	Tel emedi ci ne	0	0	0	0	-	0	1
20.00	Total (sum of lines 1-19)	0	0	o o	Ö	_	Ö	1
21. 00	Total cost to be allocated	l o	0	Ō	Ö	-	0	21. 00
22.00	Unit cost multiplier	0. 000000	0. 000000	0. 000000	0. 000000	0. 000000	0. 000000	22.00
			OTHER GENERAL					
			SERVI CE					
	Cost Center Description	SOCI AL	I NSERVI CE					
		SERVI CE	EDUCATI ON					
		(TIME SPENT)	(GROSS CHAR					
		17. 00	GES) 18. 00	_				
1. 00	Administrative and General	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	l o	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
	Clinic	0	0					14.00
	Health Promotion Activities	0	0					15.00
16.00		0						16.00
17. 00 18. 00	Home Delivered Meals Program Homemaker Service	0	0					17. 00 18. 00
19.00	All Others (specify)		0					19.00
19. 50	Telemedicine		0					19. 50
	Total (sum of lines 1-19)		0					20.00
21. 00	Total cost to be allocated	1 0	0					21.00
	Unit cost multiplier	0. 000000	0. 000000					22.00
	I Provide the Providence of th			1				

Heal th Financial Systems

APPORTIONMENT OF PATIENT SERVICE COSTS

HEALTH FOR THE PROPERTY OF 
Worksheet H-3 From 06/01/2022 Part I HHA CCN: 14-7450 То 05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm Title XVIII Home Health **PPS** Agency I Total Visits Cost Center Description From, Wkst. Facility Shared Total HHA Average Cost H-2, Part I, Costs (from Ancillary Costs (cols. Per Visit (col. 3 ÷ col. 28, line Wkst. H-2. Costs (from 1 + 2Part I) Part II) 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 2.00 900, 420 900, 420 4, 507 199. 78 1.00 2.00 Physical Therapy 3.00 116, 742 116, 742 3, 247 35.95 2.00 0 3.00 4.00 0 47, 889 47, 889 1, 157 41. 39 3.00 Occupational Therapy 4.00 Speech Pathology 5.00 0 20,004 20,004 172 116.30 4.00 5.00 Medical Social Services 6.00 0 28 0.00 5.00 6.00 Home Health Aide 7.00 910 61.31 6.00 55. 793 55 793 7.00 Total (sum of lines 1-6) 956, 213 184, 635 1, 140, 848 10, 021 7.00 Program Visits Part B Not Subject Cost Center Description Cost Limits CBSA No. (1) Part A Subject to to Deducti bl es Deductibles & Coi nsurance 0 1. 00 2.00 3.00 4.00 5.00 Limitation Cost Computation 8.00 Skilled Nursing Care 19340 1,430 8.00 99914 8.01 Skilled Nursing Care 0 769 8.01 Physical Therapy Physical Therapy 9 00 19340 0 936 9.00 9.01 99914 C 719 9.01 10.00 Occupational Therapy 19340 202 10.00 Occupational Therapy 10.01 99914 0 377 10.01 Speech Pathology 19340 0 11 00 11.00 15 11.01 Speech Pathology 99914 0 49 11.01 Medical Social Services 19340 5 12.00 12.00 12.01 Medical Social Services 99914 0 6 12.01 13.00 Home Health Aide 0 19340 13.00 412 13.01 Home Health Aide 99914 217 13.01 14.00 Total (sum of lines 8-13) 5, 137 14.00 Cost Center Description From Wkst. Facility Total HHA Total Charges Shared Ratio (col. H-2 Part I, Ancillary Costs (from Costs (cols. (from HHA ÷ col. 4) col. 28, line Wkst. H-2, Costs (from 1 + 2)Records) Part I) Part II) 1.00 2.00 3.00 4.00 5.00 Supplies and Drugs Cost Computations 15.00 Cost of Medical Supplies 8.00 99, 631 99, 631 0.000000 15.00 16.00 Cost of Drugs 9.00 0.000000 16.00 Program Visits Cost of Servi ces Part B Part B Cost Center Description Part A Not Subject Subject to Not Subject Subject to Part A Deductibles & Deductibles & to to Deductibles & Coi nsurance Deductibles & Coi nsurance Coi nsurance Coi nsurance 11.00 8.00 6.00 7.00 9.00 10.00 PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care 1.00 0 2.199 439, 316 1.00 0 2.00 Physical Therapy 1,655 59, 497 2.00 3.00 Occupational Therapy 0 579 0 23, 965 3.00 Speech Pathology 0 0 7, 443 4.00 4.00 64 5.00 Medical Social Services 11 5 00 6.00 38, 564 6.00 Home Heal th Aide 0 629 0 7.00 Total (sum of lines 1-6) 5, 137 568, 785 7.00

In Lieu of Form CMS-2552-10

Heal th Financial Systems

APPORTIONMENT OF PATIENT SERVICE COSTS

HEALTH FINANCIAL SYSTEMS

Provider CCN: 14-1319 | Period:

Worksheet H-3 From 06/01/2022 Part I HHA CCN: 14-7450 05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm Title XVIII Home Health PPS Agency I Cost Center Description 7.00 8.00 9.00 10.00 11.00 6.00 Limitation Cost Computation 8.00 Skilled Nursing Care 8.00 Skilled Nursing Care 8 01 8.01 9.00 9.00 Physical Therapy 9.01 Physical Therapy 9.01 Occupational Therapy 10.00 10.00 Occupational Therapy 10 01 10 01 11.00 Speech Pathology 11.00 Speech Pathology 11.01 11.01 Medical Social Services Medical Social Services 12.00 12.00 12.01 12 01 13.00 Home Health Aide 13.00 13.01 Home Heal th Aide 13.01 14.00 Total (sum of lines 8-13) 14.00 Program Covered Charges Cost of Servi ces Part B Part B Not Subject Cost Center Description Part A Subject to Part A Subject to Not Subject to Deductibles & to Deductibles & Deductibles & Coi nsurance Deductibles & Coi nsurance Coi nsurance Coi nsurance 6. 00 7. 00 8.00 9.00 10.00 11. 00 Supplies and Drugs Cost Computations 15 00 15.00 Cost of Medical Supplies 0 0 0 16.00 Cost of Drugs 0 0 0 16.00 Total Program Cost Center Description Cost (sum of col s. 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 439, 316 1.00 2.00 Physical Therapy 59, 497 2.00 3.00 Occupational Therapy 23, 965 3.00 Speech Pathology 4.00 7,443 4 00 5.00 Medical Social Services 0 5.00 6.00 Home Heal th Aide 38, 564 6.00 Total (sum of lines 1-6) 7.00 568, 785 7.00 Cost Center Description 12. 00 Limitation Cost Computation Skilled Nursing Care 8.00 8.00 8.01 Skilled Nursing Care 8.01 Physical Therapy 9.00 9.00 9.01 Physical Therapy 9.01 10.00 Occupational Therapy 10.00 10.01 Occupational Therapy 10.01 Speech Pathology 11.00 11.00 Speech Pathology 11.01 11.01 12.00 Medical Social Services 12.00 Medical Social Services 12.01 12.01

In Lieu of Form CMS-2552-10

13.00

13.01

14.00

13.00

13.01

Home Health Aide

Home Health Aide

14.00 Total (sum of lines 8-13)

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In Lieu of Form CMS-2552-10 APPORTIONMENT OF PATIENT SERVICE COSTS Provi der CCN: 14-1319 Worksheet H-3 Peri od: From 06/01/2022 Part II Date/Time Prepared: 10/24/2023 5:18 pm HHA CCN: 14-7450 То 05/31/2023 Home Health PPS Agency I Transfer to From Wkst. C, Cost Center Description Cost to Total HHA HHA Shared Ancillary Part I, col. 9, line Charge Ratio Part I as Charge (from provi der Costs (col. 1 Indi cated records) x col. 2) 3.00 0 1.00 2.00 4.00 PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS
Physical Therapy 66.00 0.382617 305,114 116,742 co 116,742 col. 2, line 2.00 1.00 1.00 2.00 Occupational Therapy 67.00 0. 311397 153, 788 47,889 col. 2, line 3.00 2.00 Speech Pathology Cost of Medical Supplies 20,004 col. 2, line 4.00 0 col. 2, line 15.00 0 col. 2, line 16.00 3.00 68.00 0. 529064 37, 810 3.00 71.00 0. 268633 4.00 4.00 C Cost of Drugs 0. 468802 0 5.00 5.00 73.00

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Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,

Health Financial Systems

Health Financial Systems

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Health Financial Systems

Health Financial Systems

In Lieu of Form CMS-2552-10

Provider CCN: 14-1319

Period: From 06/01/2022 Part I-II

HHA CCN:

14-7450

05/31/2023

Date/Time Prepared:

0 35.00

10/24/2023 5:18 pm Title XVIII Home Health Agency I Part B Part A Not Subject Subject to to Deductibles & Deductibles & Coi nsurance Coi nsurance 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) 1.00 Total charges 0 2.00 2.00 0 0 Customary Charges 3.00 Amount actually collected from patients liable for payment for services 0 0 0 3.00 on a charge basis (from your records) Amount that would have been realized from patients liable for payment 0 4 00 0 Ω 4 00 for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b) 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) 6.00 Excess of total customary charges over total reasonable cost (complete 0 7.00 0 0 7.00 only if line 6 exceeds line 1) 8.00 Excess of reasonable cost over customary charges (complete only if line 0 0 0 8.00 1 exceeds line 6) 9.00 Primary payer amounts 0 9.00 Part A Part B Servi ces Servi ces 1.00 2.00 PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT 10.00 0 Total reasonable cost (see instructions) 10.00 0 Total PPS Reimbursement - Full Episodes without Outliers 505, 772 11.00 11.00 Total PPS Reimbursement - Full Episodes with Outliers 0 184, 871 12.00 12.00 Total PPS Reimbursement - LUPA Episodes 13.00 0 0 6, 993 13.00 Total PPS Reimbursement - PEP Epi sodes 3, 420 14.00 14.00 15.00 Total PPS Outlier Reimbursement - Full Episodes with Outliers 65, 682 15.00 Total PPS Outlier Reimbursement - PEP Episodes 16.00 0 0 0 9, 419 16.00 17.00 Total Other Payments 0 17.00 DME Payments 18 00 0 18 00 19.00 Oxygen Payments 0 19.00 20.00 Prosthetic and Orthotic Payments 0 0 20.00 Part B deductibles billed to Medicare patients (exclude coinsurance) 21.00 21.00 Subtotal (sum of lines 10 thru 20 minus line 21) 0 22.00 776, 157 22.00 23.00 Excess reasonable cost (from line 8) 0 0 23.00 24.00 Subtotal (line 22 minus line 23) 0 776, 157 24.00 25.00 Coinsurance billed to program patients (from your records) 25.00 26.00 Net cost (line 24 minus line 25) 0 776, 157 26.00 27.00 Allowable bad debts (from your records) 0 27.00 27.01 Adjusted reimbursable bad debts (see instructions) 27.01 0 28.00 Allowable bad debts for dual eligible (see instructions) Λ 28.00 Total costs - current cost reporting period (see instructions) 776, 157 29.00 29.00 30.00 OTHER ADJUSTMENTS 0 0 -904 30.00 Pioneer ACO demonstration payment adjustment (see instructions) 30.50 0 30 50 30.99 Demonstration payment adjustment amount before sequestration 30.99 0 31.00 Subtotal (see instructions) 0 0 0 775, 253 31.00 Sequestration adjustment (see instructions) 14, 917 31.01 31.01 31.02 Demonstration payment adjustment amount after sequestration 31.02 0 31.75 Sequestration adjustment for non-claims based amounts (see instructions) 0 31.75 Interim payments (see instructions) 760, 337 32.00 32.00 0 Tentative settlement (for contractor use only) 33.00 33.00 0 Balance due provider/program (line 31 minus lines 31.01, 31.02, 31.75, 32, and 33) 34 00 -1 34.00

35.00

Health Financial Systems

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED

In Lieu of Form CMS-2552-10

Peri od: Worksnee: ...
From 06/01/2022
To 05/31/2023 Date/Ti me Prepared: 10/24/2023 5: 18 pm PPS Provi der CCN: 14-1319 TO PROGRAM BENEFICIARIES HHA CCN: 14-7450

				Agency I		
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider 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,		0		760, 337 0	1. 00 2. 00
3.00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.00
3. 01			0		0	3. 01
3. 02			O		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 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0	3. 54 3. 99
3. 99	3. 50-3. 98)		0		ا	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		760, 337	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5.00
0.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					0.00
F 01	Program to Provider		0		0	5. 01
5. 01 5. 02					0	5. 01
5. 02					0	5. 02
5.05	Provider to Program				0	5.05
5. 50	1. O. T. G. T. O. T. O. G.		0		0	5. 50
5. 51			ő		ő	5. 51
5. 52			Ō		o	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		0		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		1	6. 02
7. 00	Total Medicare program liability (see instructions)		0		760, 336	7.00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0 00	Name of Contractor	NATIONAL COVED		1. 00 06101	2. 00	9 00
8. 00		NATIONAL GOVER INC.	NINIENI SERVICES	06101		8. 00

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Health Financial Systems

H. Wayn-HENRY COST TAL

In Lieu of Form CMS-2552-10

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1319
Component CCN: 14-8576
Period:
From 06/01/2022
To 05/31/2023 5: 18 pm

						10/24/2023 5:	18 pm
					RHC I	Cost	
	·	Compensation	Other Costs	Total (col 1	Recl assi fi cat	Recl assi fi ed	
		oomponsa tron	011101 00313	+ col . 2)	i ons	Tri al Balance	
				+ (01. 2)	1 0115		
						(col. 3 +	
						col. 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	449, 808	0	449, 808	227, 729	677, 537	1.00
2.00	Physician Assistant	128, 610				128, 610	2.00
							3.00
3. 00	Nurse Practitioner	548, 365	0	548, 365	0	548, 365	
4.00	Visiting Nurse	0	0	0	0	0	4.00
5. 00	Other Nurse	314, 744	0	314, 744	0	314, 744	5. 00
6.00	Clinical Psychologist	0	0	0	0	0	6. 00
7.00	Clinical Social Worker	0	n	1	0	0	7.00
8.00	Laboratory Techni ci an	0	0	١	0	0	8.00
		407 407		407.407	45.074	_	
9. 00	Other Facility Health Care Staff Costs	187, 127	0			•	
10.00	Subtotal (sum of lines 1 through 9)	1, 628, 654	0	1, 628, 654	161, 753	1, 790, 407	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	1 0	0	0	12.00
13. 00	Other Costs Under Agreement	0	0		0	0	13.00
	Subtotal (sum of lines 11 through 13)	0	0		0	_	14.00
14.00		U	450.040	450 040	U	0	
15. 00	Medical Supplies	0	159, 343	159, 343	0	159, 343	
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	1	0	0	18. 00
19.00	Other Health Care Costs	0	0		0	0	19.00
20.00	Allowable GME Costs	O		Ĭ		ľ	20.00
		0	150 242	150 040		150 040	
21. 00	Subtotal (sum of lines 15 through 20)		159, 343			159, 343	
22.00	Total Cost of Health Care Services (sum of	1, 628, 654	159, 343	1, 787, 997	161, 753	1, 949, 750	22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	С	0	0	23.00
24.00	Dental	0	0	1	0	0	24.00
25. 00	Optometry	0	0		0	0	25. 00
	1	0			0	_	
25. 01	Tel eheal th	0	U		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	0	0	1	0	0	
20.00	through 27)	O		Ĭ		ľ	20.00
	FACILITY OVERHEAD						
00 00		0	(0.007	(0.007		(0.007	00 00
29. 00	Facility Costs	0	,			60, 097	29.00
30. 00	Administrative Costs	189, 686					
31.00	Total Facility Overhead (sum of lines 29 and	189, 686	333, 317	523, 003	45, 624	568, 627	31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	1, 818, 340	492, 660	2, 311, 000	207, 377	2, 518, 377	32.00
	and 31)	,		'- '-			
	1		ı	1	1	1	'

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ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS In Lieu of Form CMS-2552-10

Provider CCN: 14-1319 Peri od: From 06/01/2022 To 05/31/2023 Worksheet M-1 Date/Time Prepared: 10/24/2023 5:18 pm Component CCN: 14-8576

					RHC I	Cost	э рііі
		Adiustmonts	Net Expenses		KIIC I	COST	
		Adjustments	for				
			Allocation				
			(col. 5 +				
	•	/ 00	col. 6)				
	FACILITY HEALTH CARE CTAFE COCTO	6. 00	7. 00				
4 00	FACILITY HEALTH CARE STAFF COSTS		/77 507	I			4 00
1.00	Physi ci an	0	677, 537				1.00
2. 00	Physician Assistant	0	128, 610				2.00
3.00	Nurse Practitioner	0	548, 365	1			3.00
4.00	Visiting Nurse	0	0	1			4.00
5.00	Other Nurse	0	314, 744			•	5.00
6. 00	Clinical Psychologist	0	0				6.00
7.00	Clinical Social Worker	0	0				7.00
8.00	Laboratory Techni ci an	0	0				8.00
9.00	Other Facility Health Care Staff Costs	0	121, 151				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1, 790, 407			1	10.00
11.00	Physician Services Under Agreement	0	0			1	11.00
12.00	Physician Supervision Under Agreement	0	0			1	12.00
13.00	Other Costs Under Agreement	0	0			1	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0			1	14. 00
15. 00	Medical Supplies	0	159, 343				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	O	0				20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	159, 343			•	21. 00
22. 00	Total Cost of Health Care Services (sum of	0	1, 949, 750	1			22.00
22.00	lines 10, 14, and 21)	U	1, 747, 730			4	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	0			2	23. 00
24.00	Dental	0	0			•	23. 00 24. 00
	1	0	0	1			
25. 00	Optometry	0	1	1		•	25. 00
25. 01	Tel eheal th	0	0	ł			25. 01
25. 02	Chronic Care Management	0	0	1		•	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	0	0			2	28. 00
	through 27)						
	FACILITY OVERHEAD		T	1			
29. 00		0		1			29. 00
30.00	Administrative Costs	0	000,000	1		•	30. 00
31.00	Total Facility Overhead (sum of lines 29 and	0	568, 627			3	31. 00
	30)						
32.00	Total facility costs (sum of lines 22, 28	0	2, 518, 377			3	32. 00
	and 31)						

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Health Financial Systems	Н	D-HENRY YOU I TAL		In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der CCN: 14	1-1319 Peri od:	Worksheet M-1

From 06/01/2022 Component CCN: 14-8587 05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm RHC III Cost Recl assi fi ed Compensation Other Costs Total (col. 1 Reclassi fi cat Trial Balance + col. 2) i ons (col. 3 +col 4) 2.00 1.00 3.00 4.00 5.00 FACILITY HEALTH CARE STAFF COSTS 540, 907 540, 907 229, 489 1 00 770.396 1 00 Physi ci an 2.00 Physician Assistant 4, 207 0 4, 207 4, 207 2.00 3.00 Nurse Practitioner 590, 044 590, 044 0 590, 044 3.00 Visiting Nurse 4.00 0 0 4.00 C 0 Other Nurse 318, 565 318, 565 318, 565 5.00 0 0 5 00 6.00 Clinical Psychologist 6.00 7.00 Clinical Social Worker 0 0 0 7.00 Laboratory Techni ci an 8.00 8.00 0 0 0 0 Other Facility Health Care Staff Costs 232, 874 228, 551 9.00 Ω 232.874 -4.323 9 00 10.00 Subtotal (sum of lines 1 through 9) 1, 686, 597 1, 686, 597 225, 166 1, 911, 763 10.00 11.00 Physician Services Under Agreement 11.00 Physician Supervision Under Agreement 12.00 12.00 0 C 0 0 0 13.00 Other Costs Under Agreement 0 C 0 0 0 13.00 14.00 Subtotal (sum of lines 11 through 13) 0 14.00 Medical Supplies 0 15.00 206, 850 206, 850 206, 850 15.00 Transportation (Health Care Staff) 0 16,00 0 0 16,00 17.00 Depreciation-Medical Equipment 0 C 0 0 17.00 Professional Liability Insurance 0 0 18.00 0 0 0 18.00 Other Health Care Costs 19.00 19.00 0 20.00 Allowable GME Costs 20.00 21.00 Subtotal (sum of lines 15 through 20) 0 206, 850 206, 850 0 206, 850 21.00 Total Cost of Health Care Services (sum of 22.00 1, 686, 597 206, 850 1, 893, 447 225, 166 2, 118, 613 22.00 lines 10, 14, and 21)
COSTS OTHER THAN RHC/FQHC SERVICES Pharmacy 23.00 0 0 0 23.00 24.00 0 0 0 0 24.00 Dental 0 0 0 25.00 Optometry 0 25.00 0 0 25.01 25.01 Tel eheal th C 0 25. 02 Chronic Care Management 0 0 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 0 0 28.00 through 27) FACILITY OVERHEAD 2, 230 29.00 29.00 Facility Costs 2, 230 2.230 37, 852 30.00 Administrative Costs 206, 730 125, 966 332, 696 370, 548 30.00 31.00 Total Facility Overhead (sum of lines 29 and 206, 730 128, 196 334, 926 37, 852 372, 778 31.00 2, 491, 391 1, 893, 327 2, 228, 373 32 00 Total facility costs (sum of lines 22, 28 335 046 263, 018 32 00

and 31)

Heal th Financial Systems

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

In Lieu of Form CMS-2552-10

Provider CCN: 14-1319 Peri od: From 06/01/2022 To 05/31/2023 Worksheet M-1 Date/Time Prepared: 10/24/2023 5:18 pm Component CCN: 14-8587

					RHC III	Cost	то ріп
		Adjustments	Net Expenses		I KIIC III	0031	
		Auj ustilierits	for				
			Allocation				
			(col. 5 +				
		4 00	col. 6) 7.00	-			
	FACILITY HEALTH CARE STAFF COSTS	6. 00	7.00				
1 00	Physician		770, 396	1			1.00
1.00		0		1			
2.00	Physician Assistant	0	4, 207				2.00
3. 00	Nurse Practitioner	0	590, 044	1			3.00
4. 00	Visiting Nurse	0	0	1			4. 00
5.00	Other Nurse	0	318, 565				5.00
6. 00	Clinical Psychologist	0	0				6.00
7.00	Clinical Social Worker	0	0				7.00
8.00	Laboratory Techni ci an	0	0				8. 00
9.00	Other Facility Health Care Staff Costs	0	228, 551				9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	1, 911, 763				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	206, 850				15.00
16. 00	Transportation (Health Care Staff)	0	0	1			16.00
17. 00	Depreciation-Medical Equipment	0	0	1			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	O					20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	206, 850				21.00
22. 00	Total Cost of Health Care Services (sum of	0	2, 118, 613	1			22.00
22.00	lines 10, 14, and 21)	U	2,110,013				22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	0				23. 00
24.00	Dental	0	0				24.00
	1	0	0	1			
25. 00	Optometry	0	_	1			25.00
25. 01	Tel eheal th	0	0	ł			25. 01
25. 02	Chronic Care Management	0	0	1			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	0	0				28. 00
	through 27)						1
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	2, 230				29. 00
30.00	Administrative Costs	0	370, 548	1			30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	372, 778				31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	0	2, 491, 391				32.00
	and 31)						

Health Financial Systems

In Lieu of Form CMS-2552-10 ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS Provider CCN: 14-1319 Peri od: Worksheet M-1

From 06/01/2022 Component CCN: 14-8615 05/31/2023 To Date/Time Prepared: 10/24/2023 5:18 pm RHC IV Recl assi fi ed Compensation Other Costs Total (col. 1 Reclassi fi cat Trial Balance + col. 2) i ons (col. 3 +col. 4) 1.00 2.00 3.00 4.00 5.00 FACILITY HEALTH CARE STAFF COSTS 1 00 670 1 00 Physi ci an 670 670 2.00 Physician Assistant 33, 233 0 33, 233 23, 873 57, 106 2.00 3.00 Nurse Practitioner 212, 727 212, 727 23, 872 236, 599 3.00 Visiting Nurse 4.00 0 4.00 0 Other Nurse 19, 750 0 19,750 19,750 5.00 0 5.00 6.00 Clinical Psychologist 0 0 6.00 0 7.00 Clinical Social Worker 0 0 0 0 7.00 Laboratory Techni ci an C 8.00 8.00 0 0 0 Other Facility Health Care Staff Costs 115, 073 115, 073 52, 546 9.00 0 -62, 527 9 00 10.00 Subtotal (sum of lines 1 through 9) 381, 453 0 381, 453 -14, 782 366, 671 10.00 11.00 Physician Services Under Agreement 0 11.00 Physician Supervision Under Agreement 12.00 12.00 0 0 0 0 0 13.00 Other Costs Under Agreement 0 C 0 0 0 13.00 14.00 Subtotal (sum of lines 11 through 13) 0 14.00 0 Medical Supplies 0 0 15.00 30, 072 30,072 30, 072 15.00 Transportation (Health Care Staff) 16,00 0 0 16,00 17.00 Depreciation-Medical Equipment 0 C 0 0 0 17.00 Professional Liability Insurance 0 0 0 18.00 0 0 18.00 Other Health Care Costs 0 19.00 19.00 0 20.00 Allowable GME Costs 20.00 21.00 Subtotal (sum of lines 15 through 20) 0 30,072 30,072 0 30,072 21.00 Total Cost of Health Care Services (sum of 22.00 381, 453 30, 072 411, 525 -14, 782 396, 743 22.00 lines 10, 14, and 21)
COSTS OTHER THAN RHC/FQHC SERVICES Pharmacy 23.00 0 0 0 0 23.00 24.00 0 0 0 0 24.00 Dental 0 0 0 25.00 Optometry 0 0 25.00 0 25.01 0 25.01 Tel eheal th 0 0 25. 02 Chronic Care Management 0 0 0 0 0 25.02 26.00 All other nonreimbursable costs 0 0 0 0 26.00 27.00 Nonallowable GME costs 27.00 28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 28.00 through 27) FACILITY OVERHEAD 29.00 19, 537 29.00 Facility Costs 19, 537 19.537 16, 840 30.00 Administrative Costs 46, 294 63, 134 8.699 71,833 30.00 31.00 Total Facility Overhead (sum of lines 29 and 16,840 65, 831 82, 671 8, 699 91, 370 31.00 Total facility costs (sum of lines 22, 28 398, 293 -6, 083

95, 903

494, 196

488 113

32 00

32 00

and 31)

In Lieu of Form CMS-2552-10

Heal th Financial Systems

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS Provider CCN: 14-1319 Peri od: From 06/01/2022 To 05/31/2023 Worksheet M-1 Date/Time Prepared: 10/24/2023 5:18 pm Component CCN: 14-8615

					RHC IV	Cost	то ріп
		Adjustments	Net Expenses		INTO I V	0031	
		Auj us tilierits	for				
			Allocation				
			(col. 5 +				
			col. 6)				
	+	6. 00	7.00	-			
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00				
1. 00	Physician		670				1.00
		0		1			2.00
2.00	Physician Assistant	0	57, 106				
3.00	Nurse Practitioner	0	236, 599	1			3.00
4. 00	Visiting Nurse	0	0	I			4.00
5.00	Other Nurse	0	19, 750	1			5.00
6. 00	Clinical Psychologist	0	0				6.00
7.00	Clinical Social Worker	0	0	•			7. 00
8. 00	Laboratory Techni ci an	0	0				8. 00
9.00	Other Facility Health Care Staff Costs	0	52, 546				9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	366, 671				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	30, 072				15.00
16.00	Transportation (Health Care Staff)	0	0	1			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	Ü					20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	30, 072				21.00
22. 00	Total Cost of Health Care Services (sum of	0	396, 743	1			22.00
22.00	lines 10, 14, and 21)	O	370, 743				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	1			25.00
25. 00	Tel eheal th	0	0	1			25. 00
25. 01	Chronic Care Management	0	0	ł			25. 01
26. 00	All other nonreimbursable costs	0	0	1			26.00
		U	U				27.00
27. 00	Nonallowable GME costs	0	0				
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0				28. 00
	through 27)						
20.00	FACILITY OVERHEAD		10 507	1			20.00
29. 00	Facility Costs	0	19, 537				29.00
30.00	Administrative Costs	0	71, 833				30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	91, 370				31.00
	30)	_					
32. 00	Total facility costs (sum of lines 22, 28	0	488, 113				32.00
	and 31)			l			l

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Health Financial Systems	H_WOVE-HENRY NOOF I TAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-1319	Peri od: Worksheet M-1
		From 06/01/2022
	Component CCN: 14-8628	To 05/31/2023 Date/Time Prepared

			Component	CCN: 14-8628	To 05/31/2023	Date/Time Pre 10/24/2023 5:	
					RHC V	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
				,		(col. 3 +	
						col . 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	0		0 0	0	1.00
2.00	Physician Assistant	0	0		0 17, 289	17, 289	2.00
3. 00	Nurse Practitioner	179, 321	0	179, 32			3.00
4. 00	Visiting Nurse	0	0	1 .,,,,,,	0 0	0	4.00
5. 00	Other Nurse	59, 183	0	59, 18	٥	59, 183	5.00
6. 00	Clinical Psychologist	37, 103	0	37, 10	0 0	0	6.00
7. 00	Clinical Social Worker	0	0		0 0	0	7.00
8. 00	Laboratory Techni ci an	0	0		0	0	8.00
9. 00	Other Facility Health Care Staff Costs	34, 296	0	34, 29	4	34, 296	9.00
10.00	Subtotal (sum of lines 1 through 9)	272, 800	0	272, 80			10.00
11. 00	Physician Services Under Agreement	272, 800	0	2/2,00	0 34, 376	l	•
		0	0	1	0	0	11.00
12.00	Physician Supervision Under Agreement	U	0	1	0	ľ	12.00
13.00	Other Costs Under Agreement	U	0	1	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	10.050		0	0	14.00
15.00	Medical Supplies	0	43, 853	43, 85		43, 853	15.00
16.00	Transportation (Health Care Staff)	0	0		0	0	16.00
17. 00	Depreciation-Medical Equipment	0	0	1	0	0	17.00
18. 00	Professional Liability Insurance	0	0	1	0	0	18. 00
19. 00	Other Health Care Costs	0	0	1	0	0	19.00
20.00	Allowable GME Costs						20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	43, 853			43, 853	21. 00
22. 00	Total Cost of Health Care Services (sum of	272, 800	43, 853	316, 65	34, 578	351, 231	22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	0		0		23. 00
24. 00	Dental	0	0	1	0	0	24.00
25.00	Optometry	0	0	1	0	0	25. 00
25. 01	Tel eheal th	0	0	1	0	0	25. 01
25. 02	Chronic Care Management	0	0	1	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	0	0	1	0	0	28. 00
	through 27)						
	FACILITY OVERHEAD						
29.00	Facility Costs	0	-113, 531	-113, 53	1 0	-113, 531	29. 00
30.00	Administrative Costs	48, 221	31, 258			87, 426	30.00
31.00	Total Facility Overhead (sum of lines 29 and	·	-82, 273				31.00
	30)	·	•				
32.00	Total facility costs (sum of lines 22, 28	321, 021	-38, 420	282, 60	1 42, 525	325, 126	32.00
	and 31)		• • •	1		,	

and 31)

In Lieu of Form CMS-2552-10

Heal th Financial Systems

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS Provider CCN: 14-1319 Peri od: From 06/01/2022 To 05/31/2023 Worksheet M-1 Date/Time Prepared: 10/24/2023 5:18 pm Component CCN: 14-8628

					RHC V	Cost	то ріп
		Adjustments	Net Expenses		NIIC V	COST	
		Aujustillerits	for				
			Allocation				
			(col. 5 +				
	•	/ 00	col. 6)				
	FACILITY HEALTH CARE STAFF COSTS	6. 00	7. 00				
1 00	Physician	0	0	I			1. 00
1.00		0		1			
2.00	Physician Assistant	0	17, 289				2.00
3.00	Nurse Practitioner	0	196, 610	i			3.00
4.00	Visiting Nurse	0	0	I			4.00
5. 00	Other Nurse	0	59, 183	1			5.00
6. 00	Clinical Psychologist	0	0				6. 00
7. 00	Clinical Social Worker	0	0	•			7. 00
8. 00	Laboratory Techni ci an	0	0	1			8. 00
9. 00	Other Facility Health Care Staff Costs	0	34, 296	1			9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	307, 378	1			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	43, 853				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	43, 853				21.00
22.00	Total Cost of Health Care Services (sum of	0	351, 231				22.00
	lines 10, 14, and 21)		·				
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0				23.00
24.00	Dental	0	0				24.00
25.00	Optometry	0	Ó				25.00
25. 01	Tel eheal th	0	Ó				25. 01
25. 02	Chronic Care Management	0	Ó				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	0	0				28. 00
20.00	through 27)	Ü					20.00
	FACILITY OVERHEAD						
29. 00		0	-113, 531				29.00
30.00	Administrative Costs	0	87, 426				30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	-26, 105				31.00
51.00	30)	O	20, 103				51.00
32. 00	Total facility costs (sum of lines 22, 28	Λ	325, 126				32.00
52.00	and 31)	O	323, 120				32.00
	14.14 017		I	ı		ı	

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Allowable GME overhead (see instructions)

Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)

20.00 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)

Enter the amount from line 16

17 00

18.00

In Lieu of Form CMS-2552-10 ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES Provi der CCN: 14-1319 Peri od: Worksheet M-2 From 06/01/2022 Component CCN: 14-8576 05/31/2023 To Date/Time Prepared: 10/24/2023 5:18 pm RHC I Cost Number of FTE Total Visits Producti vi ty Mi ni mum Greater of col. 2 or Standard (1) Visits (col. Personnel col. 4 1 x col. 1.00 2.00 3.00 4.00 5.00 VISITS AND PRODUCTIVITY Posi ti ons 1 00 3, 210 4, 200 0.75 3, 150 1 00 Physi ci an 1, 785 2.00 Physician Assistant 0.85 2, 313 2, 100 2.00 3.00 Nurse Practitioner 2.67 11, 241 2, 100 5, 607 3.00 4.00 Subtotal (sum of lines 1 through 3) 4. 27 16, 764 10, 542 16, 764 4.00 5.00 Visiting Nurse 0.00 C 0 5.00 6.00 Clinical Psychologist 0.00 0 6.00 7.00 Clinical Social Worker 0.00 0 0 7.00 7.01 Medical Nutrition Therapist (FQHC only) 0.00 7.01 C 0 Diabetes Self Management Training (FQHC 7.02 0.00 C 0 7.02 only) 8.00 Total FTEs and Visits (sum of lines 4 4.27 16, 764 16, 764 8.00 through 7) Physician Services Under Agreements 9.00 Ω 9.00 1.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES Total costs of health care services (from Wkst. M-1, col. 7, line 22) 10 00 1, 949, 750 10 00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 11.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 12.00 1, 949, 750 12.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 1. 000000 13.00 13 00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 14.00 568, 627 14.00 Parent provider overhead allocated to facility (see instructions) 703, 370 15.00 16.00 Total overhead (sum of lines 14 and 15) 1, 271, 997 16.00

17.00

18.00

19.00

Ω

3, 221, 747 20.00

1, 271, 997

1, 271, 997

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20.00 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES Provi der CCN: 14-1319 Peri od: Worksheet M-2 From 06/01/2022 Component CCN: 14-8577 05/31/2023 To Date/Time Prepared: 10/24/2023 5:18 pm RHC II Cost Number of FTE Greater of Total Visits Producti vi ty Mi ni mum col. 2 or Standard (1) Personnel Visits (col. col. 4 1 x col. 1.00 2.00 3.00 4.00 5.00 VISITS AND PRODUCTIVITY Posi ti ons 1 00 4, 200 1 00 0.00 Physi ci an o 2.00 Physician Assistant 0.00 0 2, 100 2.00 3.00 Nurse Practitioner 0.00 0 2, 100 0 3.00 0 4.00 Subtotal (sum of lines 1 through 3) 0.00 ol 0 4.00 Visiting Nurse 0 5.00 0.00 0 5.00 6.00 Clinical Psychologist 0.00 0 6.00 7.00 Clinical Social Worker 0.00 0 0 7.00 Medical Nutrition Therapist (FQHC only) 7.01 0.00 0 0 7.01 Diabetes Self Management Training (FQHC 7.02 0.00 0 7.02 only) 8.00 Total FTEs and Visits (sum of lines 4 0.00 0 8.00 through 7) Physician Services Under Agreements 9.00 Ω 9.00 1. 00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES Total costs of health care services (from Wkst. M-1, col. 7, line 22) 10 00 10.00 0 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 11.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 12.00 12.00 0 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 0.000000 13 00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 14.00 0 14.00 Parent provider overhead allocated to facility (see instructions) 0 15.00 16.00 Total overhead (sum of lines 14 and 15) 0 16.00 17 00 Allowable GME overhead (see instructions) 17.00 0 18.00 Enter the amount from line 16 0 18.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 0 19.00

In Lieu of Form CMS-2552-10

0 20.00

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20.00 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES Provi der CCN: 14-1319 Peri od: Worksheet M-2 From 06/01/2022 Component CCN: 14-8587 05/31/2023 To Date/Time Prepared: 10/24/2023 5:18 pm RHC III Cost Number of FTE Total Visits Producti vi ty Mi ni mum Greater of col. 2 or Standard (1) Visits (col. Personnel col. 4 1 x col. 1.00 2.00 3.00 4.00 5.00 VISITS AND PRODUCTIVITY Posi ti ons 1 00 4, 200 4, 872 1.16 5, 274 1 00 Physi ci an 2.00 Physician Assistant 0.03 72 2, 100 2.00 3.00 Nurse Practitioner 3.26 11,846 2, 100 6, 846 3.00 4.00 Subtotal (sum of lines 1 through 3) 4.45 17, 192 11, 781 17, 192 4.00 5.00 Visiting Nurse 0.00 C 0 5.00 6.00 Clinical Psychologist 0.00 0 6.00 7.00 Clinical Social Worker 0.00 0 0 7.00 7.01 Medical Nutrition Therapist (FQHC only) 0.00 7.01 C 0 Diabetes Self Management Training (FQHC 7.02 0.00 C 0 7.02 only) 8.00 Total FTEs and Visits (sum of lines 4 4.45 17, 192 17, 192 8.00 through 7) Physician Services Under Agreements 9.00 Ω 9.00 1.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES Total costs of health care services (from Wkst. M-1, col. 7, line 22) 10 00 2, 118, 613 10 00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 11.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 12.00 2, 118, 613 12.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 1.000000 13.00 13 00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 14.00 372, 778 14.00 Parent provider overhead allocated to facility (see instructions) 947, 864 15.00 16.00 Total overhead (sum of lines 14 and 15) 1, 320, 642 16.00 17 00 Allowable GME overhead (see instructions) 17.00 Ω 18.00 Enter the amount from line 16 1, 320, 642 18.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 1, 320, 642 19.00

In Lieu of Form CMS-2552-10

3, 439, 255 20.00

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In Lieu of Form CMS-2552-10 ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES Provi der CCN: 14-1319 Peri od: Worksheet M-2 From 06/01/2022 Component CCN: 14-8615 То 05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm RHC IV Cost Number of FTE Total Visits Producti vi ty Mi ni mum Greater of Standard (1) col. 2 or col. 4 Visits (col. Personnel 1 x col. 3) 1.00 2.00 3.00 4.00 5.00 VISITS AND PRODUCTIVITY Posi ti ons 1.00 0.01 11 4, 200 1.00 Physi ci an 42 Physician Assistant 513 2, 100 420 2.00 0. 20 2.00 3.00 Nurse Practitioner 1.25 3, 433 2, 100 2, 625 3.00 Subtotal (sum of lines 1 through 3) 1.46 3, 957 3, 087 3, 957 4.00 4.00 5.00 Visiting Nurse 0.00 5.00 C 0 6.00 Clinical Psychologist 0.00 0 6.00 7.00 Clinical Social Worker 0.00 0 0 7.00 7.01 Medical Nutrition Therapist (FQHC only) 0.00 7.01 0 0 Diabetes Self Management Training (FQHC 0.00 C 7.02 7.02 0 only) 8.00 Total FTEs and Visits (sum of lines 4 1.46 3, 957 3, 957 8.00 through 7) 9.00 Physician Services Under Agreements 9.00 Ω 1.00

		1.00	1
	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)	396, 743	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)	396, 743	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)	91, 370	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	245, 485	15.00
16.00	Total overhead (sum of lines 14 and 15)	336, 855	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18. 00	Enter the amount from line 16	336, 855	18. 00
19. 00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	336, 855	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	733, 598	20.00

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20.00 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)

In Lieu of Form CMS-2552-10 ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES Provi der CCN: 14-1319 Peri od: Worksheet M-2 From 06/01/2022 Component CCN: 14-8628 05/31/2023 To Date/Time Prepared: 10/24/2023 5:18 pm RHC V Cost Number of FTE Total Visits Producti vi ty Mi ni mum Greater of col. 2 or Standard (1) Personnel Visits (col. col. 4 1 x col. 1.00 2.00 3.00 4.00 5.00 VISITS AND PRODUCTIVITY Posi ti ons 1 00 4, 200 0.01 19 1 00 Physi ci an 42 2.00 Physician Assistant 0.00 C 2, 100 2.00 3.00 Nurse Practitioner 0.84 3, 087 2, 100 1, 764 3.00 1, 806 4.00 Subtotal (sum of lines 1 through 3) 0.85 3, 106 3. 106 4.00 5.00 Visiting Nurse 0.00 C 0 5.00 6.00 Clinical Psychologist 0.00 0 6.00 7.00 Clinical Social Worker 0.00 0 0 7.00 7.01 Medical Nutrition Therapist (FQHC only) 0.00 7.01 C 0 Diabetes Self Management Training (FQHC 7.02 0.00 C 0 7.02 only) 8.00 Total FTEs and Visits (sum of lines 4 0.85 3, 106 3, 106 8.00 through 7) Physician Services Under Agreements 9.00 Ω 9.00 1.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES Total costs of health care services (from Wkst. M-1, col. 7, line 22) 10 00 351, 231 10 00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 11.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 12.00 351, 231 12.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 13.00 1.000000 13 00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 14.00 -26, 105 14.00 Parent provider overhead allocated to facility (see instructions) 283, 935 15.00 16.00 Total overhead (sum of lines 14 and 15) 257, 830 16.00 17 00 Allowable GME overhead (see instructions) 17.00 0 18.00 Enter the amount from line 16 257, 830 18.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 257, 830 19.00

609, 061 20.00

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Health Financial Systems

Health Financial Systems

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC

SERVICES

Health Financial Systems

In Lieu of Form CMS-2552-10

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

From 06/01/2022
To 05/31/2023 5: 18 pm

		Title XVIII	RHC I	Cost	i i
				1. 00	
4 00	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES	W M. O		0 001 717	4 00
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from			3, 221, 747	1.00
2. 00 3. 00	Cost of injections/infusions and their administration (from Wks			50, 282	2. 00 3. 00
4. 00	Total allowable cost excluding injections/infusions (line 1 mir Total Visits (from Wkst. M-2, column 5, line 8)	ius i i ne 2)		3, 171, 465 16, 764	4. 00
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5, li	ne 0)		10, 704	5. 00
6. 00	Total adjusted visits (line 4 plus line 5)	116 9)		16, 764	6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			189. 18	7. 00
	, , , , , , , , , , , , , , , , , , ,		Cal cul ati on		
			Rate Peri od 1	Rate Period 2	
			(06/01/2022	(01/01/2023	
			through	through	
			12/31/2022)	05/31/2023)	
			1. 00	2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6	or your contractor)	213. 80	221. 92	8. 00
9. 00	Rate for Program covered visits (see instructions)		189. 18	189. 18	9. 00
10.00	CALCULATION OF SETTLEMENT		1 (0)	1 101	10.00
10. 00 11. 00	Program covered visits excluding mental health services (from o		1, 606	1, 134	10.00
12. 00	Program cost excluding costs for mental health services (line Sprogram covered visits for mental health services (from contractions)		303, 823 0	214, 530 0	11. 00 12. 00
13. 00	Program covered cost from mental health services (line 9 x line		0	0	13.00
14. 00	Limit adjustment for mental health services (see instructions)	, 12)	o	0	14.00
15. 00	Graduate Medical Education Pass Through Cost (see instructions)	)		o .	15. 00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 a		o	518, 353	
16. 01	Total program charges (see instructions) (from contractor's reco	-		640, 039	16. 01
16. 02	Total program preventive charges (see instructions) (from provide	der's records)		95, 106	16. 02
16. 03	Total program preventive costs ((line 16.02/line 16.01) times I	ine 16)		77, 024	16.03
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.03	and 18) times .80)		316, 252	16. 04
	(Titles V and XIX see instructions.)				
16. 05	Total program cost (see instructions)		0	393, 276	16. 05
17.00	Primary payer amounts	(6		0	17.00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) (records)	Trom contractor		46, 014	18. 00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instructions	(from contractor		99, 101	19. 00
17.00	records)	s) (ITOM CONTRACTOR		77, 101	17.00
20. 00	Net Medicare cost excluding vaccines (see instructions)			393, 276	20.00
21. 00	Program cost of vaccines and their administration (from Wkst. N	M-4, line 16)		17, 837	21.00
22. 00	Total reimbursable Program cost (line 20 plus line 21)	•		411, 113	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 instru	ucti ons)		0	24.00
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25. 50	Pioneer ACO demonstration payment adjustment (see instructions)	1		0	25. 50
25. 99	Demonstration payment adjustment amount before sequestration			0	25. 99
26. 00	Net reimbursable amount (see instructions)			411, 113	
26. 01	Sequestration adjustment (see instructions)			7, 893	26. 01
26. 02	Demonstration payment adjustment amount after sequestration			394 001	26. 02 27. 00
27. 00 28. 00	Interim payments Tentative settlement (for contractor use only)			386, 091 0	27. 00 28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.02	27 and 28)		17, 129	29. 00
30. 00	Protested amounts (nonallowable cost report items) in accordance			17, 127	30.00
-2.00	chapter I, §115.2				
			. '		•

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In Lieu of Form CMS-2552-10

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC Provider CCN: 14-1319 Period:
SERVICES

From 06/01/2022

Component CCN: 14-8577

05/31/2023

Date/Time Prepared:

0 26, 01

0 26.02

0 27.00

0

0

0 30.00

28.00

29.00

10/24/2023 5:18 pm Title XVIII RHC II Cost 1.00 DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20) 2.00 Cost of injections/infusions and their administration (from Wkst. M-4, line 15) 0 2.00 Total allowable cost excluding injections/infusions (line 1 minus line 2) 3.00 0 3.00 4.00 Total Visits (from Wkst. M-2, column 5, line 8) 0 4.00 5.00 Physicians visits under agreement (from Wkst. M-2, column 5, line 9) 0 5.00 Total adjusted visits (line 4 plus line 5) 6.00 0 6.00 Adjusted cost per visit (line 3 divided by line 6) 0.00 7.00 7.00 Calculation of Limit (1) Rate Period 1 Rate Period 2 (01/01/2023 (06/01/2022 through through 12/31/2022) 05/31/2023) 1. 00 2.00 8.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor) 0.00 0.00 8.00 Rate for Program covered visits (see instructions) 9.00 0.00 0.00 9.00 CALCULATION OF SETTLEMENT Program covered visits excluding mental health services (from contractor records) 10.00 0 10.00 Program cost excluding costs for mental health services (line 9 x line 10) 0 11 00 0 11 00 12.00 Program covered visits for mental health services (from contractor records) 0 12.00 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 Graduate Medical Education Pass Through Cost (see instructions) 15 00 15 00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) \* 16.00 0 0 16.00 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 Total program preventive costs ((line 16.02/line 16.01) times line 16) 16.03 16.03 0 Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) 0 16.04 (Titles V and XIX see instructions.) Total program cost (see instructions) 0 0 16.05 17.00 0 Primary payer amounts 17.00 18.00 Less: Beneficiary deductible for RHC only (see instructions) (from contractor 0 18.00 19.00 Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor 0 19.00 records) 20 00 Ω 20 00 Net Medicare cost excluding vaccines (see instructions) 21.00 Program cost of vaccines and their administration (from Wkst. M-4, line 16) 0 21.00 Total reimbursable Program cost (line 20 plus line 21) 22.00 Allowable bad debts (see instructions) 0 23.00 23.00 Adjusted reimbursable bad debts (see instructions) 23 01 23.01 0 24.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 24.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 25.00 0 Pioneer ACO demonstration payment adjustment (see instructions) 25. 50 0 25.50 25.99 Demonstration payment adjustment amount before sequestration 0 25.99 Net reimbursable amount (see instructions) 0 26.00 26.00

26. 01

26. 02

27.00

28.00

29.00

30.00

Interim payments

chapter I, §115.2

Sequestration adjustment (see instructions)

Tentative settlement (for contractor use only)

Demonstration payment adjustment amount after sequestration

Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)

Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II,

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC
SERVICES

Health Financial Systems

Health Financial Systems

In Lieu of Form CMS-2552-10

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

From 06/01/2022
To 05/31/2023
Date/Time Prepared: 10/24/2023 5: 18 pm

		Title XVIII	RHC III	Cost	i i
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from N			3, 439, 255	1.00
2.00	Cost of injections/infusions and their administration (from Wks			65, 894	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minumental Visite (from West M.2. column F. Line 9)	us iine 2)		3, 373, 361	3. 00 4. 00
4. 00 5. 00	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5, line 8)	no (1)		17, 192 0	5. 00
6. 00	Total adjusted visits (line 4 plus line 5)	110 9)		17, 192	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			196. 22	7. 00
7.00	They desired cost per visit (Time o di vided by Time o)		Cal cul ati on		7.00
				. ,	
			Rate Period 1		
			(06/01/2022	(01/01/2023	
			through	through	
			12/31/2022)	05/31/2023) 2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6	or your contractor)	254. 55	264. 22	8. 00
9. 00	Rate for Program covered visits (see instructions)	or your contractor)	196. 22	196. 22	9. 00
7. 00	CALCULATION OF SETTLEMENT		170. 22	170. 22	7.00
10.00	Program covered visits excluding mental health services (from co	ontractor records)	1, 642	1, 158	10.00
11.00	Program cost excluding costs for mental health services (line 9	x line 10)	322, 193	227, 223	11.00
12.00	Program covered visits for mental health services (from contrac		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)	1 0) 1		540.444	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 15, co	•	0	549, 416	16.00
16. 01 16. 02	Total program charges (see instructions)(from contractor's reconstructions) revenue to the program preventive charges (see instructions) from provide			566, 978 65, 109	16. 01 16. 02
16. 02	Total program preventive charges (see Trist detroils) (Troil provide Total program preventive costs ((line 16.02/line 16.01) times li			63, 092	16. 02
16. 03	Total Program non-preventive costs ((Tine 16.02/Tine 16.07) times 16.03 a			347, 382	16. 03
10.01	(Titles V and XIX see instructions.)	and 10) trines . 00)		017,002	10.01
16. 05	Total program cost (see instructions)		0	410, 474	16. 05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (	from contractor		52, 097	18.00
	records)				
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instructions)	) (from contractor		89, 250	19. 00
20.00	records) Net Medicare cost excluding vaccines (see instructions)			410, 474	20. 00
20. 00 21. 00	Program cost of vaccines and their administration (from Wkst. M	4 Lino 16)		35, 364	
22. 00	Total reimbursable Program cost (line 20 plus line 21)	-4, Title 10)		445, 838	22.00
23. 00	Allowable bad debts (see instructions)			17, 485	23. 00
23. 01	Adjusted reimbursable bad debts (see instructions)			11, 365	
24. 00	Allowable bad debts for dual eligible beneficiaries (see instruc	ctions)		13, 284	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)			457, 203	
26. 01	Sequestration adjustment (see instructions)			8, 779	26. 01
26. 02	Demonstration payment adjustment amount after sequestration			0	26. 02
27. 00	Interim payments			445, 170	27.00
28. 00 29. 00	Tentative settlement (for contractor use only) Balance due component/program (line 26 minus lines 26.01, 26.02)	27 and 29)		0 3, 254	28. 00 29. 00
30.00	Protested amounts (nonallowable cost report items) in accordance			3, 254	29. 00 30. 00
30.00	chapter I, §115.2	c with one rub. 15-11,		ا	30.00
	1		1		li .

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC
SERVICES

Health Financial Systems

Health Financial Systems

In Lieu of Form CMS-2552-10

Provider CCN: 14-1319
Component CCN: 14-8615

From 06/01/2022
To 05/31/2023
Date/Time Prepared: 10/24/2023 5: 18 pm

		T' 11 . MU11	DUO 111	107 247 2023 5.	то ріп
		Title XVIII	RHC I V	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst. M-2, line 20)		733, 598	1.00
2.00	Cost of injections/infusions and their administration (from W	kst. M-4, line 15)		2, 110	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		731, 488	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	,		3, 957	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)	1111e 7)		3. 957	6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			184. 86	7. 00
7.00	Adjusted cost per visit (Title 3 divided by Title 6)		Col out oti on		7.00
			Cal cul ati on	OI LIMIT (I)	
			Doto Dori od 1	Doto Dori od 2	
			Rate Period 1		
			(06/01/2022	(01/01/2023	
			through	through	
			12/31/2022)	05/31/2023)	
	Ta		1.00	2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	201. 65	159. 13	8. 00
9. 00	Rate for Program covered visits (see instructions)		184. 86	159. 13	9. 00
	CALCULATION OF SETTLEMENT		1		
10. 00	Program covered visits excluding mental health services (from		148	104	10.00
11. 00	Program cost excluding costs for mental health services (line		27, 359	16, 550	11. 00
12. 00	Program covered visits for mental health services (from contr	actor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x li	ne 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 instruction	s)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	and 3) *	o	43, 909	16.00
16. 01	Total program charges (see instructions) (from contractor's re			46, 170	
16. 02	Total program preventive charges (see instructions) (from prov			675	16. 02
16. 03	Total program preventive costs ((line 16.02/line 16.01) times			642	16. 03
16. 04	Total Program non-preventive costs ((Time 10.02/Time 10.07) times			31, 170	16. 04
10.04	(Titles V and XIX see instructions.)	3 and 16) trilles . 60)		31, 170	10.04
16. 05	,		0	31, 812	16. 05
	Total program cost (see instructions)		٩		
17.00	Primary payer amounts	(6		0	17.00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		4, 304	18. 00
	records)				
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		8, 238	19. 00
	records)				
20.00	Net Medicare cost excluding vaccines (see instructions)			31, 812	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		904	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			32, 716	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		ructions)		ol	24.00
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			ol	25. 00
25. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		ő	25. 50
25. 99	Demonstration payment adjustment amount before sequestration	<i>-</i> ,		0	25. 99
26. 00	Net reimbursable amount (see instructions)			32, 716	
	,				
26. 01	Sequestration adjustment (see instructions)			628	26. 01
26. 02				0	26. 02
27. 00	Interim payments			29, 960	
28. 00	Tentative settlement (for contractor use only)			0	28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.			2, 128	29.00
30.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-II,		0	30.00
	chapter I, §115.2				

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC

SERVICES

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From CMS-2552-10

Provider CCN: 14-1319
Component CCN: 14-8628

From 06/01/2022
To 05/31/2023
Date/Time Prepared: 10/24/2023 5: 18 pm

Title XVIII RHC V

Cost

		•		10/24/2023 5:	18 pm
		Title XVIII	RHC V	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from			609, 061	1.00
2.00	Cost of injections/infusions and their administration (from Wks			13, 860	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 min	nus line 2)		595, 201	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3, 106	4. 00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, li	ne 9)		0	5.00
6. 00	Total adjusted visits (line 4 plus line 5)			3, 106	
7. 00	Adjusted cost per visit (line 3 divided by line 6)			191. 63	7.00
			Cal cul ati on	of Limit (1)	
			Rate Period 1	Rate Period 2	
			(06/01/2022	(01/01/2023	
			through	through	
			12/31/2022)	05/31/2023) 2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6	or your contractor)	113.00		8. 00
9. 00	Rate for Program covered visits (see instructions)	or your contractor)	113.00		
7. 00	CALCULATION OF SETTLEMENT		113.00	120.00	7.00
10.00	Program covered visits excluding mental health services (from c	contractor records)	223	158	10.00
11. 00	Program cost excluding costs for mental health services (line 9	-	25, 199		
	Program covered visits for mental health services (from contract		0	0	1
13. 00		-	0		
14. 00	Limit adjustment for mental health services (see instructions)	/	0	0	
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 a		0	45, 107	16.00
16. 01	Total program charges (see instructions) (from contractor's reco			71, 881	
16. 02	Total program preventive charges (see instructions) (from provide	der's records)		23, 685	16. 02
16. 03	Total program preventive costs ((line 16.02/line 16.01) times I	i ne 16)		14, 863	16. 03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03	and 18) times .80)		19, 518	16. 04
	(Titles V and XIX see instructions.)				
16. 05	Total program cost (see instructions)		0	34, 381	16. 05
17.00	Primary payer amounts			0	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) (	(from contractor		5, 846	18. 00
	records)				
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instructions	s) (from contractor		8, 395	19. 00
	records)			0.4.004	
20.00	Net Medicare cost excluding vaccines (see instructions)			34, 381	
	Program cost of vaccines and their administration (from Wkst. N	1-4, line 16)		6, 790	ı
22. 00				41, 171	ı
23.00	Allowable bad debts (see instructions)			0	
23. 01	Adjusted reimbursable bad debts (see instructions)	. 11		0	
24. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ictions)		0	
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
25. 50	Pioneer ACO demonstration payment adjustment (see instructions)	1		0	
25. 99	Demonstration payment adjustment amount before sequestration			0	
26.00	Net reimbursable amount (see instructions)			41, 171 791	1
26. 01	Sequestration adjustment (see instructions)			/91   0	
26. 02	Demonstration payment adjustment amount after sequestration Interim payments			33, 337	
28.00				33, 337	•
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02	27 and 28)		7, 043	
30.00	Protested amounts (nonallowable cost report items) in accordance			7,043	•
30.00	chapter I, §115.2	with own rub. 10-11,			30.00
	Ondp to 1   3   10   2		T	1	1

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columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST Provi der CCN: 14-1319 Peri od: Worksheet M-4 From 06/01/2022 Component CCN: 14-8576 То 05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm Title XVIII RHC I Cost PNEUMOCOCCAL INFLUENZA COVI D-19 MONOCLONAL VACCI NES **VACCINES** VACCI NES ANTI BODY **PRODUCTS** 1.00 2.00 2.01 2.02 1, 790, 407 1.00 Health care staff cost (from Wkst. M-1, col. 7, line 10) 1, 790, 407 1, 790, 407 1, 790, 407 1.00 Ratio of injection/infusion staff time to total health 2.00 0.000662 0.000747 0.000000 0.000000 2.00 care staff time 3.00 Injection/infusion health care staff cost (line 1 x line 1, 185 1.337 0 3.00 Injections/infusions and related medical supplies costs 4.00 17, 593 10, 315 0 4.00 (from your records) Direct cost of injections/infusions (line 3 plus line 4) 5 00 18,778 5 00 11, 652 0 6.00 Total direct cost of the hospital-based RHC/FQHC (from 1, 949, 750 1, 949, 750 1, 949, 750 1, 949, 750 6.00 Worksheet M-1, col. 7, line 22) 7.00 Total overhead (from Wkst. M-2, line 19) 1, 271, 997 1, 271, 997 1, 271, 997 1, 271, 997 7.00 Ratio of injection/infusion direct cost to total direct 0.000000 0.000000 8.00 0.009631 0.005976 8.00 cost (line 5 divided by line 6) 9.00 Overhead cost - injection/infusion (line 7 x line 8) 12, 251 7,601 9.00 10.00 Total injection/infusion costs and their administration 31,029 19, 253 0 0 10.00 costs (sum of lines 5 and 9) 11 00 Total number of injections/infusions (from your records) 313 353 11 00 0 12.00 Cost per injection/infusion (line 10/line 11) 99.13 54.54 0.00 0.00 12.00 13.00 Number of injection/infusion administered to Program 82 178 13.00 0 benefi ci ari es Number of COVID-19 vaccine injections/infusions 13.01 0 0 13.01 administered to MA enrollees Program cost of injections/infusions and their 14.00 8, 129 9,708 0 14.00 administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) COST OF INJECTIONS / INFUSIONS AND ADMI NI STRATI O 1.00 2.00 15.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 50 282 15.00 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of injections/infusions and their administration costs (sum of 17,837 16.00

In Lieu of Form CMS-2552-10

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columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST Provi der CCN: 14-1319 Peri od: Worksheet M-4 From 06/01/2022 Component CCN: 14-8577 То 05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm Title XVIII RHC II PNEUMOCOCCAL INFLUENZA COVI D-19 MONOCLONAL **VACCINES VACCINES** VACCI NES ANTI BODY **PRODUCTS** 1.00 2.00 2.01 2.02 1.00 Health care staff cost (from Wkst. M-1, col. 7, line 10) 0 1.00 Ratio of injection/infusion staff time to total health 2.00 0.000000 0.000000 0.000000 0.000000 2.00 care staff time 3.00 Injection/infusion health care staff cost (line 1 x line 0 0 3.00 Injections/infusions and related medical supplies costs 4.00 0 0 4.00 (from your records) Direct cost of injections/infusions (line 3 plus line 4) 5 00 O 5 00 0 6.00 Total direct cost of the hospital-based RHC/FQHC (from C 0 0 0 6.00 Worksheet M-1, col. 7, line 22) 7.00 Total overhead (from Wkst. M-2, line 19) 7.00 Ratio of injection/infusion direct cost to total direct 0.000000 0.000000 0.000000 0.000000 8.00 8.00 cost (line 5 divided by line 6) 9.00 Overhead cost - injection/infusion (line 7 x line 8) 0 0 9.00 10.00 Total injection/infusion costs and their administration 0 0 0 10.00 costs (sum of lines 5 and 9) 11 00 Total number of injections/infusions (from your records) 11 00 0 0 0.00 12.00 Cost per injection/infusion (line 10/line 11) 0.00 0.00 0.00 12.00 13.00 Number of injection/infusion administered to Program 13.00 benefi ci ari es Number of COVID-19 vaccine injections/infusions 13.01 0 0 13.01 administered to MA enrollees Program cost of injections/infusions and their 14.00 C 0 0 14.00 administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) COST OF INJECTIONS / INFUSIONS AND ADMI NI STRATI O 1.00 2.00 15.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 15.00 0 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of injections/infusions and their administration costs (sum of 0 16.00

In Lieu of Form CMS-2552-10

Heal th Fi nancial Systems STATE HEARY COST TALL PASSED RHC/FQHC VACCINE COST Provider CCN: 14-1319 Peri

Total Program cost of injections/infusions and their administration costs (sum of

columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)

Provi der CCN: 14-1319 Peri od: Worksheet M-4 From 06/01/2022 Component CCN: 14-8587 То 05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm Title XVIII RHC III Cost PNEUMOCOCCAL INFLUENZA COVI D-19 MONOCLONAL VACCI NES **VACCINES** VACCI NES ANTI BODY **PRODUCTS** 1.00 2.00 2.01 2.02 1, 911, 763 1.00 Health care staff cost (from Wkst. M-1, col. 7, line 10) 1, 911, 763 1, 911, 763 1, 911, 763 1.00 Ratio of injection/infusion staff time to total health 2.00 0.000419 0.001526 0.001074 0.000000 2.00 care staff time 3.00 2, 917 2,053 Injection/infusion health care staff cost (line 1 x line 801 0 3.00 Injections/infusions and related medical supplies costs 4.00 12,028 22, 793 0 0 4.00 (from your records) Direct cost of injections/infusions (line 3 plus line 4) 5 00 12 829 25 710 2 053 5 00 0 6.00 Total direct cost of the hospital-based RHC/FQHC (from 2, 118, 613 2, 118, 613 2, 118, 613 2, 118, 613 6.00 Worksheet M-1, col. 7, line 22) 7.00 Total overhead (from Wkst. M-2, line 19) 1, 320, 642 1, 320, 642 1, 320, 642 1, 320, 642 7.00 Ratio of injection/infusion direct cost to total direct 0.012135 0.000969 0.000000 8.00 0.006055 8.00 cost (line 5 divided by line 6) 9.00 Overhead cost - injection/infusion (line 7 x line 8) 7, 996 16,026 1, 280 9.00 10.00 Total injection/infusion costs and their administration 20,825 41,736 3, 333 0 10.00 costs (sum of lines 5 and 9) 11 00 Total number of injections/infusions (from your records) 214 780 549 11 00 0 12.00 Cost per injection/infusion (line 10/line 11) 97.31 53.51 6.07 0.00 12.00 13.00 Number of injection/infusion administered to Program 56 508 450 13.00 0 benefi ci ari es Number of COVID-19 vaccine injections/infusions 13.01 0 0 13.01 administered to MA enrollees Program cost of injections/infusions and their 14.00 5, 449 27, 183 2, 732 0 14.00 administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) COST OF INJECTIONS / INFUSIONS AND ADMI NI STRATI O 1.00 2.00 15.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 65, 894 15 00 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)

In Lieu of Form CMS-2552-10

35, 364

16.00

16.00

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COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provi der CCN: 14-1319 | Peri od:

columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)

From 06/01/2022 Component CCN: 14-8615 То 05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm Title XVIII RHC IV Cost PNEUMOCOCCAL INFLUENZA COVI D-19 MONOCLONAL VACCI NES **VACCINES** VACCI NES ANTI BODY **PRODUCTS** 2.00 1.00 2.01 2.02 366, 671 366, 671 1.00 Health care staff cost (from Wkst. M-1, col. 7, line 10) 366, 671 366, 671 1.00 Ratio of injection/infusion staff time to total health 2.00 0.000000 0.000322 0.000000 0.000000 2.00 care staff time 3.00 Injection/infusion health care staff cost (line 1 x line 118 0 3.00 Injections/infusions and related medical supplies costs 4.00 1,023 0 4.00 (from your records) Direct cost of injections/infusions (line 3 plus line 4) 5 00 5 00 1.141 0 6.00 Total direct cost of the hospital-based RHC/FQHC (from 396, 743 396, 743 396, 743 396, 743 6.00 Worksheet M-1, col. 7, line 22) 7.00 Total overhead (from Wkst. M-2, line 19) 7.00 336, 855 336, 855 336, 855 336, 855 Ratio of injection/infusion direct cost to total direct 0.000000 0.000000 0.000000 8.00 0.002876 8.00 cost (line 5 divided by line 6) 9.00 Overhead cost - injection/infusion (line 7 x line 8) 969 9.00 10.00 Total injection/infusion costs and their administration 2, 110 0 0 10.00 costs (sum of lines 5 and 9) 11 00 Total number of injections/infusions (from your records) 11 00 35 0 12.00 Cost per injection/infusion (line 10/line 11) 0.00 60.29 0. 00 0.00 12.00 13.00 Number of injection/infusion administered to Program 15 13.00 0 benefi ci ari es Number of COVID-19 vaccine injections/infusions 13.01 0 0 13.01 administered to MA enrollees Program cost of injections/infusions and their 14.00 C 904 0 14.00 administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) COST OF INJECTIONS / INFUSIONS AND ADMI NI STRATI O 1.00 2.00 15.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 2 110 15.00 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of injections/infusions and their administration costs (sum of 904 16.00

In Lieu of Form CMS-2552-10

Worksheet M-4

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columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST Provi der CCN: 14-1319 Peri od: Worksheet M-4 From 06/01/2022 Component CCN: 14-8628 То 05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm Title XVIII RHC V Cost PNEUMOCOCCAL INFLUENZA COVI D-19 MONOCLONAL VACCI NES **VACCINES** VACCI NES ANTI BODY **PRODUCTS** 2.00 1.00 2.01 2.02 307, 378 1.00 Health care staff cost (from Wkst. M-1, col. 7, line 10) 307, 378 307, 378 307, 378 1.00 Ratio of injection/infusion staff time to total health 2.00 0.000478 0.001791 0.000000 0.000000 2.00 care staff time 3.00 Injection/infusion health care staff cost (line 1 x line 147 551 0 3.00 Injections/infusions and related medical supplies costs 4.00 2, 473 4,822 0 4.00 (from your records) Direct cost of injections/infusions (line 3 plus line 4) 5 00 5, 373 5 00 2,620 0 6.00 Total direct cost of the hospital-based RHC/FQHC (from 351, 231 351, 231 351, 231 351, 231 6.00 Worksheet M-1, col. 7, line 22) 7.00 Total overhead (from Wkst. M-2, line 19) 257, 830 257, 830 7.00 257, 830 257, 830 Ratio of injection/infusion direct cost to total direct 0.007459 0.015298 0.000000 0.000000 8.00 8.00 cost (line 5 divided by line 6) 9.00 Overhead cost - injection/infusion (line 7 x line 8) 1, 923 3,944 9.00 10.00 Total injection/infusion costs and their administration 4,543 9, 317 0 0 10.00 costs (sum of lines 5 and 9) 11 00 Total number of injections/infusions (from your records) 11 00 44 165 0 12.00 Cost per injection/infusion (line 10/line 11) 103.25 56.47 0.00 0.00 12.00 13.00 Number of injection/infusion administered to Program 22 80 13.00 0 benefi ci ari es Number of COVID-19 vaccine injections/infusions 13.01 0 0 13.01 administered to MA enrollees Program cost of injections/infusions and their 14.00 2, 272 4, 518 0 14.00 administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) COST OF INJECTIONS / INFUSIONS AND ADMI NI STRATI O 1.00 2.00 15.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 13 860 15.00 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of injections/infusions and their administration costs (sum of 6,790 16.00

In Lieu of Form CMS-2552-10

SERVICES RENDERED TO PROGRAM BENEFICIARIES

In Lieu of Form CMS-2552-10 Provider CCN: 14-1319 Peri od: From 06/01/2022 To 05/31/2023 Worksheet M-5 Date/Time Prepared: 10/24/2023 5:18 pm Cost Component CCN: 14-8576

				10/24/2023 5:	18 pm
			RHC I	Cost	
	·		Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
1. 00	Total interim payments paid to hospital-based RHC/FQHC			389, 766	1.00
2.00	Interim payments payable on individual bills, either submi-	tted or to be submitted to		ا ا	2.00
	the contractor for services rendered in the cost reporting				
	"NONE" or enter a zero				
3.00	List separately each retroactive lump sum adjustment amoun	t based on subsequent			3.00
	revision of the interim rate for the cost reporting period.				
	payment. If none, write "NONE" or enter a zero. (1)	THE SECTION CASE ST. SAST.			
	Program to Provider				
3. 01	r ogram to rrovi dor		02/23/2023	26, 339	3. 01
3. 02			027 207 2020	20,007	
3. 03					3. 02
3. 04				0	3. 04
3. 04					3. 05
3.03	Provider to Program			0	3.03
3. 50	Provider to Program		01/04/2023	30, 014	3. 50
3. 50			01/04/2023	30,014	3. 50
3. 52					
					3. 52
3. 53				0	3. 53
3. 54		00)		0 (75	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			-3, 675	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	ster to Worksheet M-3, line		386, 091	4. 00
	27)				
F 00	TO BE COMPLETED BY CONTRACTOR	Alexander de la lace	6		F 00
5. 00	List separately each tentative settlement payment after dee each payment. If none, write "NONE" or enter a zero. (1)	sk review. Also show date o	Ť		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)		l ol	5. 99
6.00	Determined net settlement amount (balance due) based on the	e cost report. (1)			6.00
6. 01	SETTLEMENT TO PROVIDER			17, 129	6. 01
6.02	SETTLEMENT TO PROGRAM			0	6. 02
7. 00	Total Medicare program liability (see instructions)			403, 220	7. 00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1.00	2.00	
8. 00	Name of Contractor				8. 00
	•				

SERVICES RENDERED TO PROGRAM BENEFICIARIES

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

Peri od: From 06/01/2022 To 05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm Cost

In Lieu of Form CMS-2552-10

		RHC II	Cost	
		Par	rt 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		0	2.00
2.00	the contractor for services rendered in the cost reporting period. If none, write		Ĭ	2.00
	"NONE" or enter a zero			
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent			3.00
3.00	revision of the interim rate for the cost reporting period. Also show date of each			3.00
	payment. If none, write "NONE" or enter a zero. (1)			
	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			l ol	3. 51
3. 52			l ol	3. 52
3. 53				3. 53
3. 54				3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line		ا	4. 00
	27)			
	TO BE COMPLETED BY CONTRACTOR	_		
5. 00	List separately each tentative settlement payment after desk review. Also show date of	OT		5. 00
	each payment. If none, write "NONE" or enter a zero. (1)			
	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			l ol	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)			5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)		١	6.00
6. 01	SETTLEMENT TO PROVIDER		0	6. 01
6. 02	SETTLEMENT TO PROGRAM			6.02
0. 02				7.00
7 00			1 ())	ı /.UU
7. 00	Total Medicare program liability (see instructions)	C+	NDD D-+-	
7. 00	Total Medicare program Hability (see Instructions)	Contractor	NPR Date	
7. 00		Number	(Mo/Day/Yr)	
7.00	Name of Contractor			8. 00

Provider CCN: 14-1319 SERVICES RENDERED TO PROGRAM BENEFICIARIES

In Lieu of Form CMS-2552-10 Peri od: From 06/01/2022 To 05/31/2023 Worksheet M-5 Date/Time Prepared: 10/24/2023 5:18 pm Cost Component CCN: 14-8587

				10/24/2023 5:	18 pm
			RHC III	Cost	
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			437, 630	1.00
2.00	Interim payments payable on individual bills, either submit			0	2.00
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
3.00	List separately each retroactive lump sum adjustment amount				3.00
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3. 01			02/23/2023	36, 012	3. 01
3.02				0	3. 02
3.03				0	3. 03
3.04				0	3. 04
3.05				0	3.05
	Provider to Program		_		
3.50			01/04/2023	28, 472	3.50
3. 51				0	3. 51
				0	3. 52
				0	3. 53
				0	3. 54
				7, 540	3. 99
4. 00		fer to Worksheet M-3, line		445, 170	4.00
			.	I	
5. 00		k review. Also show date of			5.00
	Program to Provider				
				0	5. 01
				0	5.02
5.03	Don't lead to Don't come			0	5. 03
F F0	Provider to Program		T		
				0	5.50
				0	5. 51
				0	5. 52
				0	5. 99
				0.054	6.00
					6. 01
				0	6.02
7.00	lotal Medicare program Hability (see instructions)		0		7.00
		0			
	2.00				

8.00 Name of Contractor

SERVICES RENDERED TO PROGRAM BENEFICIARIES

In Lieu of Form CMS-2552-10 Provider CCN: 14-1319 Peri od: From 06/01/2022 To 05/31/2023 Worksheet M-5 Date/Time Prepared: 10/24/2023 5:18 pm Component CCN: 14-8615

			RHC IV	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1, 00	2, 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			33, 272	1. 00
	Interim payments payable on individual bills, either submit	ted or to be submitted to		0	2. 00
2.00	the contractor for services rendered in the cost reporting p	period If none write		Ĭ	2.00
	"NONE" or enter a zero	period. It mene, miles			
	List separately each retroactive lump sum adjustment amount	hased on subsequent			3.00
	revision of the interim rate for the cost reporting period.				0.00
	payment. If none, write "NONE" or enter a zero. (1)	Also show date of each			
	Program to Provider				
3. 01	- rogram to Frovider		02/23/2023	1, 533	3. 01
3. 02			02/23/2023	0	3.01
3. 03				0	3. 03
3. 04				0	3. 04
3. 05				0	3. 05
	Provider to Program				
3. 50			01/04/2023	4, 845	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 3.50-3.49	98)		-3, 312	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transf	fer to Worksheet M-3, line		29, 960	4.00
12	27)				
T	TO BE COMPLETED BY CONTRACTOR				
5. 00 I	List separately each tentative settlement payment after desl	k review. Also show date of	-		5.00
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider		<u> </u>		
5. 01				0	5. 01
5. 02				ol	5. 02
5. 03				o l	5. 03
	Provider to Program			Ü	0.00
5. 50	10VI dei 10 II ogi diii			0	5. 50
5. 51				0	5. 51
5. 52				0	5. 52
	Cubatal (compact lines 5 04 5 40 minus our of lines 5 50 5 00)			0	5. 99
				l 'I	
1		cost report. (1)		2 400	6.00
	SETTLEMENT TO PROVIDER			2, 128	6. 01
	SETTLEMENT TO PROGRAM			0	6. 02
7. 00	Total Medicare program liability (see instructions)			32, 088	7. 00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	
1 00 .8	Name of Contractor				8. 00

In Lieu of Form CMS-2552-10

Peri od: From 06/01/2022 To 05/31/2023 Date/Time Prepared: 10/24/2023 5:18 pm Cost Provider CCN: 14-1319 SERVICES RENDERED TO PROGRAM BENEFICIARIES Component CCN: 14-8628

			RHC V	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1.00	2. 00	
1. 00	Total interim payments paid to hospital-based RHC/FQHC			33, 337	1. 00
2. 00	Interim payments payable on individual bills, either submitted or to be su	ihmitted to		00,007	2. 00
2.00	the contractor for services rendered in the cost reporting period. If non			Ĭ	2.00
	"NONE" or enter a zero	ie, wii te			
3. 00	List separately each retroactive lump sum adjustment amount based on subse	auon+			3. 00
3.00					3.00
	revision of the interim rate for the cost reporting period. Also show date	e or each			
	payment. If none, write "NONE" or enter a zero. (1)				
	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				o	3.05
	Provider to Program		<u>'</u>		
3.50				0	3. 50
3. 51				ol	3. 51
3. 52				ő	3. 52
3. 53				0	3. 53
3. 54				0	3. 54
3. 99	Cubatal (cum of lines 2.01.2.40 minus cum of lines 2.50.2.00)			0	3. 99
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			ı "I	
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Workshee	et M-3, line		33, 337	4. 00
	27)				
	TO BE COMPLETED BY CONTRACTOR		Т		
5. 00	List separately each tentative settlement payment after desk review. Also	show date of			5. 00
	each payment. If none, write "NONE" or enter a zero. (1)				
	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)		Ĭ	6. 00
6. 01	SETTLEMENT TO PROVIDER			7, 043	6. 01
6. 01	SETTLEMENT TO PROVIDER  SETTLEMENT TO PROGRAM			7,043	6. 01
0. UZ				١	
7 00			T.	40, 380	7. 00
7. 00	Total Medicare program liability (see instructions)		0	NDD D. L.	
7.00	Total Medicare program Hability (see Instructions)		Contractor	NPR Date	
7. 00			Number	(Mo/Day/Yr)	
7. 00 8. 00	Name of Contractor				8. 00