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

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 09-30-2025

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1319	Period: From 06/01/2022 To 05/31/2023	Worksheet S Parts I-III Date/Time Prepared: 10/24/2023 5:18 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 10/24/2023 Time: 5:18 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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 FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Jodie 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	CFO			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-382,299	42,209	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	-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	CAMBRIDGE 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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 10/24/2023 5:18 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 600 N. COLLEGE AVENUE	PO Box:			1.00
2.00	City: GENESEO	State: IL	Zip Code: 61254-1099	County: HENRY	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	HAMMOND-HENRY HOSPITAL	141319	19340	1	06/04/2002	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	HAMMOND-HENRY SWING BED	14Z319	99914		05/21/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	HAMMOND-HENRY SKILLED NURSING	145464	99914		06/01/1983	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	HAMMOND-HENRY HOME HEALTH SERVICES	147450	99914		06/05/1986	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	HAMMOND-HENRY HOSPITAL RHP-KEWANEE	148576	99914		05/01/2017	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	HAMMOND-HENRY HOSPITAL RHP-WYOMING	148577	99914		05/01/2017	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	HAMMOND-HENRY HOSPITAL RHP-GENESEO	148587	99914		05/16/2018	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV	ANNAWAN URGENT CARE CLINIC	148615	99914		07/28/2020	N	O	N	15.03
15.04	Hospital-Based Health Clinic - RHC V	HAMMOND-HENRY HOSPITAL RHP-CAMBRIDGE	148628	99914		02/07/2022	N	O	N	15.04
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	06/01/2022	05/31/2023	20.00
21.00	Type of Control (see instructions)	11		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N		22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1319	Period: From 06/01/2022 To 05/31/2023	Worksheet S-2 Part I Date/Time Prepared: 10/24/2023 5:18 pm

		1.00	2.00	3.00	
22.04	Did this hospital receive a geographic reclassification from urban to 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 yes or "N" for no.				22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N		23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 10/24/2023 5:18 pm

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 10/24/2023 5:18 pm

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

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

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

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

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

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

		1.00	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)		
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?	N	68.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 10/24/2023 5:18 pm

		Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
		1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.		0	88.00

		Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge	
		1.00	2.00	3.00	
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		0	89.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		Y	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 10/24/2023 5:18 pm

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

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

		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	656,864	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.			123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00

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		1.00	2.00	
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

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

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

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

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

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1319	Period: From 06/01/2022 To 05/31/2023	Worksheet S-2 Part I Date/Time Prepared: 10/24/2023 5:18 pm

			1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act			
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		0.00	169.00
		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 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 reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	10/09/2023	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/12/2023	Y	10/12/2023	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 10/24/2023 5:18 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	Y	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	Y	33.00
	Provider-Based Physicians		
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAVID	GOODMAN	41.00
42.00	Enter the employer/company name of the cost report preparer.	WIPFLI, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	608-270-2962	DGOODMAN@WIPFLI.COM	43.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 10/24/2023 5:18 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	23	8,395	29,280.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		23	8,395	29,280.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		23	8,395	29,280.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	38	13,870		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	46.00	0	0			21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	99.10				0	25.10
26.00	KEWANEE RHC	88.00				0	26.00
26.02	GENESEO RHC	88.02				0	26.02
26.03	ANNAWAN RHC	88.03				0	26.03
26.04	CAMBRIDGE 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	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 10/24/2023 5:18 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	654	0	1,220			1.00
2.00	HMO and other (see instructions)	108	39				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	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 beds) (see instructions)	1,056	0	1,726			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	1,056	0	1,726	0.00	223.25	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	441	0	12,864	0.00	24.59	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE			0	0.00	0.00	21.00
22.00	HOME HEALTH AGENCY	5,137	0	10,021	0.00	7.47	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00	KEWANEE RHC	2,740	0	16,764	0.00	18.93	26.00
26.02	GENESEO RHC	2,800	0	17,192	0.00	20.48	26.02
26.03	ANNAWAN RHC	252	0	3,957	0.00	4.36	26.03
26.04	CAMBRIDGE RHC	381	0	3,106	0.00	3.69	26.04
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	302.77	27.00
28.00	Observation Bed Days		0	769			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 10/24/2023 5:18 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	202	0	335	1.00
2.00	HMO and other (see instructions)			23	5		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	202	0	335	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	0.00				0	21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					25.10
26.00	KEWANEE RHC	0.00					26.00
26.02	GENESEO RHC	0.00					26.02
26.03	ANNAWAN RHC	0.00					26.03
26.04	CAMBRIDGE RHC	0.00					26.04
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 14-1319 | Component CCN: 14-7450 | Period: From 06/01/2022 To 05/31/2023 | Worksheet S-4 | Date/Time Prepared: 10/24/2023 5:18 pm

Home Health Agency I | PPS

						1.00	
0.00	County				HENRY		0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	13,709	0	0	13,709	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	178.00	19.00	41.00	238.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)	40.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			1.01	0.00	1.01	5.00
6.00	Direct Nursing Service			0.00	0.00	0.00	6.00
7.00	Nursing Supervisor			1.02	0.00	1.02	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			6.59	0.00	6.59	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
						CBSA Data	
						1.00	
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.					2	19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).					19340	20.00
20.01						99914	20.01
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,381	743	32	43	2,199	21.00
22.00	Skilled Nursing Visit Charges	236,013	126,979	5,469	7,349	375,810	22.00
23.00	Physical Therapy Visits	916	694	8	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	4	22	579	25.00
26.00	Occupational Therapy Visit Charges	40,622	78,406	874	4,805	124,707	26.00
27.00	Speech Pathology Visits	15	49	0	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	5	5	0	1	11	29.00
30.00	Medical Social Service Visit Charges	1,300	1,300	0	0	2,600	30.00
31.00	Home Health Aide Visits	409	212	1	7	629	31.00
32.00	Home Health Aide Visit Charges	38,855	20,140	95	475	59,565	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,920	2,062	45	110	5,137	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	520,120	389,097	8,185	20,710	938,112	35.00
36.00	Total Number of Episodes (standard/non outlier)	315		30	5	350	36.00
37.00	Total Number of Outlier Episodes		113		4	117	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1319 | Component CCN: 14-8576 | Period: From 06/01/2022 To 05/31/2023 | Worksheet S-8 | 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			
4.00	Community Health Center (Section 330(d), PHS Act)			4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00

		1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:00	17:30	07:00	11.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		HENRY				2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:30	07:00	17:30	07:00	17:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 14-1319 Component CCN: 14-8576	Period: From 06/01/2022 To 05/31/2023	Worksheet S-8 Date/Time Prepared: 10/24/2023 5:18 pm
		RHC I	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	17:30				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1319 | Component CCN: 14-8587 | Period: From 06/01/2022 To 05/31/2023 | Worksheet S-8 | 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	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	GENESEO		IL	61254-1099	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:00	17:30	07:00	11.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		HENRY				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:30	07:00	17:30	07:00	17:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 14-1319 Component CCN: 14-8587	Period: From 06/01/2022 To 05/31/2023	Worksheet S-8 Date/Time Prepared: 10/24/2023 5:18 pm
		RHC III	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	17:30				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1319 | Component CCN: 14-8615 | Period: From 06/01/2022 To 05/31/2023 | Worksheet S-8 | 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		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ANNAWAN		IL	61234	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:00	19:00	07:00	11.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		HENRY				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	19:00	07:00	19:00	07:00	19:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 14-1319 Component CCN: 14-8615	Period: From 06/01/2022 To 05/31/2023	Worksheet S-8 Date/Time Prepared: 10/24/2023 5:18 pm

RHC IV | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	19:00	08:00	14:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1319 | Component CCN: 14-8628 | Period: From 06/01/2022 To 05/31/2023 | Worksheet S-8 | 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		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	CAMBRIDGE		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					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	16:30	08:00	11.00

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

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

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

			County			
			4.00			
2.00	City, State, ZIP Code, County		HENRY			2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:30			08:00	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 14-1319 Component CCN: 14-8628	Period: From 06/01/2022 To 05/31/2023	Worksheet S-8 Date/Time Prepared: 10/24/2023 5:18 pm
		RHC V	Cost

		Friday		Saturday			
		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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet S-10 | Date/Time Prepared: 10/24/2023 5:18 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.381613	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,480,041	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	8,306,801	6.00
7.00	Medicaid cost (line 1 times line 6)	3,169,983	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,689,942	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,689,942	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	104,120	0	104,120	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	39,734	0	39,734	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	39,734	0	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 imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,755,103	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	58,326	27.00
27.01	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
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	666,933	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	706,667	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,396,609	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet A | Date/Time Prepared: 10/24/2023 5:18 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		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
5.01	00550	DATA PROCESSING	386,358	1,366,829	1,753,187	0	1,753,187	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	204,240	13,341	217,581	0	217,581	5.02
5.03	00570	ADMITTING	237,357	47,340	284,697	0	284,697	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	553,172	454,675	1,007,847	0	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
7.00	00700	OPERATION OF PLANT	286,725	1,095,344	1,382,069	0	1,382,069	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	33,375	77,546	110,921	0	110,921	8.00
9.00	00900	HOUSEKEEPING	442,032	148,597	590,629	0	590,629	9.00
10.00	01000	DIETARY	658,199	506,478	1,164,677	0	1,164,677	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	138,158	50,081	188,239	0	188,239	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	77,430	77,430	0	77,430	14.00
15.00	01500	PHARMACY	373,742	164,479	538,221	52,033	590,254	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	515,733	222,037	737,770	0	737,770	16.00
17.00	01700	SOCIAL SERVICE	126,334	1,877	128,211	0	128,211	17.00
18.00	01080	INSERVICE EDUCATION	0	1,826	1,826	0	1,826	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,199,914	158,552	2,358,466	109,104	2,467,570	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,517,951	235,057	1,753,008	253,550	2,006,558	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,318,004	1,679,786	2,997,790	-579,140	2,418,650	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,189,541	1,030,469	2,220,010	30,955	2,250,965	54.00
60.00	06000	LABORATORY	929,987	1,484,127	2,414,114	24,497	2,438,611	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	77,524	77,524	0	77,524	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,816,839	92,516	1,909,355	10,887	1,920,242	66.00
67.00	06700	OCCUPATIONAL THERAPY	418,774	29,254	448,028	0	448,028	67.00
68.00	06800	SPEECH PATHOLOGY	151,314	7,844	159,158	0	159,158	68.00
69.00	06900	ELECTROCARDIOLOGY	260,586	86,467	347,053	0	347,053	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	579,140	579,140	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,225,947	1,225,947	0	1,225,947	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	106,776	57,342	164,118	0	164,118	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		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	WYOMING RHC	0	0	0	0	0	88.01
88.02	08802	GENESEO RHC	1,893,327	335,046	2,228,373	263,018	2,491,391	88.02
88.03	08803	ANNAWAN RHC	398,293	95,903	494,196	-6,083	488,113	88.03
88.04	08804	CAMBRIDGE RHC	321,021	-38,420	282,601	42,525	325,126	88.04
90.00	09000	CLINIC	696,918	123,557	820,475	136,175	956,650	90.00
90.01	09001	PAIN CLINIC	66,292	53,176	119,468	2,188	121,656	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	1,150,039	48,111	1,198,150	200,584	1,398,734	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	2,602,302	844,871	3,447,173	313,156	3,760,329	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	598,233	120,675	718,908	0	718,908	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		577,925	577,925	-577,925	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,105,914	23,975,353	49,081,267	49,941	49,131,208	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	544,263	60,494	604,757	-124,182	480,575	192.03
192.04	19204	ANNAWAN CLINIC	0	0	0	0	0	192.04
192.05	19205	CAMBRIDGE CLINIC	0	0	0	0	0	192.05
192.06	19206	PORT BYRON CLINIC	326,232	73,842	400,074	45,698	445,772	192.06
192.07	19207	ORION CLINIC	190,283	102,223	292,506	28,543	321,049	192.07

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet A | Date/Time Prepared: 10/24/2023 5:18 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
194.00	07955	FOUNDATION	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	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	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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet A | Date/Time Prepared: 10/24/2023 5:18 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	30,033	1,801,157		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	2,013,072		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,179,266		4.00
5.01	00550	DATA PROCESSING	0	1,753,187		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-157,140	60,441		5.02
5.03	00570	ADMITTING	0	284,697		5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	-68,124	939,723		5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	-117,056	3,532,504		5.05
7.00	00700	OPERATION OF PLANT	0	1,382,069		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	110,921		8.00
9.00	00900	HOUSEKEEPING	0	590,629		9.00
10.00	01000	DIETARY	-192,108	972,569		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	188,239		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	77,430		14.00
15.00	01500	PHARMACY	-43,361	546,893		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,360	734,410		16.00
17.00	01700	SOCIAL SERVICE	0	128,211		17.00
18.00	01080	INSERVICE EDUCATION	0	1,826		18.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-630,174	1,837,396		30.00
43.00	04300	NURSERY	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	-1,419	2,005,139		44.00
46.00	04600	OTHER LONG TERM CARE	0	0		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-378,485	2,040,165		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,250,965		54.00
60.00	06000	LABORATORY	-1,150	2,437,461		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	77,524		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	-184,839	1,735,403		66.00
67.00	06700	OCCUPATIONAL THERAPY	-173	447,855		67.00
68.00	06800	SPEECH PATHOLOGY	0	159,158		68.00
69.00	06900	ELECTROCARDIOLOGY	-3,216	343,837		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	579,140		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,225,947		73.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	-346	163,772		76.01
76.02	03950	IV THERAPY	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	KEWANEE RHC	0	2,518,377		88.00
88.01	08801	WYOMING RHC	0	0		88.01
88.02	08802	GENESEO RHC	0	2,491,391		88.02
88.03	08803	ANNAWAN RHC	0	488,113		88.03
88.04	08804	CAMBRIDGE RHC	0	325,126		88.04
90.00	09000	CLINIC	-494,386	462,264		90.00
90.01	09001	PAIN CLINIC	-54,589	67,067		90.01
90.02	09002	SPECIALTY CLINIC	0	0		90.02
90.03	09003	SURGICAL CLINIC	-1,115,441	283,293		90.03
90.04	09004	GENESEO CLINIC	0	0		90.04
91.00	09100	EMERGENCY	-1,080,756	2,679,573		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				92.00
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	-5,250	713,658		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,501,340	44,629,868		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0		192.00
192.01	19203	MUSCATINE CLINIC	0	0		192.01
192.02	19201	CARDIOLOGY CLINIC	0	0		192.02
192.03	19202	LEASED SPACE	0	480,575		192.03
192.04	19204	ANNAWAN CLINIC	0	0		192.04
192.05	19205	CAMBRIDGE CLINIC	0	0		192.05
192.06	19206	PORT BYRON CLINIC	0	445,772		192.06
192.07	19207	ORION CLINIC	0	321,049		192.07
194.00	07955	FOUNDATION	0	0		194.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet A | Date/Time Prepared: 10/24/2023 5:18 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
194.01	07950	SPORTS MEDICINE	0	218,580		194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0		194.02
194.03	07952	ANESTHESIA BILLNG	0	0		194.03
194.04	07953	SPECIALTY CLINIC	0	0		194.04
194.05	07954	COLONA CLINIC	0	0		194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0		194.06
194.07	07957	COMMUNITY HEALTH	0	17,272		194.07
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,501,340	46,113,116		200.00

RECLASSIFICATIONS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet A-6 | Date/Time Prepared: 10/24/2023 5:18 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - OFFSITE CLINIC BUILDING DEPRECIATION				
1.00	CLINIC	90.00	0	35,696	1.00
2.00	ORION CLINIC	192.07	0	2,897	2.00
	TOTALS		0	38,593	
	C - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	395,818	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	182,107	2.00
	TOTALS		0	577,925	
	E - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	85,342	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	27,295	2.00
3.00	CLINIC	90.00	0	1,800	3.00
4.00	ORION CLINIC	192.07	0	152	4.00
	TOTALS		0	114,589	
	H - IMPLANT EXP RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	579,140	1.00
	TOTALS		0	579,140	
	I - RECLASS PROVIDER BENEFITS				
1.00	CLINIC	90.00	0	87,334	1.00
2.00	PAIN CLINIC	90.01	0	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	CAMBRIDGE RHC	88.04	0	34,578	8.00
9.00	SURGICAL CLINIC	90.03	0	197,044	9.00
10.00	EMERGENCY	91.00	0	313,156	10.00
11.00	ADULTS & PEDIATRICS	30.00	0	109,104	11.00
	TOTALS		0	1,310,384	
	J - RECLASS SNF DEPRECIATION AND INTERST				
1.00	SKILLED NURSING FACILITY	44.00	0	161,945	1.00
2.00	SKILLED NURSING FACILITY	44.00	0	62,977	2.00
3.00	SKILLED NURSING FACILITY	44.00	0	14,174	3.00
	TOTALS		0	239,096	
	L - RHC LAB AND RADIOLOGY COSTS				
1.00	LABORATORY	60.00	4,262	0	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	128,564	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		132,826	0	
	N - CLINIC ADMIN COSTS				
1.00	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	CAMBRIDGE 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	SURGICAL CLINIC	90.03	3,142	398	7.00
8.00	PORT BYRON CLINIC	192.06	5,226	663	8.00
9.00	ORION CLINIC	192.07	2,744	348	9.00
	TOTALS		110,208	13,974	
	P - ANCILLARY SERVICE SALARY				
1.00	PHYSICAL THERAPY	66.00	10,887	0	1.00
2.00	SKILLED NURSING FACILITY	44.00	14,454	0	2.00
3.00	PHARMACY	15.00	8,672	0	3.00
4.00	PHARMACY	15.00	43,361	0	4.00
5.00	LABORATORY	60.00	20,235	0	5.00
	TOTALS		97,609	0	
500.00	Grand Total: Increases		340,643	2,873,701	500.00

RECLASSIFICATIONS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet A-6 | Date/Time Prepared: 10/24/2023 5:18 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - OFFSITE CLINIC BUILDING DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	38,593	9		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	38,593			
	C - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	577,925	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	577,925			
	E - OTHER CAPITAL COSTS						
1.00	ALL OTHER ADMINISTRATIVE AND GE	5.05	0	114,589	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		0	114,589			
	H - IMPLANT EXP RECLASS						
1.00	OPERATING ROOM	50.00	0	579,140	0		1.00
	TOTALS		0	579,140			
	I - RECLASS PROVIDER BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,310,384	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
	TOTALS		0	1,310,384			
	J - RECLASS SNF DEPRECIATION AND INTERST						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	161,945	9		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	62,977	11		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	14,174	9		3.00
	TOTALS		0	239,096			
	L - RHC LAB AND RADIOLOGY COSTS						
1.00	KEWANEE RHC	88.00	65,976	0	0		1.00
2.00	GENESEO RHC	88.02	4,323	0	0		2.00
3.00	ANNAWAN RHC	88.03	62,527	0	0		3.00
	TOTALS		132,826	0			
	N - CLINIC ADMIN COSTS						
1.00	LEASED SPACE	192.03	110,208	13,974	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
	TOTALS		110,208	13,974			
	P - ANCILLARY SERVICE SALARY						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	97,609	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	TOTALS		97,609	0			
500.00	Grand Total: Decreases		340,643	2,873,701			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet A-7 Part I | Date/Time Prepared: 10/24/2023 5:18 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,358,669	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

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
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

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet A-7 Part II | Date/Time Prepared: 10/24/2023 5:18 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,553,479	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,817,844	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,371,323	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	1,553,479		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,817,844		2.00
3.00	Total (sum of lines 1-2)	0	3,371,323		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet A-7 Part III Date/Time Prepared: 10/24/2023 5:18 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	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	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,352,941	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

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	362,874	85,342	0	0	1,801,157	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	182,107	27,295	0	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

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet A-8 | Date/Time Prepared: 10/24/2023 5:18 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	A	0	PURCHASING RECEIVING AND STORES	5.02	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	A	-157,140	PURCHASING RECEIVING AND STORES	5.02	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-2,063	ALL OTHER ADMINISTRATIVE AND GE	5.05	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,748,391			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-191,587	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-3,360	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-521	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet A-8 | Date/Time Prepared: 10/24/2023 5:18 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	ADVERTISING EXPENSE	A	-97,690	ALL OTHER ADMINISTRATIVE AND GE	5.05	0	33.00
33.01	PART B BILLING	A	-68,124	CASHIERING/ACCOUNTS RECEIVABLE	5.04	0	33.01
33.02	PHYSICIAN RECRUITING	A	-1,144	ALL OTHER ADMINISTRATIVE AND GE	5.05	0	33.02
33.03	UNAMMORTIZED BOND ISSUE COST	B	30,033	CAP REL COSTS-BLDG & FIXT	1.00	11	33.03
33.04	TV SERVICE - MED SURG	A	-4,328	ADULTS & PEDIATRICS	30.00	0	33.04
33.05	TV SERVICE - CARDIAC	A	-346	ELECTROCARDIOLOGY	69.00	0	33.05
33.06	TV SERVICE - LTC	A	-7,099	SKILLED NURSING FACILITY	44.00	0	33.06
33.07	TV SERVICE - OR	A	-2,770	OPERATING ROOM	50.00	0	33.07
33.08	TV SERVICE - ER	A	-1,212	EMERGENCY	91.00	0	33.08
33.09	TV SERVICE - PT	A	-519	PHYSICAL THERAPY	66.00	0	33.09
33.10	TV SERVICE - OT	A	-173	OCCUPATIONAL THERAPY	67.00	0	33.10
33.11	TV SERVICE - SLEEP	A	-346	SLEEP LAB	76.01	0	33.11
33.12	SNF MISCELLANEOUS REVENUE	B	-41	SKILLED NURSING FACILITY	44.00	0	33.12
33.13	UNAMMORTIZED BOND ISSUE COST	A	5,721	SKILLED NURSING FACILITY	44.00	0	33.13
33.14	LOBBYING	A	-16,159	ALL OTHER ADMINISTRATIVE AND GE	5.05	0	33.14
33.15	EMPLOYEE LAB TEST REVENUE	B	-1,150	LABORATORY	60.00	0	33.15
33.16	PT SPECIAL EDUCATION REVENUE	B	-59,475	PHYSICAL THERAPY	66.00	0	33.16
33.17	LIFELINE REVENUE	B	-5,250	HOME HEALTH AGENCY	101.00	0	33.17
33.18	SUMMIT WELLNESS REVENUE	B	-124,845	PHYSICAL THERAPY	66.00	0	33.18
33.19	340B PHARMACY SALARY	A	-43,361	PHARMACY	15.00	0	33.19
33.21	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.21
33.23	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.23
33.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.24
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,501,340				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
  A. Costs - if cost, including applicable overhead, can be determined.
  B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 10/24/2023 5:18 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	10,897	0	10,897	0	0	1.00
2.00	91.00	EMERGENCY	2,414,548	1,079,544	1,335,004	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	2,870	2,870	0	0	0	3.00
4.00	90.00	CLINIC	494,386	494,386	0	0	0	4.00
5.00	90.03	SURGICAL CLINIC	1,115,441	1,115,441	0	0	0	5.00
6.00	50.00	OPERATING ROOM	375,715	375,715	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	8,221	8,221	0	0	0	7.00
8.00	30.00	ADULTS & PEDIATRICS	617,625	617,625	0	0	0	8.00
9.00	90.01	PAIN CLINIC	54,589	54,589	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			5,094,292	3,748,391	1,345,901		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	90.00	CLINIC	0	0	0	0	0	4.00
5.00	90.03	SURGICAL CLINIC	0	0	0	0	0	5.00
6.00	50.00	OPERATING ROOM	0	0	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	7.00
8.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	8.00
9.00	90.01	PAIN CLINIC	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	0		1.00
2.00	91.00	EMERGENCY	0	0	0	1,079,544		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	2,870		3.00
4.00	90.00	CLINIC	0	0	0	494,386		4.00
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	0	8,221		7.00
8.00	30.00	ADULTS & PEDIATRICS	0	0	0	617,625		8.00
9.00	90.01	PAIN CLINIC	0	0	0	54,589		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,748,391		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet B Part I | Date/Time Prepared: 10/24/2023 5:18 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,801,157	1,801,157				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,013,072		2,013,072			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,179,266	8,306	20,524	4,208,096		4.00
5.01	00550	DATA PROCESSING	1,753,187	34,174	137,460	83,564	2,008,385	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	60,441	51,870	0	44,174	8,178	5.02
5.03	00570	ADMITTING	284,697	22,499	4,309	51,337	22,897	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	939,723	28,671	2,205	112,464	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	HOUSEKEEPING	590,629	23,267	336	95,606	4,143	9.00
10.00	01000	DIETARY	972,569	58,942	4,133	142,360	10,031	10.00
11.00	01100	CAFETERIA	0	38,928	0	0	2,726	11.00
13.00	01300	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	9,478	82,711	170,638	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	734,410	27,336	3,358	111,546	126,087	16.00
17.00	01700	SOCIAL SERVICE	128,211	0	1,672	27,324	2,181	17.00
18.00	01080	INSERVICE EDUCATION	1,826	0	825	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,837,396	226,846	49,419	357,597	170,311	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,005,139	0	0	331,439	26,713	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,040,165	253,965	713,525	285,067	51,682	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,250,965	149,390	361,724	263,977	87,772	54.00
60.00	06000	LABORATORY	2,437,461	40,946	96,482	206,442	71,417	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	77,524	1,518	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,735,403	223,227	24,131	395,312	61,059	66.00
67.00	06700	OCCUPATIONAL 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	ELECTROCARDIOLOGY	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	IMPL. 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	0	23,094	6,215	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	2,518,377	0	65,087	141,022	92,134	88.00
88.01	08801	WYOMING RHC	0	0	0	0	0	88.01
88.02	08802	GENESEO RHC	2,491,391	54,372	20,675	167,178	112,349	88.02
88.03	08803	ANNAWAN RHC	488,113	0	91,637	22,559	42,632	88.03
88.04	08804	CAMBRIDGE RHC	325,126	0	150,146	33,492	25,405	88.04
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	SURGICAL CLINIC	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	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	713,658	18,797	253	129,390	67,274	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST 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
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	16,478	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	3,101	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	480,575	12,926	7,489	93,880	0	192.03
192.04	19204	ANNAWAN CLINIC	0	0	0	0	0	192.04

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet B Part I Date/Time Prepared: 10/24/2023 5:18 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
192.05	19205	CAMBRIDGE CLINIC	0	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	FOUNDATION	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	TRINITY/DIALYSIS LEASED SPACE	0	43,198	0	0	0	194.06
194.07	07957	COMMUNITY 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

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet B Part I | Date/Time Prepared: 10/24/2023 5:18 pm

		Cost Center Description	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	ALL OTHER ADMINISTRATIVE AND GE	
			5.02	5.03	5.04	5A.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	164,663					5.02
5.03	00570	ADMITTING	147	385,886				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	106	0	1,165,054			5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	1,416	0	0	4,134,502	4,134,502	5.05
7.00	00700	OPERATION OF PLANT	4,992	0	0	1,627,799	160,488	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	264	0	0	131,330	12,948	8.00
9.00	00900	HOUSEKEEPING	3,063	0	0	717,044	70,695	9.00
10.00	01000	DIETARY	3,909	0	0	1,191,944	117,516	10.00
11.00	01100	CAFETERIA	0	0	0	41,654	4,107	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	228,262	22,505	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,398	0	0	81,828	8,068	14.00
15.00	01500	PHARMACY	482	0	0	838,155	82,635	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	195	0	0	1,002,932	98,881	16.00
17.00	01700	SOCIAL SERVICE	24	0	0	159,412	15,717	17.00
18.00	01080	INSERVICE EDUCATION	98	0	0	2,749	271	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,546	11,978	30,209	2,690,302	265,242	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,899	0	30,310	2,396,500	236,276	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,922	58,480	147,487	3,554,293	350,428	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,066	102,975	259,854	3,496,723	344,749	54.00
60.00	06000	LABORATORY	48,681	101,423	255,787	3,258,639	321,276	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	682	1,719	81,443	8,030	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,492	34,200	86,251	2,561,075	252,502	66.00
67.00	06700	OCCUPATIONAL THERAPY	393	9,239	23,300	598,310	58,989	67.00
68.00	06800	SPEECH PATHOLOGY	120	1,855	4,678	209,418	20,647	68.00
69.00	06900	ELECTROCARDIOLOGY	611	18,631	46,988	613,078	60,445	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,474	3,717	5,191	512	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	31,131	2,339	5,900	618,510	60,980	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	21,053	53,095	1,300,095	128,179	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	414	3,542	8,932	218,428	21,535	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	4,079	0	57,154	2,877,853	283,733	88.00
88.01	08801	WYOMING RHC	0	0	0	0	0	88.01
88.02	08802	GENESEO RHC	4,703	0	47,419	2,898,087	285,728	88.02
88.03	08803	ANNAWAN RHC	1,483	0	10,897	657,321	64,807	88.03
88.04	08804	CAMBRIDGE RHC	739	0	9,955	544,863	53,719	88.04
90.00	09000	CLINIC	3,616	0	14,215	664,773	65,541	90.00
90.01	09001	PAIN CLINIC	526	0	243	103,254	10,180	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	1,073	0	1,619	356,257	35,124	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	5,987	18,015	45,433	3,379,395	333,181	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	2,967	0	8,641	940,980	92,773	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	160,542	385,886	1,153,803	44,182,399	3,948,407	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	16,478	1,625	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	3,101	306	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	1,024	0	0	595,894	58,750	192.03
192.04	19204	ANNAWAN CLINIC	0	0	0	0	0	192.04
192.05	19205	CAMBRIDGE CLINIC	0	0	0	0	0	192.05
192.06	19206	PORT BYRON CLINIC	1,033	0	7,377	556,584	54,875	192.06
192.07	19207	ORION CLINIC	1,962	0	3,874	419,352	41,345	192.07
194.00	07955	FOUNDATION	0	0	0	15,562	1,534	194.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet B Part I Date/Time Prepared: 10/24/2023 5:18 pm

		Cost Center Description	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	ALL OTHER ADMINISTRATIVE AND GE	
			5.02	5.03	5.04	5A.04	5.05	
194.01	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

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet B Part I | Date/Time Prepared: 10/24/2023 5:18 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE						5.05
7.00	00700	OPERATION OF PLANT	1,788,287					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	13,522	157,800				8.00
9.00	00900	HOUSEKEEPING	24,340	21,167	833,246			9.00
10.00	01000	DIETARY	61,660	375	27,154	1,398,649		10.00
11.00	01100	CAFETERIA	40,723	0	4,854	921,663	1,013,001	11.00
13.00	01300	NURSING ADMINISTRATION	10,608	0	0	0	35,508	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	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	0	0	2,124	0	9,701	17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	237,306	22,173	167,272	81,714	110,633	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	312,926	39,610	211,669	395,272	131,329	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	265,676	18,733	154,631	0	79,761	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	156,279	15,956	37,065	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	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	233,520	13,043	25,839	0	111,828	66.00
67.00	06700	OCCUPATIONAL 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	ELECTROCARDIOLOGY	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	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	13,033	1,895	1,011	0	7,503	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0	0	0	0	0	88.00
88.01	08801	WYOMING RHC	0	0	0	0	0	88.01
88.02	08802	GENESEO RHC	56,880	422	37,065	0	111,159	88.02
88.03	08803	ANNAWAN RHC	0	0	0	0	0	88.03
88.04	08804	CAMBRIDGE RHC	0	0	0	0	0	88.04
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PAIN CLINIC	454	621	0	0	4,110	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	4,571	0	7,737	0	22,557	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	161,130	23,805	57,544	0	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	INTEREST 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
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	17,238	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	13,522	0	25,030	0	19,928	192.03
192.04	19204	ANNAWAN CLINIC	0	0	0	0	0	192.04
192.05	19205	CAMBRIDGE CLINIC	0	0	0	0	0	192.05
192.06	19206	PORT BYRON CLINIC	0	0	0	0	0	192.06
192.07	19207	ORION CLINIC	0	0	0	0	0	192.07
194.00	07955	FOUNDATION	6,927	0	0	0	8,554	194.00
194.01	07950	SPORTS MEDICINE	0	0	0	0	0	194.01

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet B Part I Date/Time Prepared: 10/24/2023 5:18 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
194.02	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	COMMUNITY 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

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet B Part I | Date/Time Prepared: 10/24/2023 5:18 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	296,883					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	89,896				14.00
15.00	01500	PHARMACY	16,728	0	996,245			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,185,623		16.00
17.00	01700	SOCIAL SERVICE	6,152	0	0	0	193,106	17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	70,152	0	0	31,720	136,379	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	3,219	49,226	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	50,576	0	0	154,865	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	49,819	0	0	272,821	0	54.00
60.00	06000	LABORATORY	52,637	0	0	268,583	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	1,805	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	90,566	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	24,466	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	4,912	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	49,339	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	89,896	0	3,903	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,195	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	996,245	55,751	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	4,758	0	0	9,378	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	60,013	0	88.00
88.01	08801	WYOMING RHC	0	0	0	0	0	88.01
88.02	08802	GENESEO RHC	0	0	0	49,791	0	88.02
88.03	08803	ANNAWAN RHC	0	0	0	11,442	0	88.03
88.04	08804	CAMBRIDGE RHC	0	0	0	10,453	0	88.04
90.00	09000	CLINIC	0	0	0	14,926	0	90.00
90.01	09001	PAIN CLINIC	2,606	0	0	255	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	0	1,700	0	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	43,455	0	0	47,706	7,501	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	296,883	89,896	996,245	1,173,809	193,106	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	0	0	0	0	192.03
192.04	19204	ANNAWAN CLINIC	0	0	0	0	0	192.04
192.05	19205	CAMBRIDGE CLINIC	0	0	0	0	0	192.05
192.06	19206	PORT BYRON CLINIC	0	0	0	7,746	0	192.06
192.07	19207	ORION CLINIC	0	0	0	4,068	0	192.07
194.00	07955	FOUNDATION	0	0	0	0	0	194.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet B Part I Date/Time Prepared: 10/24/2023 5:18 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
194.01	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	0	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

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet B Part I | Date/Time Prepared: 10/24/2023 5:18 pm

		Cost Center Description	OTHER GENERAL SERVICE INSERVICE EDUCATION	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			18.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
18.00	01080	INSERVICE EDUCATION	3,020					18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	78	3,812,971	0	3,812,971		30.00
43.00	04300	NURSERY	0	0	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	79	3,776,106	0	3,776,106		44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0		46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	382	4,629,345	0	4,629,345		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	697	4,452,675	0	4,452,675		54.00
60.00	06000	LABORATORY	663	4,065,112	0	4,065,112		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	4	92,870	0	92,870		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	223	3,288,596	0	3,288,596		66.00
67.00	06700	OCCUPATIONAL THERAPY	60	723,031	0	723,031		67.00
68.00	06800	SPEECH PATHOLOGY	12	246,609	0	246,609		68.00
69.00	06900	ELECTROCARDIOLOGY	122	768,364	0	768,364		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	10	99,512	0	99,512		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15	685,700	0	685,700		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	138	2,480,408	0	2,480,408		73.00
76.00	03020	ACUPUNCTURE	0	0	0	0		76.00
76.01	03610	SLEEP LAB	23	277,564	0	277,564		76.01
76.02	03950	IV THERAPY	0	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	148	3,221,747	0	3,221,747		88.00
88.01	08801	WYOMING RHC	0	0	0	0		88.01
88.02	08802	GENESEO RHC	123	3,439,255	0	3,439,255		88.02
88.03	08803	ANNAWAN RHC	28	733,598	0	733,598		88.03
88.04	08804	CAMBRIDGE RHC	26	609,061	0	609,061		88.04
90.00	09000	CLINIC	37	745,277	0	745,277		90.00
90.01	09001	PAIN CLINIC	1	121,481	0	121,481		90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0		90.02
90.03	09003	SURGICAL CLINIC	4	427,950	0	427,950		90.03
90.04	09004	GENESEO CLINIC	0	0	0	0		90.04
91.00	09100	EMERGENCY	118	4,122,366	0	4,122,366		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	1,055,844	0	1,055,844		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,991	43,875,442	0	43,875,442		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	35,341	0	35,341		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0		192.00
192.01	19203	MUSCATINE CLINIC	0	3,407	0	3,407		192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0		192.02
192.03	19202	LEASED SPACE	0	713,124	0	713,124		192.03
192.04	19204	ANNAWAN CLINIC	0	0	0	0		192.04

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet B Part I Date/Time Prepared: 10/24/2023 5:18 pm

		Cost Center Description	OTHER GENERAL SERVICE INSERVICE EDUCATION	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			18.00	24.00	25.00	26.00		
192.05	19205	CAMBRIDGE CLINIC	0	0	0	0		192.05
192.06	19206	PORT BYRON CLINIC	19	619,224	0	619,224		192.06
192.07	19207	ORION CLINIC	10	464,775	0	464,775		192.07
194.00	07955	FOUNDATION	0	32,577	0	32,577		194.00
194.01	07950	SPORTS MEDICINE	0	287,673	0	287,673		194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0		194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0		194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0		194.04
194.05	07954	COLONA CLINIC	0	0	0	0		194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	60,492	0	60,492		194.06
194.07	07957	COMMUNITY 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

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet B Part II | Date/Time Prepared: 10/24/2023 5:18 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,306	20,524	28,830	28,830	4.00
5.01	00550	DATA PROCESSING	0	34,174	137,460	171,634	573	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	51,870	0	51,870	303	5.02
5.03	00570	ADMITTING	0	22,499	4,309	26,808	352	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	28,671	2,205	30,876	771	5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	0	66,231	28,923	95,154	2,105	5.05
7.00	00700	OPERATION OF PLANT	0	135,881	11,549	147,430	425	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,926	0	12,926	49	8.00
9.00	00900	HOUSEKEEPING	0	23,267	336	23,603	655	9.00
10.00	01000	DIETARY	0	58,942	4,133	63,075	975	10.00
11.00	01100	CAFETERIA	0	38,928	0	38,928	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,141	0	10,141	205	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	27,953	9,478	37,431	567	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	27,336	3,358	30,694	764	16.00
17.00	01700	SOCIAL SERVICE	0	0	1,672	1,672	187	17.00
18.00	01080	INSERVICE EDUCATION	0	0	825	825	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	226,846	49,419	276,265	2,450	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	2,271	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	253,965	713,525	967,490	1,953	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	149,390	361,724	511,114	1,809	54.00
60.00	06000	LABORATORY	0	40,946	96,482	137,428	1,415	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	1,518	0	1,518	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	223,227	24,131	247,358	2,703	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	11,325	903	12,228	621	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,702	0	2,702	224	68.00
69.00	06900	ELECTROCARDIOLOGY	0	20,431	119,132	139,563	386	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	12,459	0	12,459	158	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	65,087	65,087	966	88.00
88.01	08801	WYOMING RHC	0	0	0	0	0	88.01
88.02	08802	GENESEO RHC	0	54,372	20,675	75,047	1,146	88.02
88.03	08803	ANNAWAN RHC	0	0	91,637	91,637	155	88.03
88.04	08804	CAMBRIDGE RHC	0	0	150,146	150,146	229	88.04
90.00	09000	CLINIC	0	0	14,198	14,198	399	90.00
90.01	09001	PAIN CLINIC	0	434	417	851	84	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	4,370	0	4,370	246	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	154,027	50,787	204,814	1,532	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	18,797	253	19,050	887	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,721,934	1,983,288	3,705,222	27,565	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	16,478	0	16,478	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	3,101	3,101	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	12,926	7,489	20,415	643	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

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet B Part II Date/Time Prepared: 10/24/2023 5:18 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
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	FOUNDATION	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	COMMUNITY 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

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet B Part II | Date/Time Prepared: 10/24/2023 5:18 pm

		Cost Center Description	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	ALL OTHER ADMINISTRATIVE AND GE	
			5.01	5.02	5.03	5.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING	172,207					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	701	52,874				5.02
5.03	00570	ADMITTING	1,963	47	29,170			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	7,021	34	0	38,702		5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	16,997	455	0	0	114,711	5.05
7.00	00700	OPERATION OF PLANT	2,683	1,603	0	0	4,452	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	85	0	0	359	8.00
9.00	00900	HOUSEKEEPING	355	983	0	0	1,961	9.00
10.00	01000	DIETARY	860	1,255	0	0	3,260	10.00
11.00	01100	CAFETERIA	234	0	0	0	114	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	624	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,412	0	0	224	14.00
15.00	01500	PHARMACY	14,631	155	0	0	2,292	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,811	63	0	0	2,743	16.00
17.00	01700	SOCIAL SERVICE	187	8	0	0	436	17.00
18.00	01080	INSERVICE EDUCATION	0	32	0	0	8	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,603	2,102	906	1,002	7,358	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,291	931	0	1,006	6,554	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,431	1,259	4,424	4,894	9,739	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,526	6,443	7,768	8,663	9,564	54.00
60.00	06000	LABORATORY	6,124	15,634	7,672	8,488	8,912	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	52	57	223	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	5,235	479	2,587	2,862	7,005	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,262	126	699	773	1,636	67.00
68.00	06800	SPEECH PATHOLOGY	701	38	140	155	573	68.00
69.00	06900	ELECTROCARDIOLOGY	608	196	1,409	1,559	1,677	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	112	123	14	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,996	177	196	1,692	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,593	1,762	3,556	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	533	133	268	296	597	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	7,900	1,310	0	1,897	7,871	88.00
88.01	08801	WYOMING RHC	0	0	0	0	0	88.01
88.02	08802	GENESEO RHC	9,633	1,510	0	1,574	7,926	88.02
88.03	08803	ANNAWAN RHC	3,655	476	0	362	1,798	88.03
88.04	08804	CAMBRIDGE RHC	2,178	237	0	330	1,490	88.04
90.00	09000	CLINIC	9,620	1,161	0	472	1,818	90.00
90.01	09001	PAIN CLINIC	1,917	169	0	8	282	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	2,571	344	0	54	974	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	17,325	1,922	1,363	1,508	9,243	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	5,768	953	0	287	2,574	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	160,324	51,551	29,170	38,328	109,549	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	45	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	8	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	329	0	0	1,630	192.03
192.04	19204	ANNAWAN CLINIC	0	0	0	0	0	192.04
192.05	19205	CAMBRIDGE CLINIC	0	0	0	0	0	192.05
192.06	19206	PORT BYRON CLINIC	5,740	332	0	245	1,522	192.06
192.07	19207	ORION CLINIC	5,376	630	0	129	1,147	192.07
194.00	07955	FOUNDATION	767	0	0	0	43	194.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet B Part II Date/Time Prepared: 10/24/2023 5:18 pm

		Cost Center Description	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	ALL OTHER ADMINISTRATIVE AND GE	
			5.01	5.02	5.03	5.04	5.05	
194.01	07950	SPORTS MEDICINE	0	31	0	0	716	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	1	0	0	51	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)	172,207	52,874	29,170	38,702	114,711	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet B Part II | Date/Time Prepared: 10/24/2023 5:18 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE						5.05
7.00	00700	OPERATION OF PLANT	156,593					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,184	14,603				8.00
9.00	00900	HOUSEKEEPING	2,131	1,959	31,647			9.00
10.00	01000	DIETARY	5,399	35	1,031	75,890		10.00
11.00	01100	CAFETERIA	3,566	0	184	50,009	93,035	11.00
13.00	01300	NURSING ADMINISTRATION	929	0	0	0	3,261	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	2,561	0	118	0	2,423	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,504	0	77	0	4,885	16.00
17.00	01700	SOCIAL SERVICE	0	0	81	0	891	17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,780	2,052	6,353	4,434	10,161	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	27,402	3,665	8,038	21,447	12,061	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,264	1,734	5,873	0	7,325	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,685	1,477	1,408	0	7,216	54.00
60.00	06000	LABORATORY	3,751	0	1,423	0	7,624	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	139	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	20,448	1,207	981	0	10,270	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,037	0	177	0	2,269	67.00
68.00	06800	SPEECH PATHOLOGY	248	0	0	0	808	68.00
69.00	06900	ELECTROCARDIOLOGY	1,872	0	277	0	1,536	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	1,141	175	38	0	689	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0	0	0	0	0	88.00
88.01	08801	WYOMING RHC	0	0	0	0	0	88.01
88.02	08802	GENESEO RHC	4,981	39	1,408	0	10,209	88.02
88.03	08803	ANNAWAN RHC	0	0	0	0	0	88.03
88.04	08804	CAMBRIDGE RHC	0	0	0	0	0	88.04
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PAIN CLINIC	40	57	0	0	377	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	400	0	294	0	2,072	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	14,109	2,203	2,186	0	6,294	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	1,722	0	92	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	153,293	14,603	30,039	75,890	90,371	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	1,509	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	1,184	0	951	0	1,830	192.03
192.04	19204	ANNAWAN CLINIC	0	0	0	0	0	192.04
192.05	19205	CAMBRIDGE CLINIC	0	0	0	0	0	192.05
192.06	19206	PORT BYRON CLINIC	0	0	0	0	0	192.06
192.07	19207	ORION CLINIC	0	0	0	0	0	192.07
194.00	07955	FOUNDATION	607	0	0	0	786	194.00
194.01	07950	SPORTS MEDICINE	0	0	0	0	0	194.01

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet B Part II Date/Time Prepared: 10/24/2023 5:18 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
194.02	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	657	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	0	48	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)	156,593	14,603	31,647	75,890	93,035	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet B Part II | Date/Time Prepared: 10/24/2023 5:18 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	15,160					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,636				14.00
15.00	01500	PHARMACY	854	0	61,032			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	52,541		16.00
17.00	01700	SOCIAL SERVICE	314	0	0	0	3,776	17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,582	0	0	1,406	2,666	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	143	963	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,583	0	0	6,864	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	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	0	0	0	80	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,014	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,084	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	218	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,187	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,636	0	173	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	275	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	61,032	2,471	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	243	0	0	416	0	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0	0	0	2,660	0	88.00
88.01	08801	WYOMING RHC	0	0	0	0	0	88.01
88.02	08802	GENESEO RHC	0	0	0	2,207	0	88.02
88.03	08803	ANNAWAN RHC	0	0	0	507	0	88.03
88.04	08804	CAMBRIDGE RHC	0	0	0	463	0	88.04
90.00	09000	CLINIC	0	0	0	662	0	90.00
90.01	09001	PAIN CLINIC	133	0	0	11	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	0	75	0	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	2,219	0	0	2,114	147	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,160	1,636	61,032	52,018	3,776	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	0	0	0	0	192.03
192.04	19204	ANNAWAN CLINIC	0	0	0	0	0	192.04
192.05	19205	CAMBRIDGE CLINIC	0	0	0	0	0	192.05
192.06	19206	PORT BYRON CLINIC	0	0	0	343	0	192.06
192.07	19207	ORION CLINIC	0	0	0	180	0	192.07
194.00	07955	FOUNDATION	0	0	0	0	0	194.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet B Part II Date/Time Prepared: 10/24/2023 5:18 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
194.01	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	0	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

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet B Part II | Date/Time Prepared: 10/24/2023 5:18 pm

		Cost Center Description	OTHER GENERAL SERVICE INSERVICE EDUCATION	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			18.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
18.00	01080	INSERVICE EDUCATION	865					18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24	356,144	0	356,144		30.00
43.00	04300	NURSERY	0	0	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	24	86,796	0	86,796		44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0		46.00
		ANCILLARY SERVICE COST CENTERS						
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	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	150	591,451	0	591,451		54.00
60.00	06000	LABORATORY	204	213,267	0	213,267		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	1	2,070	0	2,070		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	69	305,218	0	305,218		66.00
67.00	06700	OCCUPATIONAL THERAPY	19	21,931	0	21,931		67.00
68.00	06800	SPEECH PATHOLOGY	4	5,811	0	5,811		68.00
69.00	06900	ELECTROCARDIOLOGY	37	151,307	0	151,307		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	3	2,061	0	2,061		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5	12,341	0	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	7	17,153	0	17,153		76.01
76.02	03950	IV THERAPY	0	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	46	87,737	0	87,737		88.00
88.01	08801	WYOMING RHC	0	0	0	0		88.01
88.02	08802	GENESEO RHC	38	115,718	0	115,718		88.02
88.03	08803	ANNAWAN RHC	9	98,599	0	98,599		88.03
88.04	08804	CAMBRIDGE RHC	8	155,081	0	155,081		88.04
90.00	09000	CLINIC	11	28,341	0	28,341		90.00
90.01	09001	PAIN CLINIC	0	3,929	0	3,929		90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0		90.02
90.03	09003	SURGICAL CLINIC	1	11,401	0	11,401		90.03
90.04	09004	GENESEO CLINIC	0	0	0	0		90.04
91.00	09100	EMERGENCY	36	267,015	0	267,015		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	31,333	0	31,333		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	856	3,677,111	0	3,677,111		118.00
		NONREIMBURSABLE COST CENTERS						
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
192.01	19203	MUSCATINE CLINIC	0	3,109	0	3,109		192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0		192.02
192.03	19202	LEASED SPACE	0	26,982	0	26,982		192.03
192.04	19204	ANNAWAN CLINIC	0	0	0	0		192.04

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet B Part II Date/Time Prepared: 10/24/2023 5:18 pm

		Cost Center Description	OTHER GENERAL SERVICE INSERVICE EDUCATION	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			18.00	24.00	25.00	26.00		
192.05	19205	CAMBRIDGE CLINIC	0	0	0	0		192.05
192.06	19206	PORT BYRON CLINIC	6	15,282	0	15,282		192.06
192.07	19207	ORION CLINIC	3	19,881	0	19,881		192.07
194.00	07955	FOUNDATION	0	8,824	0	8,824		194.00
194.01	07950	SPORTS MEDICINE	0	1,043	0	1,043		194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0		194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0		194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0		194.04
194.05	07954	COLONA CLINIC	0	0	0	0		194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	43,855	0	43,855		194.06
194.07	07957	COMMUNITY HEALTH	0	110	0	110		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)	865	3,814,229	0	3,814,229		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet B-1 | Date/Time Prepared: 10/24/2023 5:18 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (TIME SPENT)	PURCHASING RECEIVING AND STORES (SUPPLY COST)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	107,992					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,966,463				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	498	20,049	19,456,090			4.00
5.01	00550	DATA PROCESSING	2,049	134,277	386,358	92,099		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	3,110	0	204,240	375	3,063,332	5.02
5.03	00570	ADMITTING	1,349	4,209	237,357	1,050	2,734	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,719	2,154	519,975	3,755	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	1,435	92,870	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	775	0	33,375	0	4,910	8.00
9.00	00900	HOUSEKEEPING	1,395	328	442,032	190	56,975	9.00
10.00	01000	DIETARY	3,534	4,037	658,199	460	72,714	10.00
11.00	01100	CAFETERIA	2,334	0	0	125	0	11.00
13.00	01300	NURSING ADMINISTRATION	608	0	138,158	0	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	5,782	3,633	16.00
17.00	01700	SOCIAL SERVICE	0	1,633	126,334	100	448	17.00
18.00	01080	INSERVICE EDUCATION	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	7,810	121,784	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	1,532,405	1,225	53,930	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,227	697,007	1,318,004	2,370	72,958	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,957	353,349	1,220,496	4,025	373,299	54.00
60.00	06000	LABORATORY	2,455	94,248	954,484	3,275	905,648	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	91	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	13,384	23,572	1,827,726	2,800	27,752	66.00
67.00	06700	OCCUPATIONAL THERAPY	679	882	418,774	675	7,309	67.00
68.00	06800	SPEECH PATHOLOGY	162	0	151,314	375	2,226	68.00
69.00	06900	ELECTROCARDIOLOGY	1,225	116,374	260,586	325	11,376	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	579,140	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	747	0	106,776	285	7,697	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0	63,580	652,014	4,225	75,885	88.00
88.01	08801	WYOMING RHC	0	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	0	89,515	104,301	1,955	27,592	88.03
88.04	08804	CAMBRIDGE RHC	0	146,670	154,852	1,165	13,745	88.04
90.00	09000	CLINIC	0	13,869	269,476	5,145	67,276	90.00
90.01	09001	PAIN CLINIC	26	407	56,474	1,025	9,787	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	262	0	166,065	1,375	19,957	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	9,235	49,611	1,033,506	9,265	111,384	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	1,127	247	598,233	3,085	55,198	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	103,242	1,937,369	18,603,026	85,744	2,986,656	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	988	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	3,029	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	775	7,316	434,055	0	19,052	192.03
192.04	19204	ANNAWAN CLINIC	0	0	0	0	0	192.04

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet B-1 | Date/Time Prepared: 10/24/2023 5:18 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (TIME SPENT)	PURCHASING RECEIVING AND STORES (SUPPLY COST)	
			1.00	2.00	4.00	5.01	5.02	
192.05	19205	CAMBRIDGE CLINIC	0	0	0	0	0	192.05
192.06	19206	PORT BYRON CLINIC	0	6,738	132,032	3,070	19,223	192.06
192.07	19207	ORION CLINIC	0	12,011	80,800	2,875	36,509	192.07
194.00	07955	FOUNDATION	397	0	0	410	0	194.00
194.01	07950	SPORTS MEDICINE	0	0	199,636	0	1,807	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	2,590	0	0	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	6,541	0	85	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,801,157	2,013,072	4,208,096	2,008,385	164,663	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.678615	1.023702	0.216287	21.806806	0.053753	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			28,830	172,207	52,874	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001482	1.869803	0.017260	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet B-1 | Date/Time Prepared: 10/24/2023 5:18 pm

		Cost Center Description	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	ALL OTHER ADMINISTRATIVE AND GE (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING	96,991,359					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	116,094,786				5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE	0	0	-4,134,502	41,935,416		5.05
7.00	00700	OPERATION OF PLANT	0	0	0	1,627,799	102,494	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	131,330	775	8.00
9.00	00900	HOUSEKEEPING	0	0	0	717,044	1,395	9.00
10.00	01000	DIETARY	0	0	0	1,191,944	3,534	10.00
11.00	01100	CAFETERIA	0	0	0	41,654	2,334	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	228,262	608	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	81,828	0	14.00
15.00	01500	PHARMACY	0	0	0	838,155	1,676	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,002,932	1,639	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	159,412	0	17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	2,749	0	18.00
		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	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	3,020,431	0	2,396,500	17,935	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,697,271	14,697,271	0	3,554,293	15,227	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,890,532	25,890,532	0	3,496,723	8,957	54.00
60.00	06000	LABORATORY	25,489,520	25,489,520	0	3,258,639	2,455	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	171,333	171,333	0	81,443	91	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	8,595,016	8,595,016	0	2,561,075	13,384	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,321,895	2,321,895	0	598,310	679	67.00
68.00	06800	SPEECH PATHOLOGY	466,123	466,123	0	209,418	162	68.00
69.00	06900	ELECTROCARDIOLOGY	4,682,425	4,682,425	0	613,078	1,225	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	370,438	370,438	0	5,191	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	587,932	587,932	0	618,510	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,290,955	5,290,955	0	1,300,095	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	890,053	890,053	0	218,428	747	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0	5,695,426	0	2,877,853	0	88.00
88.01	08801	WYOMING RHC	0	0	0	0	0	88.01
88.02	08802	GENESEO RHC	0	4,725,333	0	2,898,087	3,260	88.02
88.03	08803	ANNAWAN RHC	0	1,085,886	0	657,321	0	88.03
88.04	08804	CAMBRIDGE RHC	0	992,059	0	544,863	0	88.04
90.00	09000	CLINIC	0	1,416,506	0	664,773	0	90.00
90.01	09001	PAIN CLINIC	0	24,204	0	103,254	26	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	161,366	0	356,257	262	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	4,527,477	4,527,477	0	3,379,395	9,235	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	861,058	0	940,980	1,127	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	96,991,359	114,973,628	-4,134,502	40,047,897	100,334	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	16,478	988	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	3,101	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	0	0	595,894	775	192.03
192.04	19204	ANNAWAN CLINIC	0	0	0	0	0	192.04
192.05	19205	CAMBRIDGE CLINIC	0	0	0	0	0	192.05
192.06	19206	PORT BYRON CLINIC	0	735,133	0	556,584	0	192.06

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet B-1 | Date/Time Prepared: 10/24/2023 5:18 pm

		Cost Center Description	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	ALL OTHER ADMINISTRATIVE AND GE (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	7.00	
192.07	19207	ORION CLINIC	0	386,025	0	419,352	0	192.07
194.00	07955	FOUNDATION	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, Part I)	385,886	1,165,054		4,134,502	1,788,287	202.00
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, Part II)	29,170	38,702		114,711	156,593	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000301	0.000333		0.002735	1.527826	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet B-1 | Date/Time Prepared: 10/24/2023 5:18 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	197,978					8.00
9.00	00900	HOUSEKEEPING	26,557	411,960				9.00
10.00	01000	DIETARY	470	13,425	137,136			10.00
11.00	01100	CAFETERIA	0	2,400	90,368	21,197		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	743	9,797	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	1,535	0	552	552	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,000	0	1,113	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,050	0	203	203	17.00
18.00	01080	INSERVICE EDUCATION	0	0	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	0	0	0	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	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,503	76,450	0	1,669	1,669	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,018	18,325	0	1,644	1,644	54.00
60.00	06000	LABORATORY	0	18,525	0	1,737	1,737	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	16,364	12,775	0	2,340	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,300	0	517	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	184	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,600	0	350	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	2,378	500	0	157	157	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0	0	0	0	0	88.00
88.01	08801	WYOMING RHC	0	0	0	0	0	88.01
88.02	08802	GENESEO RHC	530	18,325	0	2,326	0	88.02
88.03	08803	ANNAWAN RHC	0	0	0	0	0	88.03
88.04	08804	CAMBRIDGE RHC	0	0	0	0	0	88.04
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PAIN CLINIC	779	0	0	86	86	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	3,825	0	472	0	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	29,866	28,450	0	1,434	1,434	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	1,200	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	197,978	391,035	137,136	20,590	9,797	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	12,375	0	417	0	192.03
192.04	19204	ANNAWAN CLINIC	0	0	0	0	0	192.04
192.05	19205	CAMBRIDGE CLINIC	0	0	0	0	0	192.05
192.06	19206	PORT BYRON CLINIC	0	0	0	0	0	192.06
192.07	19207	ORION CLINIC	0	0	0	0	0	192.07

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet B-1 | Date/Time Prepared: 10/24/2023 5:18 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES)	
			8.00	9.00	10.00	11.00	13.00	
194.00	07955	FOUNDATION	0	0	0	179	0	194.00
194.01	07950	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	8,550	0	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	11	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	157,800	833,246	1,398,649	1,013,001	296,883	202.00
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, Part II)	14,603	31,647	75,890	93,035	15,160	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.073761	0.076821	0.553392	4.389064	1.547412	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet B-1 | Date/Time Prepared: 10/24/2023 5:18 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQ UIS)	PHARMACY (COSTED REQ UIS)	MEDICAL RECORDS & LIBRARY (GROSS PT. CHARGES)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE INSERVICE EDUCATION (GROSS CHAR GES)	
			14.00	15.00	16.00	17.00	18.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	ALL OTHER ADMINISTRATIVE AND GE						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	100					14.00
15.00	01500	PHARMACY	0	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	112,518,784			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	89,665		17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	0	115,233,728	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	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	305,487	22,857	3,020,431	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	14,697,271	0	14,697,271	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	25,890,532	0	25,890,532	54.00
60.00	06000	LABORATORY	0	0	25,489,520	0	25,489,520	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	171,333	0	171,333	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	8,595,016	0	8,595,016	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,321,895	0	2,321,895	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	466,123	0	466,123	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	4,682,425	0	4,682,425	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	100	0	370,438	0	370,438	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	587,932	0	587,932	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	5,290,955	0	5,290,955	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	890,053	0	890,053	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0	0	5,695,426	0	5,695,426	88.00
88.01	08801	WYOMING RHC	0	0	0	0	0	88.01
88.02	08802	GENESEO RHC	0	0	4,725,333	0	4,725,333	88.02
88.03	08803	ANNAWAN RHC	0	0	1,085,886	0	1,085,886	88.03
88.04	08804	CAMBRIDGE RHC	0	0	992,059	0	992,059	88.04
90.00	09000	CLINIC	0	0	1,416,506	0	1,416,506	90.00
90.01	09001	PAIN CLINIC	0	0	24,204	0	24,204	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	161,366	0	161,366	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	4,527,477	3,483	4,527,477	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	111,397,626	89,665	114,112,570	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	0	0	0	0	192.03
192.04	19204	ANNAWAN CLINIC	0	0	0	0	0	192.04

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet B-1 | Date/Time Prepared: 10/24/2023 5:18 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQ UIS)	PHARMACY (COSTED REQ UIS)	MEDICAL RECORDS & LIBRARY (GROSS PT. CHARGES)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE INSERVICE EDUCATION (GROSS CHAR GES)	
			14.00	15.00	16.00	17.00	18.00	
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	FOUNDATION	0	0	0	0	0	194.00
194.01	07950	SPORTS MEDICINE	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
194.07	07957	COMMUNITY HEALTH	0	0	0	0	0	194.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	89,896	996,245	1,185,623	193,106	3,020	202.00
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, Part II)	1,636	61,032	52,541	3,776	865	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	16.360000	610.320000	0.000467	0.042112	0.000008	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet C Part I Date/Time Prepared: 10/24/2023 5:18 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,812,971		3,812,971	0	3,812,971	30.00
43.00	04300	NURSERY	0		0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	3,776,106		3,776,106	0	3,776,106	44.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,629,345		4,629,345	0	4,629,345	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,452,675		4,452,675	0	4,452,675	54.00
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	INTRAVENOUS THERAPY	0		0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	3,288,596	0	3,288,596	0	3,288,596	66.00
67.00	06700	OCCUPATIONAL THERAPY	723,031	0	723,031	0	723,031	67.00
68.00	06800	SPEECH PATHOLOGY	246,609	0	246,609	0	246,609	68.00
69.00	06900	ELECTROCARDIOLOGY	768,364		768,364	0	768,364	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	99,512		99,512	0	99,512	71.00
72.00	07200	IMPL. 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		0	0	0	76.00
76.01	03610	SLEEP LAB	277,564		277,564	0	277,564	76.01
76.02	03950	IV THERAPY	0		0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	3,221,747		3,221,747	0	3,221,747	88.00
88.01	08801	WYOMING RHC	0		0	0	0	88.01
88.02	08802	GENESEO RHC	3,439,255		3,439,255	0	3,439,255	88.02
88.03	08803	ANNAWAN RHC	733,598		733,598	0	733,598	88.03
88.04	08804	CAMBRIDGE RHC	609,061		609,061	0	609,061	88.04
90.00	09000	CLINIC	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	0		0	0	0	90.02
90.03	09003	SURGICAL CLINIC	427,950		427,950	0	427,950	90.03
90.04	09004	GENESEO CLINIC	0		0	0	0	90.04
91.00	09100	EMERGENCY	4,122,366		4,122,366	0	4,122,366	91.00
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
101.00	10100	HOME HEALTH AGENCY	1,055,844		1,055,844		1,055,844	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	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		1,175,224		1,175,224	201.00
202.00		Total (see instructions)	43,875,442	0	43,875,442	0	43,875,442	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet C Part I Date/Time Prepared: 10/24/2023 5:18 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,056,304		2,056,304			30.00
43.00	04300	NURSERY	0		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		0			46.00
		ANCILLARY SERVICE COST CENTERS						
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	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	304,011	25,586,521	25,890,532	0.171981	0.000000	54.00
60.00	06000	LABORATORY	877,234	24,612,286	25,489,520	0.159482	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	34,716	136,617	171,333	0.542044	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	730,075	7,864,942	8,595,017	0.382617	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	486,743	1,835,152	2,321,895	0.311397	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	32,239	433,884	466,123	0.529064	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	371,883	4,310,542	4,682,425	0.164095	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	231,627	138,811	370,438	0.268633	0.000000	71.00
72.00	07200	IMPL. 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	0.468802	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	IV THERAPY	0	0	0	0.000000	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0	5,695,426	5,695,426			88.00
88.01	08801	WYOMING RHC	0	0	0			88.01
88.02	08802	GENESEO RHC	0	4,725,333	4,725,333			88.02
88.03	08803	ANNAWAN RHC	0	1,085,886	1,085,886			88.03
88.04	08804	CAMBRIDGE RHC	0	992,059	992,059			88.04
90.00	09000	CLINIC	300	1,416,206	1,416,506	0.526138	0.000000	90.00
90.01	09001	PAIN CLINIC	0	24,204	24,204	5.019046	0.000000	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0.000000	0.000000	90.02
90.03	09003	SURGICAL CLINIC	0	161,366	161,366	2.652046	0.000000	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0.000000	0.000000	90.04
91.00	09100	EMERGENCY	3,000	4,524,477	4,527,477	0.910522	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	113,254	840,831	954,085	1.231781	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	861,058	861,058			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	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						201.00
202.00		Total (see instructions)	11,341,313	103,632,316	114,973,629			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet C Part I Date/Time Prepared: 10/24/2023 5:18 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.314980		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171981		54.00
60.00	06000	LABORATORY	0.159482		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.542044		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600	PHYSICAL THERAPY	0.382617		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.311397		67.00
68.00	06800	SPEECH PATHOLOGY	0.529064		68.00
69.00	06900	ELECTROCARDIOLOGY	0.164095		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.268633		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.166291		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.468802		73.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.311851		76.01
76.02	03950	IV THERAPY	0.000000		76.02
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	KEWANEE RHC			88.00
88.01	08801	WYOMING RHC			88.01
88.02	08802	GENESEO RHC			88.02
88.03	08803	ANNAWAN RHC			88.03
88.04	08804	CAMBRIDGE RHC			88.04
90.00	09000	CLINIC	0.526138		90.00
90.01	09001	PAIN CLINIC	5.019046		90.01
90.02	09002	SPECIALTY CLINIC	0.000000		90.02
90.03	09003	SURGICAL CLINIC	2.652046		90.03
90.04	09004	GENESEO CLINIC	0.000000		90.04
91.00	09100	EMERGENCY	0.910522		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.231781		92.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF			99.10
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet C Part I Date/Time Prepared: 10/24/2023 5:18 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,812,971		3,812,971	0	3,812,971	30.00
43.00	04300	NURSERY	0		0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	3,776,106		3,776,106	0	3,776,106	44.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,629,345		4,629,345	0	4,629,345	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,452,675		4,452,675	0	4,452,675	54.00
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	INTRAVENOUS THERAPY	0		0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	3,288,596	0	3,288,596	0	3,288,596	66.00
67.00	06700	OCCUPATIONAL THERAPY	723,031	0	723,031	0	723,031	67.00
68.00	06800	SPEECH PATHOLOGY	246,609	0	246,609	0	246,609	68.00
69.00	06900	ELECTROCARDIOLOGY	768,364		768,364	0	768,364	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	99,512		99,512	0	99,512	71.00
72.00	07200	IMPL. 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		0	0	0	76.00
76.01	03610	SLEEP LAB	277,564		277,564	0	277,564	76.01
76.02	03950	IV THERAPY	0		0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	3,221,747		3,221,747	0	3,221,747	88.00
88.01	08801	WYOMING RHC	0		0	0	0	88.01
88.02	08802	GENESEO RHC	3,439,255		3,439,255	0	3,439,255	88.02
88.03	08803	ANNAWAN RHC	733,598		733,598	0	733,598	88.03
88.04	08804	CAMBRIDGE RHC	609,061		609,061	0	609,061	88.04
90.00	09000	CLINIC	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	0		0	0	0	90.02
90.03	09003	SURGICAL CLINIC	427,950		427,950	0	427,950	90.03
90.04	09004	GENESEO CLINIC	0		0	0	0	90.04
91.00	09100	EMERGENCY	4,122,366		4,122,366	0	4,122,366	91.00
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
101.00	10100	HOME HEALTH AGENCY	1,055,844		1,055,844		1,055,844	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	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		1,175,224		1,175,224	201.00
202.00		Total (see instructions)	43,875,442	0	43,875,442	0	43,875,442	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet C Part I Date/Time Prepared: 10/24/2023 5:18 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,056,304		2,056,304			30.00
43.00	04300	NURSERY	0		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		0			46.00
		ANCILLARY SERVICE COST CENTERS						
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	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	304,011	25,586,521	25,890,532	0.171981	0.000000	54.00
60.00	06000	LABORATORY	877,234	24,612,286	25,489,520	0.159482	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	34,716	136,617	171,333	0.542044	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	730,075	7,864,942	8,595,017	0.382617	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	486,743	1,835,152	2,321,895	0.311397	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	32,239	433,884	466,123	0.529064	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	371,883	4,310,542	4,682,425	0.164095	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	231,627	138,811	370,438	0.268633	0.000000	71.00
72.00	07200	IMPL. 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	0.468802	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	IV THERAPY	0	0	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	WYOMING RHC	0	0	0	0.000000	0.000000	88.01
88.02	08802	GENESEO RHC	0	4,725,333	4,725,333	0.727833	0.000000	88.02
88.03	08803	ANNAWAN RHC	0	1,085,886	1,085,886	0.675576	0.000000	88.03
88.04	08804	CAMBRIDGE RHC	0	992,059	992,059	0.613936	0.000000	88.04
90.00	09000	CLINIC	300	1,416,206	1,416,506	0.526138	0.000000	90.00
90.01	09001	PAIN CLINIC	0	24,204	24,204	5.019046	0.000000	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0.000000	0.000000	90.02
90.03	09003	SURGICAL CLINIC	0	161,366	161,366	2.652046	0.000000	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0.000000	0.000000	90.04
91.00	09100	EMERGENCY	3,000	4,524,477	4,527,477	0.910522	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	113,254	840,831	954,085	1.231781	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	861,058	861,058			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	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						201.00
202.00		Total (see instructions)	11,341,313	103,632,316	114,973,629			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet C Part I Date/Time Prepared: 10/24/2023 5:18 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.000000		76.01
76.02	03950	IV THERAPY	0.000000		76.02
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	KEWANEE RHC	0.000000		88.00
88.01	08801	WYOMING RHC	0.000000		88.01
88.02	08802	GENESEO RHC	0.000000		88.02
88.03	08803	ANNAWAN RHC	0.000000		88.03
88.04	08804	CAMBRIDGE RHC	0.000000		88.04
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	PAIN CLINIC	0.000000		90.01
90.02	09002	SPECIALTY CLINIC	0.000000		90.02
90.03	09003	SURGICAL CLINIC	0.000000		90.03
90.04	09004	GENESEO CLINIC	0.000000		90.04
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF			99.10
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

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

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,041,951	14,697,271	0.070894	765,841	54,294	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	591,451	25,890,532	0.022844	258,381	5,902	54.00
60.00	06000	LABORATORY	213,267	25,489,520	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	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
66.00	06600	PHYSICAL THERAPY	305,218	8,595,017	0.035511	125,675	4,463	66.00
67.00	06700	OCCUPATIONAL 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	ELECTROCARDIOLOGY	151,307	4,682,425	0.032314	201,304	6,505	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2,061	370,438	0.005564	137,037	762	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,341	587,932	0.020991	6,132	129	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,456	5,290,955	0.013316	546,309	7,275	73.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	17,153	890,053	0.019272	0	0	76.01
76.02	03950	IV THERAPY	0	0	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	87,737	5,695,426	0.015405	0	0	88.00
88.01	08801	WYOMING RHC	0	0	0.000000	0	0	88.01
88.02	08802	GENESEO RHC	115,718	4,725,333	0.024489	0	0	88.02
88.03	08803	ANNAWAN RHC	98,599	1,085,886	0.090801	0	0	88.03
88.04	08804	CAMBRIDGE RHC	155,081	992,059	0.156322	0	0	88.04
90.00	09000	CLINIC	28,341	1,416,506	0.020008	0	0	90.00
90.01	09001	PAIN CLINIC	3,929	24,204	0.162329	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0.000000	0	0	90.02
90.03	09003	SURGICAL CLINIC	11,401	161,366	0.070653	0	0	90.03
90.04	09004	GENESEO CLINIC	0	0	0.000000	0	0	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	954,085	0.115052	3,184	366	92.00
200.00		Total (lines 50 through 199)	3,312,607	109,035,836		2,659,781	85,186	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

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

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0	0	0	0	0	88.00
88.01	08801	WYOMING RHC	0	0	0	0	0	88.01
88.02	08802	GENESEO RHC	0	0	0	0	0	88.02
88.03	08803	ANNAWAN RHC	0	0	0	0	0	88.03
88.04	08804	CAMBRIDGE RHC	0	0	0	0	0	88.04
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PAIN CLINIC	0	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	0	0	0	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

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

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	14,697,271	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	25,890,532	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	25,489,520	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	171,333	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,595,017	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,321,895	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	466,123	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,682,425	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	370,438	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	587,932	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,290,955	0.000000	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	890,053	0.000000	76.01
76.02	03950	IV THERAPY	0	0	0	0	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0	0	0	5,695,426	0.000000	88.00
88.01	08801	WYOMING RHC	0	0	0	0	0.000000	88.01
88.02	08802	GENESEO RHC	0	0	0	4,725,333	0.000000	88.02
88.03	08803	ANNAWAN RHC	0	0	0	1,085,886	0.000000	88.03
88.04	08804	CAMBRIDGE RHC	0	0	0	992,059	0.000000	88.04
90.00	09000	CLINIC	0	0	0	1,416,506	0.000000	90.00
90.01	09001	PAIN CLINIC	0	0	0	24,204	0.000000	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0.000000	90.02
90.03	09003	SURGICAL CLINIC	0	0	0	161,366	0.000000	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0.000000	90.04
91.00	09100	EMERGENCY	0	0	0	4,527,477	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	954,085	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	109,035,836		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

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

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	765,841	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	258,381	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	497,965	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.000000	15,478	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.000000	125,675	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	88,764	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	10,969	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	201,304	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	137,037	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	6,132	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	546,309	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0.000000	0	0	0	0	88.00
88.01	08801	WYOMING RHC	0.000000	0	0	0	0	88.01
88.02	08802	GENESEO RHC	0.000000	0	0	0	0	88.02
88.03	08803	ANNAWAN RHC	0.000000	0	0	0	0	88.03
88.04	08804	CAMBRIDGE RHC	0.000000	0	0	0	0	88.04
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	PAIN CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	GENESEO CLINIC	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.000000	2,742	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000	3,184	0	0	0	92.00
200.00		Total (lines 50 through 199)		2,659,781	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet D Part V Date/Time Prepared: 10/24/2023 5:18 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.314980	0	3,699,250	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171981	0	6,928,429	0	0	54.00
60.00	06000	LABORATORY	0.159482	0	6,318,933	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.542044	0	51,039	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.382617	0	2,506,797	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.311397	0	552,696	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.529064	0	104,794	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.164095	0	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	IMPL. 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	0	135,896	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC						88.00
88.01	08801	WYOMING RHC						88.01
88.02	08802	GENESEO RHC						88.02
88.03	08803	ANNAWAN RHC						88.03
88.04	08804	CAMBRIDGE RHC						88.04
90.00	09000	CLINIC	0.526138	0	122,985	1,856	0	90.00
90.01	09001	PAIN CLINIC	5.019046	0	12,473	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	2.652046	0	31,159	0	0	90.03
90.04	09004	GENESEO CLINIC	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.910522	0	1,075,966	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.231781	0	333,206	0	0	92.00
200.00		Subtotal (see instructions)		0	25,269,493	9,480	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	25,269,493	9,480	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet D Part V Date/Time Prepared: 10/24/2023 5:18 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,165,190	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,191,558	0		54.00
60.00	06000	LABORATORY	1,007,756	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	27,665	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	959,143	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	172,108	0		67.00
68.00	06800	SPEECH PATHOLOGY	55,443	0		68.00
69.00	06900	ELECTROCARDIOLOGY	245,878	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	11,686	0		71.00
72.00	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				
88.00	08800	KEWANEE RHC				88.00
88.01	08801	WYOMING RHC				88.01
88.02	08802	GENESEO RHC				88.02
88.03	08803	ANNAWAN RHC				88.03
88.04	08804	CAMBRIDGE RHC				88.04
90.00	09000	CLINIC	64,707	977		90.00
90.01	09001	PAIN CLINIC	62,603	0		90.01
90.02	09002	SPECIALTY CLINIC	0	0		90.02
90.03	09003	SURGICAL CLINIC	82,635	0		90.03
90.04	09004	GENESEO CLINIC	0	0		90.04
91.00	09100	EMERGENCY	979,691	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	410,437	0		92.00
200.00		Subtotal (see instructions)	7,460,999	4,551		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	7,460,999	4,551		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1319 | Component CCN: 14-Z319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet D Part V | Date/Time Prepared: 10/24/2023 5:18 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.314980	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171981	0	0	0	0	54.00
60.00	06000	LABORATORY	0.159482	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.542044	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.382617	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.311397	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.529064	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.164095	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.268633	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.166291	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.468802	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.311851	0	0	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC						88.00
88.01	08801	WYOMING RHC						88.01
88.02	08802	GENESEO RHC						88.02
88.03	08803	ANNAWAN RHC						88.03
88.04	08804	CAMBRIDGE RHC						88.04
90.00	09000	CLINIC	0.526138	0	0	0	0	90.00
90.01	09001	PAIN CLINIC	5.019046	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	2.652046	0	0	0	0	90.03
90.04	09004	GENESEO CLINIC	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.910522	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.231781	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1319 | Component CCN: 14-Z319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet D Part V | Date/Time Prepared: 10/24/2023 5:18 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.02	03950	IV THERAPY	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	KEWANEE RHC				88.00
88.01	08801	WYOMING RHC				88.01
88.02	08802	GENESEO RHC				88.02
88.03	08803	ANNAWAN RHC				88.03
88.04	08804	CAMBRIDGE RHC				88.04
90.00	09000	CLINIC	0	0		90.00
90.01	09001	PAIN CLINIC	0	0		90.01
90.02	09002	SPECIALTY CLINIC	0	0		90.02
90.03	09003	SURGICAL CLINIC	0	0		90.03
90.04	09004	GENESEO CLINIC	0	0		90.04
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

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

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0	0	0	0	0	88.00
88.01	08801	WYOMING RHC	0	0	0	0	0	88.01
88.02	08802	GENESEO RHC	0	0	0	0	0	88.02
88.03	08803	ANNAWAN RHC	0	0	0	0	0	88.03
88.04	08804	CAMBRIDGE RHC	0	0	0	0	0	88.04
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PAIN CLINIC	0	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	0	0	0	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

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

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

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

Title XVIII

Skilled Nursing Facility

PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	14,697,271	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	25,890,532	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	25,489,520	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	171,333	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,595,017	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,321,895	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	466,123	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,682,425	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	370,438	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	587,932	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,290,955	0.000000	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	890,053	0.000000	76.01
76.02	03950	IV THERAPY	0	0	0	0	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0	0	0	5,695,426	0.000000	88.00
88.01	08801	WYOMING RHC	0	0	0	0	0.000000	88.01
88.02	08802	GENESEO RHC	0	0	0	4,725,333	0.000000	88.02
88.03	08803	ANNAWAN RHC	0	0	0	1,085,886	0.000000	88.03
88.04	08804	CAMBRIDGE RHC	0	0	0	992,059	0.000000	88.04
90.00	09000	CLINIC	0	0	0	1,416,506	0.000000	90.00
90.01	09001	PAIN CLINIC	0	0	0	24,204	0.000000	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0.000000	90.02
90.03	09003	SURGICAL CLINIC	0	0	0	161,366	0.000000	90.03
90.04	09004	GENESEO CLINIC	0	0	0	0	0.000000	90.04
91.00	09100	EMERGENCY	0	0	0	4,527,477	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	954,085	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	109,035,836		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

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

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	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	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	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	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.000000	196,711	0	0	0	66.00
67.00	06700	OCCUPATIONAL 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	ELECTROCARDIOLOGY	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	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	76,725	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC	0.000000	0	0	0	0	88.00
88.01	08801	WYOMING RHC	0.000000	0	0	0	0	88.01
88.02	08802	GENESEO RHC	0.000000	0	0	0	0	88.02
88.03	08803	ANNAWAN RHC	0.000000	0	0	0	0	88.03
88.04	08804	CAMBRIDGE RHC	0.000000	0	0	0	0	88.04
90.00	09000	CLINIC	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	SURGICAL CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	GENESEO CLINIC	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		442,760	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

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

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.314980	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171981	0	0	0	0	54.00
60.00	06000	LABORATORY	0.159482	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.542044	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.382617	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.311397	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.529064	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.164095	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.268633	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.166291	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.468802	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.311851	0	0	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	KEWANEE RHC						88.00
88.01	08801	WYOMING RHC						88.01
88.02	08802	GENESEO RHC						88.02
88.03	08803	ANNAWAN RHC						88.03
88.04	08804	CAMBRIDGE RHC						88.04
90.00	09000	CLINIC	0.526138	0	0	0	0	90.00
90.01	09001	PAIN CLINIC	5.019046	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	2.652046	0	0	0	0	90.03
90.04	09004	GENESEO CLINIC	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.910522	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.231781	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

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

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.02	03950	IV THERAPY	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	KEWANEE RHC				88.00
88.01	08801	WYOMING RHC				88.01
88.02	08802	GENESEO RHC				88.02
88.03	08803	ANNAWAN RHC				88.03
88.04	08804	CAMBRIDGE RHC				88.04
90.00	09000	CLINIC	0	0		90.00
90.01	09001	PAIN CLINIC	0	0		90.01
90.02	09002	SPECIALTY CLINIC	0	0		90.02
90.03	09003	SURGICAL CLINIC	0	0		90.03
90.04	09004	GENESEO CLINIC	0	0		90.04
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1319	Period: From 06/01/2022 To 05/31/2023	Worksheet D-1 Date/Time Prepared: 10/24/2023 5:18 pm
	Title XVIII	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,495	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,989	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,220	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	263	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	243	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	37	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	-37	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	654	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	149	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	253	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	133.47	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	133.47	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,812,971	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	4,938	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	-4,938	25.00
26.00	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
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,039,682	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,528.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	999,469	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	999,469	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet D-1 | Date/Time Prepared: 10/24/2023 5:18 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	794,525	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	1,793,994	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 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)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	227,708	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	386,645	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	614,353	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	769	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,528.25	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1319	Period: From 06/01/2022 To 05/31/2023	Worksheet D-1 Date/Time Prepared: 10/24/2023 5:18 pm
	Title XVIII	Hospital	Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,175,224	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	356,144	3,812,971	0.093403	1,175,224	109,769	90.00
91.00	Nursing Program cost	0	3,812,971	0.000000	1,175,224	0	91.00
92.00	Allied health cost	0	3,812,971	0.000000	1,175,224	0	92.00
93.00	All other Medical Education	0	3,812,971	0.000000	1,175,224	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1319 Component CCN: 14-5464	Period: From 06/01/2022 To 05/31/2023	Worksheet D-1 Date/Time Prepared: 10/24/2023 5:18 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	12,864	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,864	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	12,864	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	441	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,776,106	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,776,106	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,776,106	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet D-1

Component CCN: 14-5464 | Date/Time Prepared: 10/24/2023 5:18 pm

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)		48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
55.01	Permanent adjustment amount per discharge		55.01
55.02	Adjustment amount per discharge (contractor use only)		55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)		59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)		60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	3,776,106	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	293.54	71.00
72.00	Program routine service cost (line 9 x line 71)	129,451	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	129,451	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	129,451	83.00
84.00	Program inpatient ancillary services (see instructions)	162,452	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	291,903	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-1319 Component CCN: 14-5464	Period: From 06/01/2022 To 05/31/2023	Worksheet D-1 Date/Time Prepared: 10/24/2023 5:18 pm
	Title XVIII	Skilled Nursing Facility	PPS

	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)	0	89.00

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet D-3 | Date/Time Prepared: 10/24/2023 5:18 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		946,390		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST 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	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	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 & PACKED RED BLOOD	0.542044	15,478	8,390	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.382617	125,675	48,085	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.311397	88,764	27,641	67.00
68.00	06800	SPEECH PATHOLOGY	0.529064	10,969	5,803	68.00
69.00	06900	ELECTROCARDIOLOGY	0.164095	201,304	33,033	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.268633	137,037	36,813	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.166291	6,132	7,152	72.00
73.00	07300	DRUGS CHARGED TO 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	IV THERAPY	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	KEWANEE RHC	0.000000		0	88.00
88.01	08801	WYOMING RHC	0.000000		0	88.01
88.02	08802	GENESEO RHC	0.000000		0	88.02
88.03	08803	ANNAWAN RHC	0.000000		0	88.03
88.04	08804	CAMBRIDGE 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 CLINIC	0.000000	0	0	90.02
90.03	09003	SURGICAL CLINIC	2.652046	0	0	90.03
90.04	09004	GENESEO CLINIC	0.000000	0	0	90.04
91.00	09100	EMERGENCY	0.910522	2,742	2,497	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.231781	3,184	3,922	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,659,781	794,525	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,659,781		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet D-3

Component CCN: 14-Z319 | Date/Time Prepared: 10/24/2023 5:18 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				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	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	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	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.382617	151,081	57,806	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.311397	113,017	35,193	67.00
68.00	06800	SPEECH PATHOLOGY	0.529064	5,049	2,671	68.00
69.00	06900	ELECTROCARDIOLOGY	0.164095	21,861	3,587	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.268633	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.166291	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.468802	114,231	53,552	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	IV THERAPY	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	KEWANEE RHC	0.000000		0	88.00
88.01	08801	WYOMING RHC	0.000000		0	88.01
88.02	08802	GENESEO RHC	0.000000		0	88.02
88.03	08803	ANNAWAN RHC	0.000000		0	88.03
88.04	08804	CAMBRIDGE 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 CLINIC	0.000000	0	0	90.02
90.03	09003	SURGICAL CLINIC	2.652046	0	0	90.03
90.04	09004	GENESEO CLINIC	0.000000	0	0	90.04
91.00	09100	EMERGENCY	0.910522	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.231781	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		528,239	181,795	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		528,239		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1319 | Component CCN: 14-5464 | Period: From 06/01/2022 To 05/31/2023 | Worksheet D-3 | Date/Time Prepared: 10/24/2023 5:18 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.314980	15,252	4,804	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.171981	4,145	713	54.00
60.00	06000	LABORATORY	0.159482	13,373	2,133	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.542044	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.382617	196,711	75,265	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.311397	131,743	41,024	67.00
68.00	06800	SPEECH PATHOLOGY	0.529064	4,539	2,401	68.00
69.00	06900	ELECTROCARDIOLOGY	0.164095	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.268633	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.166291	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.468802	76,725	35,969	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	IV THERAPY	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	KEWANEE RHC	0.000000		0	88.00
88.01	08801	WYOMING RHC	0.000000		0	88.01
88.02	08802	GENESEO RHC	0.000000		0	88.02
88.03	08803	ANNAWAN RHC	0.000000		0	88.03
88.04	08804	CAMBRIDGE RHC	0.000000		0	88.04
90.00	09000	CLINIC	0.526138	272	143	90.00
90.01	09001	PAIN CLINIC	5.019046	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0.000000	0	0	90.02
90.03	09003	SURGICAL CLINIC	2.652046	0	0	90.03
90.04	09004	GENESEO CLINIC	0.000000	0	0	90.04
91.00	09100	EMERGENCY	0.910522	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.231781	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		442,760	162,452	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		442,760		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet E Part B Date/Time Prepared: 10/24/2023 5:18 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,465,550	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	7,465,550	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	7,540,206	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)	61,684	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3,749,211	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,729,311	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	3,729,311	30.00
31.00	Primary payer payments	403	31.00
32.00	Subtotal (line 30 minus line 31)	3,728,908	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	44,763	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	29,096	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	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	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	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,758,004	40.00
40.01	Sequestration adjustment (see instructions)	72,153	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	3,643,642	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	42,209	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1319	Period: From 06/01/2022 To 05/31/2023	Worksheet E Part B Date/Time Prepared: 10/24/2023 5:18 pm
	Title XVIII	Hospital	Cost

		1.00	
	MEDICARE PART B ANCILLARY COSTS		
200.00	Part B Combined Billed Days	0	200.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1319 Component CCN: 14-5464	Period: From 06/01/2022 To 05/31/2023	Worksheet E Part B Date/Time Prepared: 10/24/2023 5:18 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
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	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	0	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	0	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	0	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	0	37.00
38.00	MSP-LCC reconciliation amount from PS&R		38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	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	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	0	40.00
40.01	Sequestration adjustment (see instructions)	0	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	0	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	0	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1319 Component CCN: 14-5464	Period: From 06/01/2022 To 05/31/2023	Worksheet E Part B Date/Time Prepared: 10/24/2023 5:18 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
94.00	Total (sum of lines 91 and 93)		94.00
		1.00	
	MEDICARE PART B ANCILLARY COSTS		
200.00	Part B Combined Billed Days		200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet E-1 Part I Date/Time Prepared: 10/24/2023 5:18 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,563,171		3,641,891	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	02/23/2023	440,453	02/23/2023	249,906	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	01/04/2023	78,916	01/04/2023	248,155	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		361,537		1,751	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,924,708		3,643,642	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		42,209	6.01
6.02	SETTLEMENT TO PROGRAM		382,299		0	6.02
7.00	Total Medicare program liability (see instructions)		1,542,409		3,685,851	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.	06101		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 10/24/2023 5:18 pm

Component CCN: 14-Z319 | Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		871,946		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	02/23/2023	106,228		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		106,228		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		978,174		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		208,140		0	6.02
7.00	Total Medicare program liability (see instructions)		770,034		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.	06101		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1319	Period: From 06/01/2022 To 05/31/2023	Worksheet E-1 Part I Date/Time Prepared: 10/24/2023 5:18 pm
Component CCN: 14-5464		
Title XVIII	Skilled Nursing Facility	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		166,053		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		166,053		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		166,053		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.		06101		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1319	Period: From 06/01/2022 To 05/31/2023	Worksheet E-1 Part II Date/Time Prepared: 10/24/2023 5:18 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days (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. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1319 | Component CCN: 14-Z319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet E-2 | Date/Time Prepared: 10/24/2023 5:18 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	620,497	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	183,613	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	402	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	804,110	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	804,110	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	804,110	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	19,002	0	13.00
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	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	785,108	0	19.00
19.01	Sequestration adjustment (see instructions)	15,074	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	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	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	-208,140	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1319	Period: From 06/01/2022 To 05/31/2023	Worksheet E-3 Part V Date/Time Prepared: 10/24/2023 5:18 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,793,994	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	1,793,994	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,811,934	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,811,934	19.00
20.00	Deductibles (exclude professional component)	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
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	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,572,603	30.00
30.01	Sequestration adjustment (see instructions)	30,194	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	1,924,708	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-382,299	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1319 Component CCN: 14-5464	Period: From 06/01/2022 To 05/31/2023	Worksheet E-3 Part VI Date/Time Prepared: 10/24/2023 5:18 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	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, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	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
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	169,270	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.98	Recovery of accelerated depreciation.	0	14.98
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	169,270	15.00
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	Interim payments	166,053	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet G | Date/Time Prepared: 10/24/2023 5:18 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	17,448,993	0	0	0	1.00
2.00	Temporary investments	45,695,441	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	32,628,632	0	0	0	4.00
5.00	Other receivable	1,164,718	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-30,199,706	0	0	0	6.00
7.00	Inventory	823,342	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	1,805,728	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	69,367,148	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,358,669	0	0	0	12.00
13.00	Land improvements	1,658,717	0	0	0	13.00
14.00	Accumulated depreciation	-1,360,671	0	0	0	14.00
15.00	Buildings	46,560,826	0	0	0	15.00
16.00	Accumulated depreciation	-30,644,480	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	21,335,163	0	0	0	19.00
20.00	Accumulated depreciation	-14,228,902	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	1,844,531	0	0	0	23.00
24.00	Accumulated depreciation	-1,224,209	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	881,117	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	26,180,761	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	14,697,631	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	14,697,631	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	110,245,540	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	0	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,628,578	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	661,508	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	5,292,510	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,582,596	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	3,294,149	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	25,135,459	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	28,429,608	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	38,012,204	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	72,233,336				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	72,233,336	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	110,245,540	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet G-1 | Date/Time Prepared: 10/24/2023 5:18 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		64,225,421		0		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		0		3.00
4.00	NET INCOME FROM FOUNDATION	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		72,331,220		0		11.00
12.00	NET LOSS FROM FOUNDATION	108,288		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		108,288		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		72,222,932		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	NET INCOME FROM FOUNDATION		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	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 sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet G-2 Parts I & II | Date/Time Prepared: 10/24/2023 5:18 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,056,304		2,056,304	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	3,020,431		3,020,431	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,076,735		5,076,735	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,076,735		5,076,735	17.00
18.00	Ancillary services	6,264,576	88,670,777	94,935,353	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	KEWANEE RHC	0	5,695,426	5,695,426	20.00
20.01	WYOMING RHC	0	0	0	20.01
20.02	GENESEO RHC	0	4,725,333	4,725,333	20.02
20.03	ANNAWAN RHC	0	1,085,886	1,085,886	20.03
20.04	CAMBRIDGE RHC	0	992,059	992,059	20.04
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		861,058	861,058	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	COLONA CLINIC	0	1,416,506	1,416,506	27.00
27.01	PAIN CLINIC	0	24,204	24,204	27.01
27.02	SURGICAL CLINIC	0	441,920	441,920	27.02
27.03	PROFESSIONAL FEES	597,876	6,760,444	7,358,320	27.03
27.04	CAMBRIDGE CLINIC	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	0	0	0	27.07
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	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		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		2,355,103		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)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		52,969,559		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet G-3 | Date/Time Prepared: 10/24/2023 5:18 pm

		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	2.00
3.00	Net patient revenues (line 1 minus line 2)	54,498,469	3.00
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 INCOME		
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 discounts	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	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	3,360	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	CHANGE IN IMRF PENSION	-320,505	24.00
24.01	RENTAL INCOME	195,907	24.01
24.02	PROPERTY INCOME	1,078,512	24.02
24.03	340B PHARMACY REVENUE	1,248,806	24.03
24.04	OTHER (SPECIFY)	0	24.04
24.05	OTHER OPERATING REVENUE	280,233	24.05
24.06	FORGIVENESS OF PPP LOAN	0	24.06
24.50	COVID-19 PHE Funding	3,920,725	24.50
25.00	Total other income (sum of lines 6-24)	7,628,383	25.00
26.00	Total (line 5 plus line 25)	9,157,293	26.00
27.00	340B PHARMACY EXPENSES	1,014,285	27.00
27.02	LOSS ON SALE OF FIXED ASSETS	37,209	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	1,051,494	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	8,105,799	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet H

HHA CCN: 14-7450 | Date/Time Prepared: 10/24/2023 5:18 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	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	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	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	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	598,232	0	46,071	7,312	67,293	718,908	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	161,257	-5,250	156,007			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	475,563	0	475,563			6.00
7.00	Physical Therapy	0	0	0	0			7.00
8.00	Occupational Therapy	0	0	0	0			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	29,467	0	29,467			11.00
12.00	Supplies (see instructions)	0	52,621	0	52,621			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	0	718,908	-5,250	713,658			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-1319 | HHA CCN: 14-7450 | Period: From 06/01/2022 To 05/31/2023 | Worksheet H-1 Part I | Date/Time Prepared: 10/24/2023 5:18 pm

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	156,007	0	0	0	0	156,007	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	475,563	0	0	0	0	475,563	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	29,467	0	0	0	0	29,467	11.00
12.00	Supplies (see instructions)	52,621	0	0	0	0	52,621	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	713,658	0	0	0	0	713,658	24.00

		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	156,007						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	133,042	608,605					6.00
7.00	Physical Therapy	0	0					7.00
8.00	Occupational Therapy	0	0					8.00
9.00	Speech Pathology	0	0					9.00
10.00	Medical Social Services	0	0					10.00
11.00	Home Health Aide	8,244	37,711					11.00
12.00	Supplies (see instructions)	14,721	67,342					12.00
13.00	Drugs	0	0					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
23.50	Telemedicine	0	0					23.50
24.00	Total (sum of lines 1-23)		713,658					24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 14-1319 | HHA CCN: 14-7450 | Period: From 06/01/2022 To 05/31/2023 | Worksheet H-1 Part II Date/Time Prepared: 10/24/2023 5:18 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-156,007	557,651	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	475,563	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	29,467	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	52,621	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-156,007	557,651	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		156,007	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.279757	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet H-2 Part I
HHA CCN: 14-7450 | Date/Time Prepared: 10/24/2023 5:18 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	PURCHASING RECEIVING AND STORES	
			BLDG & FIXT	MVBLE EQUIP				
		0	1.00	2.00	4.00	5.01	5.02	
1.00	Administrative and General	0	18,797	253	129,390	67,274	2,967	1.00
2.00	Skilled Nursing Care	608,605	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	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	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	713,658	18,797	253	129,390	67,274	2,967	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	ALL OTHER ADMINISTRATIVE AND GE	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5.03	5.04	5A.04	5.05	7.00	8.00	
1.00	Administrative and General	0	8,641	227,322	22,412	19,664	0	1.00
2.00	Skilled Nursing Care	0	0	608,605	60,004	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	37,711	3,718	0	0	7.00
8.00	Supplies (see instructions)	0	0	67,342	6,639	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	8,641	940,980	92,773	19,664	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.000000				21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1319 | HHA CCN: 14-7450 | Period: From 06/01/2022 To 05/31/2023 | Worksheet H-2 Part I | Date/Time Prepared: 10/24/2023 5:18 pm

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	Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	2,427	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	2,427	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE INSERVICE EDUCATION	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		16.00	17.00	18.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	0	271,825	0	271,825	1.00
2.00	Skilled Nursing Care	0	0	0	668,609	0	668,609	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	41,429	0	41,429	7.00
8.00	Supplies (see instructions)	0	0	0	73,981	0	73,981	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	1,055,844	0	1,055,844	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

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

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

Worksheet H-2
Part I
Date/Time Prepared:
10/24/2023 5:18 pm

Home Health Agency I

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	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs				
		27.00	28.00				
1.00	Administrative and General						1.00
2.00	Skilled Nursing Care	231,811	900,420				2.00
3.00	Physical Therapy	0	0				3.00
4.00	Occupational Therapy	0	0				4.00
5.00	Speech Pathology	0	0				5.00
6.00	Medical Social Services	0	0				6.00
7.00	Home Health Aide	14,364	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	0				19.00
19.50	Telemedicine	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 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.346707					21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

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

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

Worksheet H-2 Part II Date/Time Prepared: 10/24/2023 5:18 pm

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (TIME SPENT)	PURCHASING RECEIVING AND STORES (SUPPLY COST)	ADMITTING (GROSS CHARGES)	
		1.00	2.00	4.00	5.01	5.02	5.03	
1.00	Administrative and General	1,127	247	598,233	3,085	55,198	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,127	247	598,233	3,085	55,198	0	20.00
21.00	Total cost to be allocated	18,797	253	129,390	67,274	2,967	0	21.00
22.00	Unit cost multiplier	16.678793	1.024291	0.216287	21.806807	0.053752	0.000000	22.00

	Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	ALL OTHER ADMINISTRATIVE AND GE (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		5.04	5A.05	5.05	7.00	8.00	9.00	
1.00	Administrative and General	861,058	0	227,322	1,127	0	1,200	1.00
2.00	Skilled Nursing Care	0	0	608,605	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	37,711	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	67,342	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	861,058		940,980	1,127	0	1,200	20.00
21.00	Total cost to be allocated	8,641		92,773	19,664	0	2,427	21.00
22.00	Unit cost multiplier	0.010035		0.098592	17.448092	0.000000	2.022500	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

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

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

Worksheet H-2
Part II
Date/Time Prepared:
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	Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (GROSS PT. CHARGES)	
		10.00	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	0	0	20.00
21.00	Total cost to be allocated	0	0	0	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	22.00

	Cost Center Description	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE INSERVICE EDUCATION (GROSS CHARGES)					
		17.00	18.00					
1.00	Administrative and General	0	0					1.00
2.00	Skilled Nursing Care	0	0					2.00
3.00	Physical Therapy	0	0					3.00
4.00	Occupational Therapy	0	0					4.00
5.00	Speech Pathology	0	0					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	0	0					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
19.50	Telemedicine	0	0					19.50
20.00	Total (sum of lines 1-19)	0	0					20.00
21.00	Total cost to be allocated	0	0					21.00
22.00	Unit cost multiplier	0.000000	0.000000					22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1319 | HHA CCN: 14-7450 | Period: From 06/01/2022 To 05/31/2023 | Worksheet H-3 Part I | Date/Time Prepared: 10/24/2023 5:18 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	900,420		900,420	4,507	199.78	1.00
2.00	Physical Therapy	3.00	0	116,742	116,742	3,247	35.95	2.00
3.00	Occupational Therapy	4.00	0	47,889	47,889	1,157	41.39	3.00
4.00	Speech Pathology	5.00	0	20,004	20,004	172	116.30	4.00
5.00	Medical Social Services	6.00	0		0	28	0.00	5.00
6.00	Home Health Aide	7.00	55,793		55,793	910	61.31	6.00
7.00	Total (sum of lines 1-6)		956,213	184,635	1,140,848	10,021		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		19340	0	1,430			8.00
8.01	Skilled Nursing Care		99914	0	769			8.01
9.00	Physical Therapy		19340	0	936			9.00
9.01	Physical Therapy		99914	0	719			9.01
10.00	Occupational Therapy		19340	0	202			10.00
10.01	Occupational Therapy		99914	0	377			10.01
11.00	Speech Pathology		19340	0	15			11.00
11.01	Speech Pathology		99914	0	49			11.01
12.00	Medical Social Services		19340	0	5			12.00
12.01	Medical Social Services		99914	0	6			12.01
13.00	Home Health Aide		19340	0	412			13.00
13.01	Home Health Aide		99914	0	217			13.01
14.00	Total (sum of lines 8-13)			0	5,137			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	99,631	0	99,631	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	2,199		0	439,316		1.00
2.00	Physical Therapy	0	1,655		0	59,497		2.00
3.00	Occupational Therapy	0	579		0	23,965		3.00
4.00	Speech Pathology	0	64		0	7,443		4.00
5.00	Medical Social Services	0	11		0	0		5.00
6.00	Home Health Aide	0	629		0	38,564		6.00
7.00	Total (sum of lines 1-6)	0	5,137		0	568,785		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-1319 | HHA CCN: 14-7450 | Period: From 06/01/2022 To 05/31/2023 | Worksheet H-3 Part I | Date/Time Prepared: 10/24/2023 5:18 pm

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	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

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

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	439,316	1.00
2.00	Physical Therapy	59,497	2.00
3.00	Occupational Therapy	23,965	3.00
4.00	Speech Pathology	7,443	4.00
5.00	Medical Social Services	0	5.00
6.00	Home Health Aide	38,564	6.00
7.00	Total (sum of lines 1-6)	568,785	7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
8.01	Skilled Nursing Care		8.01
9.00	Physical Therapy		9.00
9.01	Physical Therapy		9.01
10.00	Occupational Therapy		10.00
10.01	Occupational Therapy		10.01
11.00	Speech Pathology		11.00
11.01	Speech Pathology		11.01
12.00	Medical Social Services		12.00
12.01	Medical Social Services		12.01
13.00	Home Health Aide		13.00
13.01	Home Health Aide		13.01
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

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

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

Worksheet H-3
Part II
Date/Time Prepared:
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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.382617	305,114	116,742	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.311397	153,788	47,889	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.529064	37,810	20,004	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.268633	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.468802	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT | Provider CCN: 14-1319 | HHA CCN: 14-7450 | Period: From 06/01/2022 To 05/31/2023 | Worksheet H-4 Part I-II | Date/Time Prepared: 10/24/2023 5:18 pm

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	505,772	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	184,871	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	6,993	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	3,420	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	65,682	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	9,419	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	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)		0	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)		0	27.01
28.00	Allowable bad debts for dual eligible (see instructions)		0	28.00
29.00	Total costs - current cost reporting period (see instructions)	0	776,157	29.00
30.00	OTHER ADJUSTMENTS	0	-904	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	775,253	31.00
31.01	Sequestration adjustment (see instructions)	0	14,917	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
31.75	Sequestration adjustment for non-claims based amounts (see instructions)	0	0	31.75
32.00	Interim payments (see instructions)	0	760,337	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 31.75, 32, and 33)	0	-1	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

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

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

Worksheet H-5

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

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		760,337	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		760,337	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1	6.02
7.00	Total Medicare program liability (see instructions)		0		760,336	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.		06101		8.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

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

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	449,808	0	449,808	227,729	677,537	1.00
2.00	Physician Assistant	128,610	0	128,610	0	128,610	2.00
3.00	Nurse Practitioner	548,365	0	548,365	0	548,365	3.00
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	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	187,127	0	187,127	-65,976	121,151	9.00
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	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	159,343	159,343	0	159,343	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	159,343	159,343	0	159,343	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,628,654	159,343	1,787,997	161,753	1,949,750	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	60,097	60,097	0	60,097	29.00
30.00	Administrative Costs	189,686	273,220	462,906	45,624	508,530	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	189,686	333,317	523,003	45,624	568,627	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,818,340	492,660	2,311,000	207,377	2,518,377	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

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

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	677,537		1.00
2.00	Physician Assistant	0	128,610		2.00
3.00	Nurse Practitioner	0	548,365		3.00
4.00	Visiting Nurse	0	0		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 Technician	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		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	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				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 lines 10, 14, and 21)	0	1,949,750		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	60,097		29.00
30.00	Administrative Costs	0	508,530		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	568,627		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,518,377		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

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

RHC III | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	540,907	0	540,907	229,489	770,396	1.00
2.00	Physician Assistant	4,207	0	4,207	0	4,207	2.00
3.00	Nurse Practitioner	590,044	0	590,044	0	590,044	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	318,565	0	318,565	0	318,565	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	232,874	0	232,874	-4,323	228,551	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,686,597	0	1,686,597	225,166	1,911,763	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	206,850	206,850	0	206,850	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	206,850	206,850	0	206,850	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,686,597	206,850	1,893,447	225,166	2,118,613	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	2,230	2,230	0	2,230	29.00
30.00	Administrative Costs	206,730	125,966	332,696	37,852	370,548	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	206,730	128,196	334,926	37,852	372,778	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,893,327	335,046	2,228,373	263,018	2,491,391	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

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

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	770,396		1.00
2.00	Physician Assistant	0	4,207		2.00
3.00	Nurse Practitioner	0	590,044		3.00
4.00	Visiting Nurse	0	0		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 Technician	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		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	206,850		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,118,613		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	2,230		29.00
30.00	Administrative Costs	0	370,548		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	372,778		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,491,391		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1319 | Component CCN: 14-8615 | Period: From 06/01/2022 To 05/31/2023 | Worksheet M-1 | Date/Time Prepared: 10/24/2023 5:18 pm

RHC IV | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	670	0	670	0	670	1.00
2.00	Physician Assistant	33,233	0	33,233	23,873	57,106	2.00
3.00	Nurse Practitioner	212,727	0	212,727	23,872	236,599	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	19,750	0	19,750	0	19,750	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	115,073	0	115,073	-62,527	52,546	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	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	30,072	30,072	0	30,072	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	30,072	30,072	0	30,072	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	381,453	30,072	411,525	-14,782	396,743	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	19,537	19,537	0	19,537	29.00
30.00	Administrative Costs	16,840	46,294	63,134	8,699	71,833	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	16,840	65,831	82,671	8,699	91,370	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	398,293	95,903	494,196	-6,083	488,113	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1319
Component CCN: 14-8615
Period: From 06/01/2022 To 05/31/2023
Worksheet M-1
Date/Time Prepared: 10/24/2023 5:18 pm

RHC IV | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	670		1.00
2.00	Physician Assistant	0	57,106		2.00
3.00	Nurse Practitioner	0	236,599		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	19,750		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	52,546		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		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	30,072		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	396,743		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		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	19,537		29.00
30.00	Administrative Costs	0	71,833		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	91,370		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	488,113		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1319 | Component CCN: 14-8628 | Period: From 06/01/2022 To 05/31/2023 | Worksheet M-1 | Date/Time Prepared: 10/24/2023 5:18 pm

RHC V | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	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	179,321	17,289	196,610	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	59,183	0	59,183	0	59,183	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	34,296	0	34,296	0	34,296	9.00
10.00	Subtotal (sum of lines 1 through 9)	272,800	0	272,800	34,578	307,378	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	43,853	43,853	0	43,853	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	43,853	43,853	0	43,853	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	272,800	43,853	316,653	34,578	351,231	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	-113,531	-113,531	0	-113,531	29.00
30.00	Administrative Costs	48,221	31,258	79,479	7,947	87,426	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	48,221	-82,273	-34,052	7,947	-26,105	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	321,021	-38,420	282,601	42,525	325,126	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1319 | Component CCN: 14-8628 | Period: From 06/01/2022 To 05/31/2023 | Worksheet M-1 | Date/Time Prepared: 10/24/2023 5:18 pm

RHC V | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	17,289		2.00
3.00	Nurse Practitioner	0	196,610		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	59,183		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	34,296		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	307,378		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 lines 10, 14, and 21)	0	351,231		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	-113,531		29.00
30.00	Administrative Costs	0	87,426		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	-26,105		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	325,126		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

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

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

Worksheet M-2

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

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	RHC I Greater of col. 2 or col. 4	Cost	
		1.00	2.00	3.00	4.00	5.00		
	VISITS AND PRODUCTIVITY							
	Positions							
1.00	Physician	0.75	3,210	4,200	3,150			1.00
2.00	Physician Assistant	0.85	2,313	2,100	1,785			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	0			0		5.00
6.00	Clinical Psychologist	0.00	0			0		6.00
7.00	Clinical Social Worker	0.00	0			0		7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0		7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0		7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.27	16,764			16,764		8.00
9.00	Physician Services Under Agreements		0			0		9.00
						1.00		
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,949,750		10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0		11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,949,750		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)					568,627		14.00
15.00	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	Allowable GME overhead (see instructions)					0		17.00
18.00	Enter the amount from line 16					1,271,997		18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,271,997		19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,221,747		20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

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

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

Worksheet M-2

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

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	RHC II Greater of col. 2 or col. 4	Cost
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.00	0		0	0	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.00	0			0	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					0	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)					0	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					0	14.00
15.00	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)					0	17.00
18.00	Enter the amount from line 16					0	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					0	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					0	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1319 | Component CCN: 14-8587 | Period: From 06/01/2022 To 05/31/2023 | Worksheet M-2 | Date/Time Prepared: 10/24/2023 5:18 pm

RHC III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.16	5,274	4,200	4,872		1.00
2.00	Physician Assistant	0.03	72	2,100	63		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	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.45	17,192			17,192	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					2,118,613	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)					2,118,613	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)					372,778	14.00
15.00	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)					0	17.00
18.00	Enter the amount from line 16					1,320,642	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,320,642	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,439,255	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

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

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

Worksheet M-2

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

RHC IV

Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.01	11	4,200	42		1.00
2.00	Physician Assistant	0.20	513	2,100	420		2.00
3.00	Nurse Practitioner	1.25	3,433	2,100	2,625		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.46	3,957		3,087	3,957	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.46	3,957			3,957	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					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

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

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

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

Worksheet M-2

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

RHC V

Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.01	19	4,200	42		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.84	3,087	2,100	1,764		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.85	3,106		1,806	3,106	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.85	3,106			3,106	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					351,231	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)					351,231	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)					-26,105	14.00
15.00	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)					0	17.00
18.00	Enter the amount from line 16					257,830	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					257,830	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					609,061	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1319 Component CCN: 14-8576	Period: From 06/01/2022 To 05/31/2023	Worksheet M-3 Date/Time Prepared: 10/24/2023 5:18 pm
	Title XVIII	RHC I	Cost

		1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)	3,221,747	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	50,282	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)	3,171,465	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	16,764	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)	0	5.00
6.00	Total adjusted visits (line 4 plus line 5)	16,764	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	189.18	7.00

		Calculation of Limit (1)		
		Rate Period 1 (06/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 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
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	1,606	1,134	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	303,823	214,530	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	518,353	16.00
16.01	Total program charges (see instructions)(from contractor's records)		640,039	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		95,106	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		77,024	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		316,252	16.04
16.05	Total program cost (see instructions)	0	393,276	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		46,014	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		99,101	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		393,276	20.00
21.00	Program cost of vaccines and their administration (from Wkst. 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 instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		411,113	26.00
26.01	Sequestration adjustment (see instructions)		7,893	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		386,091	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		17,129	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1319 Component CCN: 14-8577	Period: From 06/01/2022 To 05/31/2023	Worksheet M-3 Date/Time Prepared: 10/24/2023 5:18 pm
	Title XVIII	RHC II	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		0	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		0	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		0	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		0	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		0.00	7.00

		Calculation of Limit (1)		
		Rate Period 1 (06/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 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
9.00	Rate for Program covered visits (see instructions)	0.00	0.00	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	0	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	0	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		0	16.04
16.05	Total program cost (see instructions)	0	0	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		0	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		0	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		0	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		0	26.00
26.01	Sequestration adjustment (see instructions)		0	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		0	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		0	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1319 Component CCN: 14-8587	Period: From 06/01/2022 To 05/31/2023	Worksheet M-3 Date/Time Prepared: 10/24/2023 5:18 pm
	Title XVIII	RHC III	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		3,439,255	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		65,894	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		3,373,361	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		17,192	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)		17,192	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		196.22	7.00

		Calculation of Limit (1)		
		Rate Period 1 (06/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 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)	254.55	264.22	8.00
9.00	Rate for Program covered visits (see instructions)	196.22	196.22	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor 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 contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	549,416	16.00
16.01	Total program charges (see instructions)(from contractor's records)		566,978	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		65,109	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		63,092	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		347,382	16.04
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 records)		52,097	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		89,250	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		410,474	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		35,364	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		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	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		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	26.00
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	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		3,254	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1319 Component CCN: 14-8615	Period: From 06/01/2022 To 05/31/2023	Worksheet M-3 Date/Time Prepared: 10/24/2023 5:18 pm
	Title XVIII	RHC IV	Cost

		1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)	733,598	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	2,110	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus 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)	3,957	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	184.86	7.00

		Calculation of Limit (1)		
		Rate Period 1 (06/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 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)	201.65	159.13	8.00
9.00	Rate for Program covered visits (see instructions)	184.86	159.13	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	148	104	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	27,359	16,550	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	43,909	16.00
16.01	Total program charges (see instructions)(from contractor's records)		46,170	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		675	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		642	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		31,170	16.04
16.05	Total program cost (see instructions)	0	31,812	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		4,304	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		8,238	19.00
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	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		32,716	26.00
26.01	Sequestration adjustment (see instructions)		628	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		29,960	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		2,128	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1319 Component CCN: 14-8628	Period: From 06/01/2022 To 05/31/2023	Worksheet M-3 Date/Time Prepared: 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 Wkst. M-2, line 20)	609,061	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)	13,860	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus 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, line 9)	0	5.00
6.00	Total adjusted visits (line 4 plus line 5)	3,106	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	191.63	7.00

		Calculation of Limit (1)		
		Rate Period 1 (06/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 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)	113.00	126.00	8.00
9.00	Rate for Program covered visits (see instructions)	113.00	126.00	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	223	158	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	25,199	19,908	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	45,107	16.00
16.01	Total program charges (see instructions)(from contractor's records)		71,881	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		23,685	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		14,863	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		19,518	16.04
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 records)		5,846	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		8,395	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		34,381	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		6,790	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		41,171	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		41,171	26.00
26.01	Sequestration adjustment (see instructions)		791	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		33,337	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		7,043	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet M-4

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

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,790,407	1,790,407	1,790,407	1,790,407	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000662	0.000747	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	1,185	1,337	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	17,593	10,315	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	18,778	11,652	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,949,750	1,949,750	1,949,750	1,949,750	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,271,997	1,271,997	1,271,997	1,271,997	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.009631	0.005976	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	12,251	7,601	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	31,029	19,253	0	0	10.00
11.00	Total number of injections/infusions (from your records)	313	353	0	0	11.00
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 beneficiaries	82	178	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	8,129	9,708	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		50,282	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		17,837	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet M-4

Component CCN: 14-8577 | Date/Time Prepared: 10/24/2023 5:18 pm

Title XVIII | RHC II | Cost

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

		COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		0	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		0	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1319 Component CCN: 14-8587 Period: From 06/01/2022 To 05/31/2023 Worksheet M-4 Date/Time Prepared: 10/24/2023 5:18 pm

Title XVIII RHC III Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,911,763	1,911,763	1,911,763	1,911,763	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000419	0.001526	0.001074	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	801	2,917	2,053	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	12,028	22,793	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	12,829	25,710	2,053	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,118,613	2,118,613	2,118,613	2,118,613	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,320,642	1,320,642	1,320,642	1,320,642	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.006055	0.012135	0.000969	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	7,996	16,026	1,280	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	20,825	41,736	3,333	0	10.00
11.00	Total number of injections/infusions (from your records)	214	780	549	0	11.00
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 beneficiaries	56	508	450	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	5,449	27,183	2,732	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		65,894	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		35,364	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet M-4

Component CCN: 14-8615 | Date/Time Prepared: 10/24/2023 5:18 pm

Title XVIII | RHC IV | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	366,671	366,671	366,671	366,671	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000000	0.000322	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	0	118	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	0	1,023	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	1,141	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	396,743	396,743	396,743	396,743	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	336,855	336,855	336,855	336,855	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.002876	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	969	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	2,110	0	0	10.00
11.00	Total number of injections/infusions (from your records)	0	35	0	0	11.00
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 beneficiaries	0	15	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	904	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		2,110	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		904	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1319 | Period: From 06/01/2022 To 05/31/2023 | Worksheet M-4

Component CCN: 14-8628 | Date/Time Prepared: 10/24/2023 5:18 pm

Title XVIII | RHC V | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	307,378	307,378	307,378	307,378	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000478	0.001791	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	147	551	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	2,473	4,822	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	2,620	5,373	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	351,231	351,231	351,231	351,231	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	257,830	257,830	257,830	257,830	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.007459	0.015298	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	1,923	3,944	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	4,543	9,317	0	0	10.00
11.00	Total number of injections/infusions (from your records)	44	165	0	0	11.00
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 beneficiaries	22	80	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	2,272	4,518	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		13,860	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		6,790	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1319 Component CCN: 14-8576	Period: From 06/01/2022 To 05/31/2023	Worksheet M-5 Date/Time Prepared: 10/24/2023 5:18 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		389,766	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		02/23/2023	26,339	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	30,014	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-3,675	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		386,091	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		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 Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 14-1319 | Component CCN: 14-8577 | Period: From 06/01/2022 To 05/31/2023 | Worksheet M-5 | Date/Time Prepared: 10/24/2023 5:18 pm

RHC II | Cost

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

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

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

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

Worksheet M-5

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

RHC III | Cost

		Part B mm/dd/yyyy 1.00	Part B Amount 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 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		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
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		7,540	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		445,170	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		3,254	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		448,424	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

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

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

Worksheet M-5

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

RHC IV | Cost

		Part B mm/dd/yyyy 1.00	Part B Amount 2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		33,272	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		02/23/2023	1,533	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	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 3.50-3.98)		-3,312	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		29,960	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		2,128	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		32,088	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1319 Component CCN: 14-8628	Period: From 06/01/2022 To 05/31/2023	Worksheet M-5 Date/Time Prepared: 10/24/2023 5:18 pm
		RHC V	Cost

		Part 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 submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		33,337	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		7,043	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		40,380	7.00

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